Agenda

Solent NHS Trust In Public Board Meeting

Monday 3rd August 2020 – 9:30
Zoom Meeting

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	***Previous minutes , matters arising and action tracker**	Chair	To agree
3	09:45	5mins	**Safety and Quality first & feedback from Board to Floor Visits**	Chair	Verbal update
4	09:50	5mins	**Freedom to Speak Up matters**	Lead F2SU NED	Verbal update
5	09:55	30mins	**Patient Story – Podiatry Service**	Chief Nurse	To receive
6	10:25	30mins	**Staff Story**	Chief People Officer	To receive
7	10:55	10mins	**Break**		
Strategy & Vision					
8	11:05	30mins	**Chief Executive's Report**	Chief Executive	To receive

9	11:35	20mins	**Performance Report** *Including:* • *Operations* • *Workforce* • *Quality* • *Financial* • *Research* • *Self-Declaration*	Executive Leads	To receive
10	11:55	10mins	**Emergency Planning Resilience and Response to Covid 19**	Chief Operating Officer Southampton	To receive
11	12:05	10mins	**Infection Prevention and Control Board Assurance Framework**	Chief Nurse	To receive
Reporting Committees and Governance matters					
12	12:15	5mins	**Workforce and OD Committee -** *Exception report from meeting held 21st May, & 16th July 2020*	Committee chair	To receive
13	12:20	5mins	**Community Engagement Committee –** *Verbal update from meeting held 26th May 2020*	Committee chair	To receive
14	12:25	5mins	**Mental Health Act Scrutiny Committee –** *Exception Report from meeting held 20th July 2020* **Including:** • **Committee Annual Report**	Committee chair	To receive
15	12:30	5mins	**Audit & Risk Committee –** *Exception Report from meeting held 19th June 2020*	Committee chair	To receive
16	12:35	5mins	**Quality Assurance Committee-** *Exception Report from meeting held 21st May and 20th July 2020* **Including:** • **Committee Annual Report** *(appendix 1 of July exception report)* • **Safe Staffing Report** *(item 16.3)* • **Infection Prevention Annual Report** *(item 16.4)* • **Safeguarding Annual Report** *(item 16.5)*	Committee chair	To receive
17	12:40	5mins	**Governance and Nominations Committee –** *Exception Report from meeting held 5th June 2020* **Including:** • **Committee Annual Report** *(appendix 1 of exception report)*	Committee chair	To receive

18	12:45	5mins	**Finance & Infrastructure Committee - non-confidential update –** *Exception Report from meeting held 22nd May 2020* **Including:** • **Finance Committee Terms of Reference** *(changes highlighted) (Item 18.1)* • **Scheme of Delegation** *(Item 18.2)* • **Committee Annual Report** *(Item 18.3)*	Committee chair	To receive
19	12:50	5mins	**Board Terms of Reference- Annual Review** *(changes highlighted)*	Associate Director Corporate Affairs & Company Secretary	To agree
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Any other business					
20	12:55	5mins	**Reflections** • *lessons learnt and living our values* • *matters for cascade and/or escalation to other board committees*	Chair	-
21	13:00	5mins	**Any other business & future agenda items**	Chair	-
22	13:05	---	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Chair	-

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Date of next meeting:

- ***Monday 5th October 2020***

Minutes

Solent NHS Trust In Public Board Meeting

Monday 01 June 2020, 09:30-12:25
Virtual Zoom Meeting

Chair: Catherine Mason, Trust Chair (CM)	
Members: **Sue Harriman,** Chief Executive (SH) **Andrew Strevens,** Chief Finance Officer and Deputy CEO (AS) **David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN) **Jonathan Prosser,** Interim Medical Director (JPr) **Helen Ives**, Chief People Officer (HI) **Jackie Ardley**, Chief Nurse (JA) **Suzannah Rosenberg**, Chief Operating Officer, Portsmouth (SR) **Jon Pittam,** Non-Executive Director (JPi) **Mike Watts,** Non-Executive Director (MW) **Stephanie Elsy,** Non-Executive Director (SE) **Gaurav Kumar**, Non-Executive Director (GK) **Thoreya Swage**, Non-Executive Director (TS)	**Attendees:** **Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC) **Jayne Jenney**, Corporate Support Manager & Assistant Company Secretary (JJ) **Sadie Bell,** Data Protection Officer and Head of Information Governance & Security (SB) (Item 10 only) **Sarah Williams,** Associate Director of Research & Improvement (SW) (Items 4&5 only)

*****Judgements and decisions have been made in the context of a Level 4 National Emergency*****

1	**Chairman's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests**
1.1	There were no members of the public in attendance of the virtual meeting. No apologies were received and the meeting was confirmed as quorate.
1.2	The Board were asked to declare any new interests. There were no further updates to note.
2	***Minutes of the meeting held 02 April 2020, matters arising and action tracker**
2.1	The minutes of the last meeting were agreed as an accurate record.
2.2	It was agreed that action numbers AC001850 and AC001851 remain on the tracker with an update to be reported to the October Board meeting.
3	**Safety and Quality First and Feedback from Board to Floor Visits**
3.1	JA explained the new virtual process for Board to Floor visits during the current national emergency. It was noted that particular themes associated with issues relating to Covid are to be reviewed. Dates to be escalated for three Board members to attend the virtual visit. *Sarah Williams joined the meeting at this point.*
4	**Learning and Recovery – Reflection on patient and staff narratives**
4.1	JPr briefly introduced recovery work in progress and SW's leadership of the Academy Team during the pandemic.

	SW presented a film to the Board that provided the experiences of a Covid service user, the battle with the virus and of the care received. Varied individual staff experiences were also shared including the impact of losing a patient, feelings of isolation when working from home and challenges with telephone consultations. CM commented on the powerful messages delivered by the individual participants.
4.2	HI reflected on similar experiences shared during a recent conversation with the British Psychological Society who support community, clinical and occupational psychology. It was acknowledged that further support for differing concerns and challenges is required.
4.3	CM enquired if the Trust is aware of the number of staff accessing physical and mental health assistance at this time. HI confirmed high levels of access that has steadily increased however Solent staff accessing through additional national channels is unknown. The Board discussed staff wellbeing. JPr provided assurance of effective supporting practices in place witnessed amongst staff members.
4.4	CM asked if there is adequate capacity for staff to receive contact from patients who are waiting for treatment. SH confirmed this and highlighted the tolerance of patients in the current environment.
4.5	SW briefed the Board on areas of work undertaken and of the positive learning achieved from the current situation. SE praised the organisation on social media communications providing support to staff, and referred in particular to SH's recent video relating to remote working.
4.6	SR referred to staff lone working challenges and suggested further discussion with other staff members who are more settled into working practice changes, as a learning opportunity. SH drew attention to the need for a solution to help staff continue to feel supported and valued during this time.
4.7	JPi asked if consideration is being given on how to manage an increase in working practice risks. SH confirmed work in progress to ensure continuous engagement with the whole workforce and of consideration being given on how to manage future expected mental health risks. JPr reassured the Board of reviews being undertaken on risk levels associated with new ways of working as part of the QIA process.
4.8	SW described the exceptional evaluation approach taken within the recovery work including case studies and group work to encourage continuous engagement across services. SW also advised there to be a series of blogs available on the internet that share the feelings of staff at this time. **The Board noted the approach being taken.**
5	**Research Development Annual Report**
5.1	The report was received as read. SW informed the Board of clinical trials completed during the past year and of positive changes made to working methods as a consequence.
5.2	SW highlighted changes required to the majority of usual activity to adapt to new ways of supporting the organisation at this time.

5.3	It was suggested that consideration is given to holding a virtual research conference this year following the successful nursing conference held. It was agreed to pursue a virtual event.
5.4	CM highlighted the excellent work of the Research and Development team and of the Trust's achievement of being a leading organisation in this area of work. CM thanked SW for both the Learning from Recovery and Research Annual reports. **The Board noted the Research Development Annual Report.** *SW left the meeting at this point.*
5.5	JPi requested the inclusion of 'Freedom to Speak up Matters' on future agendas for a verbal update to be provided on any issues. It was agreed to include as a standing item at future meetings. **The Board noted the report.**
6	**Break**
Strategy & Vision	
7	**Chief Executive's Report**
7.1	SH thanked JA for her leadership of the successful International Nurses Day event and highlighted key elements of the day. The excellent work of the Communications Team with Mental Health Awareness Week activities and positive links with both local and national media by was also acknowledged.
7.2	<u>Covid Response</u> SH updated the Board on the learning and reflective approach being undertaken to understand services that can be developed and how to maintain a healthy and engaged workforce to continue the delivery of services in a Covid environment. SH briefed the Board on current bed capacity at the Adelaide and of plans to review. The Board was advised of other service reintroductions in response to national changes as they happen. It was noted that Solent continues to work within a local resilience forum and sits at bronze level in a command and control environment.
7.3	TS suggested showcasing positive changes in the media particularly research and development. It was confirmed that the Trust's national profile will be considered during the Board Strategy day. CM reiterated the commendable work of the Communications Team during the pandemic.
7.4	SH briefed the Board on well delivered focus forums with Care Groups to reflect on achievements, learning and outcomes, the themes of which will be shared at the Board Strategy Day. SH commented on the Trust's excellent innovative, creative and supporting response to the Covid pandemic.
7.5	SH updated the Board with regards to the Trust's contribution in the roll out of anti-body testing and highlighted the target to offer 1500-1600 tests per day across Hampshire and Isle of Wight. The importance of prevalence mapping was acknowledged.
7.6	It was noted that there will be no changes to guidelines with regards to the use of PPE and social distancing. The Board was assured of no issues with regards to testing access for staff.

7.7	TS asked how antibody testing links with the national Track and Trace testing initiative. HI shared the Occupation Health response to the latest Track and Trace activity and explained the process in the event of a positive test.
7.8	MW enquired how staff testing is determined. HI explained the coordinating role of the Occupational Health Team and of the recommendations for testing arrangements. **The Board noted the CEO report and further update.**
8	**Performance Report**
8.1	AS explained the purpose of the Covid-19 integrated dashboard to monitor and take action as appropriate on live data received. AS highlighted a reduction in mandatory training and clinical supervision compliance that has been communicated to Clinical Leads to address.
8.2	<u>Regulatory Exceptions</u> • AS highlighted a duplication on the caring element of the NHS Improvement Single Oversight Framework. • AS shared the current sickness rate of 5.2% due to numbers of staff impacted by the virus. • The Mental Health Friend and Family Test completions were noted as being below expectations due to the national hold on the collection of test data however, figures remain above the national average. AS confirmed work planned to improve the current position. • AS reported that data maturity is expected to reach the highest achievement of 95%.
8.3	GK commented on the positive step forward in live dashboard reporting and asked if there are plans to continue going forward. AS confirmed future live reporting intentions.
8.4	JPi enquired about the reported low occupancy in Maples. SR shared various possible reasons including a rise in community care within family units and poorly patients adhering to 'stay at home' messages. It was also noted that Maples currently has no Southern patients.
8.5	MW asked what was meant by inconclusive tests as detailed in the report. HI explained the factors that contribute to an inconclusive test result. It was noted however that all negative results are accurate. JPr added that the data did not provide meaningful statistical analysis based on the low number of cases reported.
8.6	CM asked if VTE risk assessments continue at a high level despite the relax in data capturing. JA confirmed the continuation of risk assessments despite current reporting arrangements.
8.7	<u>Quality</u> • JA highlighted the excellent work of the Communications Team in interpreting and rewriting many versions of Covid related guidance and also of the hard work undertaken by the Infection Prevention and Control Team at this time. • JA illustrated some of the changes made in response to Covid 19 and the intensions to continue with some areas of change in particular, the training of Allied Health Professionals to undertake elements of nursing care to ensure effective clinical time and the avoidance of double up care. Consideration is also being given to future virtual conferences following the successful nursing conference held. • JA informed the Board of a number of diversity and inclusion networks and groups set up including a weekly parenting group and BAME group. • JA briefed the Board on events planned in connection with National Pride month.

	• The re-opening of the complaints process was noted with 6 complaints currently in the system that are being responded to by individual services. JA confirmed that incident investigations have continued.
8.8	GK referred to feedback from the BAME network where the majority of people were open about their problems and how they were feeling. GK will attend when available and provide feedback to the Board.
8.9	TS asked if regular contact was kept with complainants during the pause in process. JA confirmed early conversations were held where possible. TS also enquired if there are lessons learnt with regards to managing complaints differently as a consequence. JA confirmed that learning work has already commenced. JPr also highlighted a review of learning from deaths in progress. CM referred to the reported unexpected deaths and asked if all incidents will be discussed at the Learning from Deaths Panel. JPr confirmed this to be the case.
8.10	SE referred to Covid related deaths and incidents and asked if any related to infection control and also asked if the Trust is confident of full compliance across all sites. JA highlighted challenges with social distancing in clinical settings however provided assurance that all staff working directly with patients wear full PPE. JA explained the process of recording deaths by GPs in the community that are recorded as Solent patients and provided assurance that inpatient unit deaths were not connected with infection control issues.
8.11	It was noted that the Infection Prevention and Control Board Assurance Framework is to be presented to future Boards to ensure oversight and accountability. JPr commented on variable compliance witnessed in wards and of a review to be conducted to ensure appropriate modelling of compliance behaviour. A paper regarding this is to be presented to the August Board following presentation at the Infection Prevention and Control meeting.
8.12	<u>Community Engagement</u> JA briefed the Board on continued work within virtual communities. It was noted that the new appointment of Gordon Muvuti as Director of Partnership will also assist in reaching local communities including businesses and charities and strengthen partnerships going forward.
8.13	<u>Finance</u> • AS confirmed the 2019-20 year-end position. • AS highlighted the concerns raised by Auditors' with regards to the Trust's Going Concern assessment - to be discussed at the Audit and Risk Committee. • Covid-19 expenditure was noted as being consistent with other STPs. AS reported that further guidance received indicates national leaders' expectations of further investment as part of the Covid-19 response. CM commended the work undertaken on finances and CIP achievements.
8.14	<u>Workforce</u> • Improvements to the information reported with the assistance of the Business Intelligence Team were noted.

	• The Board was informed of an increase in workforce size and a control in agency numbers. A reduction in sickness levels was also noted. • HI highlighted a hold on 60% of employer relations cases and of close work with union colleagues to manage the position. Opportunities for an improved future approach are to be considered. • HI explained her new responsibility for the Commercial Team and highlighted the outstanding efforts of the Procurement Team, particularly with regards to PPE. **The Board noted the Performance Report.**
9	**Professional Leadership & Engagement Report**
9.1	No further matters were raised in addition to the report presented.
9.2	TW enquired as to how the clinical strategy and organisational strategy link. JA explained the interconnection. JPr also reported on a review undertaken by service lines on their individual strategies for inclusion in the overarching strategy. It was acknowledged that further consideration of the Trust's overarching strategy will be undertaken at the forthcoming Board away day.
10	**Information Governance Briefing Paper**
10.1	*SB joined the meeting at this point.* DN updated the Board with regards to information governance activity. DN reported on nationally agreed changes to the FOI process following Covid-19 and internal processes adopted by the Trust.
10.2	SB informed the Board of the continued efficient work of the team during her long term absence. It was noted that consideration is being given to upskill staff within the IG Team to cover key areas of work and streamline other areas. SB reported that the Team are working closely with services and IG paperwork is being completed retrospectively due to the extension of the 19/20 toolkit.
10.3	GK asked if GDPR incidents are usually included in the report provided. SB confirmed that all incidents are included and will be reported next time report following a back-data analysis undertaken.
10.4	SE asked how performance reported in appendix b, compares with other organisations. DN confirmed the team to be well established and recognised. DN assured the Board of no issues and confirmed the team to be in a strong position with the only delay to note, due to Covid-19.
10.5	SH asked when previous performance is expected to return. DN confirmed the current re-establishment of practices however highlighted that improvements are dependent on the Covid crisis and how well services can respond to requests.
10.6	CM sought clarification that Board members are compliant with all training requirements. SB confirmed compliance however recommended that the Board receive further advanced bespoke training. SB confirmed that data flow is 90% complete and DN will sign on behalf of the Board when complete. **The Board noted the contents of the briefing.**
11	**Workforce Risk Factors Linked to COVID-19**
11.1	HI explained the purpose of the paper presented to provide information on steps taken to ensure the safety of specific groups of staff.

	HI informed the Board of a risk assessment tool presented and agreed at the WOD Committee, specifically in relation to BAME colleagues, its use and associated communication.
11.2	TS asked if the Trust will be measured against the Board checklist presented. HI confirmed no national monitoring currently in place however is a possibility in the future.
11.3	CM commented that non-executive colleagues do not attend staff network meetings and asked if meetings are currently held within an informal process. HI confirmed this to be the case however encouraged attendance at resource groups.
11.4	The Board discussed appropriate attendance at network meetings. CM suggested that outcomes be shared through patient stories or reported on an adhoc basis to the Board. SH endorsed this suggestion and it was agreed to reflect further on the best way to link between the Board and networks. **The Board noted the report.**
Reporting Committees and Governance Matters	
12	**Workforce and OD Committee Exception Report**
12.1	• MW informed that the May meeting reviewed areas of work currently paused, regressed and progressed. • The Committee agreed to receive regular updates on recovery planning going forward to ensure sufficient assurance of appropriate progression. • Time was given to review the Covid response from a people perspective and the exceptional work of the Occupational Health and Communications Teams was acknowledged. • A decision was made to delay agreement of committee objectives. • BAF scores were reviewed and agreed. • The Committee agreed that organisational effectiveness will be reported to the Board for discussion going forward.
12.2	CM reaffirmed the positive response of the organisation during the pandemic and the importance of successfully embedded cultural values that formed part of the Trust's response. **The Board noted the verbal update provided.**
13	**Community Engagement Committee**
13.1	• SE informed the Board of a flyer being created by the Communications Team to illustrate some of the work undertaken on community engagement that will be circulated in due course. • The Committee discussed progress on the community strategy and delivery plan. • It was noted that the Adults Mental Health BAME Community Partnership is going well with plans to integrate with Positive Minds. • The committee was informed of the significant impact of Covid-19 on the gypsy, Romany and traveller community. • SE informed the Board of support provided by the Southampton team on the setting up of a new Community Covid-19 Support Group via Facebook. • SE reported that Veterans Trauma in Portsmouth are looking at ways to support civilian trauma as a consequence of Covid, particularly for blue light, community and NHS staff.

13.2	The Board discussed the excellent progress made with community engagement and of possible opportunities to engage further going forward. CM asked if the Community Engagement strategy should be reviewed. SE confirmed that a review is planned. **The Board noted the verbal update.**
14	**Mental Health Act Scrutiny Committee**
14.1	No meeting held since the last Board.
15	**Audit & Risk Committee Exception Report**
15.1	No meeting held since the last Board.
16	**Charitable Funds Committee Exception Report**
16.1	GK highlighted key exceptions from the last meeting as per the report provided. In addition, DN advised the Board of his role as executive sponsor to oversee the appropriate spending of the grants received via NHS Charities Together and explained the agreed programmes of spending. It was noted that Mark Young from the Estates Team is in discussions with local building suppliers to ensure money is spent appropriately and updates on the work are to be reported regularly to the committee. **The Board noted the exception report and further update.**
17	**Quality Assurance Committee Exception Report**
17.1	TS provided a verbal update on key matters discussed at the May meeting. • There were no issues raised with regards to Freedom to Speak up or matters of safety. • Partnership governance arrangements across the system were discussed. • A lack of partnership risk management was discussed and Solent's lead in this area was noted. • An update was provided on GA waiting lists and enthusiasm to reinstate the service was noted. • The BAF was received and presentations on future mental health risk expectations were noted. • The Committee received an update on discussions held at the Ethics Panel.
17.2	• Quality Accounts were presented and the good work undertaken over the past year was highlighted. Quarter 4 reporting is to be reviewed in September due to the current pandemic. Whilst reporting delays due to Covid were acknowledged, the Committee was assured of no impact to the monitoring of quality during this time. • The Committee received an update from QIR and of discussions held on the hard work undertaken on medicines management and clinical supervision. The completion of 135 QIAs was noted. • An update on Mental Health Services was presented and it was noted that changes to the Mental Health Act during Covid have not been enacted to date. • The draft Annual Governance Statement was reviewed and received. **The Board noted the verbal update.**
18	**Governance and Nominations Committee**
18.1	No meeting held since the last Board meeting. Next meeting scheduled for 5 June 2020.

19	**Finance & Infrastructure Committee – non confidential update**
19.1	There were no matters to report.
20	**Governance Update**
20.1	Declaration of Interest RC explained the publication of the Board's declarations of interests in the Trust's Annual Report that is to be presented on 19 June 2020. RC explained publishing arrangements on the Solent public website. **TS commented on a further amendment to be made to her declaration of interest form. Changes to be sent to RC for updating prior to publication on the website and in the Annual Report. Action – RC.** **The Board noted the Declarations of Interest and that contemporary updates are published on the public website.**
20.2	NHSI Provider Licence Compliance – Annual Declaration RC advised the Board that the Provider Licence Compliance self-certification is published within the regular Performance Report and explained the requirement to present separately on an annual basis in order to self-certify and share on the Trust's public website, in accordance with the Licence. RC highlighted changes made to Condition 4 to highlight that a report regarding progress made against CQC recommendations will be presented to a forthcoming Quality Assurance Committee. **The Board agreed with the responses outlined against each of the Provider Licence requirements. The Chairman and the CEO formally signed the declaration in agreement.**
Any other business	
20	**Reflections**
20.1	The Board reflected on the benefits of holding virtual Board meetings.
21	**Any other business & future agenda items**
21.1	RC informed the Board of early 'virtual' AGM planning discussions and the possibility of linking with other events.
21.2	CM indicated that today's Board was the last to be attended by JPr and took the opportunity to thank him for his valuable contribution during his time as Interim Medical Director.
22	**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	02/04/2020	6.1	AC001850	BOD1- WRES and D&I Strategy	MW queried inclusion of amendments to the strategy that were requested at the Workforce and OD Committee. **Action- JA to review outside of the meeting.**	Jackie Ardley	The June Board agreed that the action remain on the tracker with an update to be reported to the October meeting.
On Target	Board meeting - In Public	02/04/2020	6.1	AC001851	BOD1- WRES and D&I Strategy	CM commented on the need for further work regarding the strategy objectives. SH agreed and highlighted the need for more in depth narrative. MW also queried full information from the Workforce and OD Committee included within the Roadmap. **It was agreed that JA review and resubmit to a future Board meeting for approval. Action - JA**	Jackie Ardley	The June Board agreed that the action remain on the tracker with an update reported to the October meeting.
Complete	Board meeting - In Public	04/06/2020	20.1	AC001952	BOD1 - Governance Update - Declaration of Interest	TS commented on a further amendment to be made to her declaration of interest form. Changes to be sent to RC for updating prior to publication on the website and in the Annual Report. **Action - RC**	Rachel Cheal	Changes provided and the declaration of interest amended accordingly. Action complete.

Item 8

CEO Report – In Public Board

Date: 27th July 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.

****In light of the Level 3 National Threat (NHS Incident Level 4) contemporary updates will be provided where appropriate in relation to our continued response****

Section 1 – Things to celebrate

Solent Heart Badges

In July, we launched a new way to thank our wonderful colleagues and people in the community for their efforts, help and support during Covid-19. We told the story of Barry Jenkins, one of our security officers at St Mary's and St James' Hospitals, who nominated Dolls House Nursery in Cosham for looking after daughter Ayla during the lockdown. Barry and his wife are both keyworkers and without the nursery they wouldn't have been able to make the additional commitments needed during this time. The badges have been designed with a rainbow pride of place - a symbol that has become synonymous with the Covid-19 pandemic; started by children, who weren't able to attend school, placing pictures of rainbows in their window. And, the heart is a way of demonstrating a connection and people working together. At the time of writing, almost 1,000 badges had been requested, with many more requests coming in. The story was published in the local media.

'Best in class' for positive speaking up culture

Solent NHS Trust has been rated 'best in class' for its positive speaking up culture for the second year in a row. The National Guardian's Office issued its latest national Freedom to Speak Up (FTSU) Index report on Thursday 9 July, which confirmed Solent as the best performing combined mental health, learning disability and community trust in the country. The Trust also had the second highest FTSU index score nationally.

Armed Forces Day

We shared the story of Matt Boyle, an army veteran who now works as a wellbeing advisor for the Positive Minds service in Portsmouth. He talked about his 24 years' service, how his father, himself an army veteran, had serious mental health issues which greatly impacted on him as a child, staying with him and eventually influencing Matt's choice to access mental health support when he knew he needed it. His story was published across our social media channels and in the Portsmouth News and BBC Radio Solent.

Children's Zoom

Children whose parents or guardians work across Team Solent were invited to join a special Zoom call hosted by Chief Executive Sue Harriman, Chief Nurse Jackie Ardley and Chief People Officer Helen Ives. It was an opportunity for the Trust to personally thank the children for supporting their parents over the lockdown and they told us how proud they were of their mums and dads. The story was featured on ITV Meridian and included an interview with Jackie Ardley.

Section 2 – Internal matters (not reported elsewhere)

Covid-19 Link to BAF #61 - Major Incident and external environmental impact on the organisation.

Local outbreaks

Our Emergency Planning lead has been working with our Infection Prevention and Control Team to produce a 'summary card' on the necessary actions to be taken in the event of a local outbreak of Covid-19. The process will be tested within in-patient areas during mid-July after which the cards will be available (following any learning that needs to be incorporated) to all staff, including bank and agency colleagues.

In the event of an outbreak Public Health England (PHE) would be informed, and their outbreak team will liaise and assist the Trust as necessary. Similarly, in the event of a local lockdown, Regional and Local Gold Command structures would be implemented.

Risk Assessments

Link to BAF #61 - Major Incident and external environmental impact on the organisation.

We have received a number of letters requiring action, from the Department of Health and Social Care and NHS England and Improvement, with regard to the completion of Covid-19 Risk Assessments for people for whom the adverse outcome of Covid-19 is known to be the greatest. This includes people who are Black, Asian or Minority Ethnic, men, those with a long-term condition, white people aged over 60 and people who are pregnant. The People Services Team and managers are working to ensure that we reach the 100% target by 31st July, acknowledging that full compliance may be difficult to achieve due to factors beyond our control (such as sickness absence and leave). These will be noted and reported accordingly. The latest reports on compliance are provided in the Appendix 1.

The 5 Steps to Safer Working risk assessments are being carried out by the Facilities and Health & Safety team in conjunction with managers. Together with individual risk assessments, they will provide the mechanism for keeping our people safe at work. The entire risk assessment approach is underpinned by compassionate and inclusive leadership and is being supported by our staff resource groups.

Vitamin D Testing

We are working with BAME staff who would like vitamin D blood test. Vitamin D is considered to be an important factor in supporting individuals to build resistance to Covid 19 and is less prevalent naturally for BAME individuals and older people. Since the commencement of this exercise, many individuals will now be going outside and getting more exposure to sunlight as a result.

Director of Infection Prevention and Control (DIPC)

From 1st August, I will be taking on the leadership role as the DIPC - my expertise as a registrant in the field of infection prevention and control enables me to provide support and leadership in the field both at a Trust and regional level. The Infection Prevention Control Team will continue to be managed within the Chief Nurse directorate.

Update from Trust Management Team (TMT) meeting

Over the last few weeks we have been considering our executive management meeting structure, and will be adjusting the remit and function and title of TMT, to 'Senior Leadership Meeting' (proposed title) – to include a briefing from the CEO and the opportunity to collectively tackle cross cutting topics and issues as a group. The new terms of reference will be implemented in September 2020, following discussion and consideration at the TMT meeting on Wednesday 29th July. An update following the meeting will be provided at the Board meeting.

Appointments

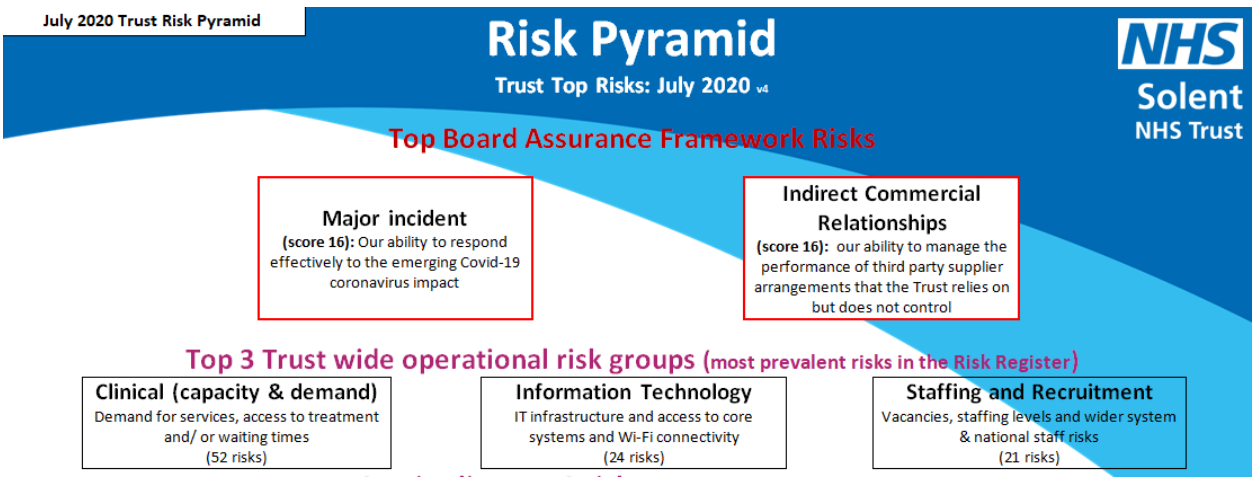
I would like to take the opportunity to formally thank Jonathan Prosser, Interim Medical Director, for his support and leadership since December 2019, and welcome Dan Baylis as our new Chief Medical Officer. Dan joins us from early August 2020 and Jonathan will be remaining with us as Chief Clinical Information Officer.

We are also delighted that NHSE/I have extended Stephanie Elsy, Non-Executive Director, for a second term, until 31/08/2024.

We informed the Board at the June meeting that Dr Sally Kidsley, Clinical Director for Sexual Health Services had succeeded in securing a consultant post in south Wales and left the Trust in early June, consequently we have appointed Clare Schofield as Interim Clinical Director.

Operational Risk Register / Board Assurance Framework

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



Services continue to raise and review risks with regards to the on-going Covid-19 response and the move to recovery/ reset. The Equality Impact Assessment and Ethics Panel process ensures that service and process change risks are reviewed, scrutinised and captured. There is no change to the Trust's overall risk profile. Clinical (capacity and demand), staffing and recruitment, and IT remain the most prevalent risk groups on the Risk Register. The Coronavirus (Covid-19) risk on the register continues to be reviewed and updated by the Trust Emergency Planning and Business Continuity Lead. Of note is a new Covid-19 risk raised in regards to risk assessment of vulnerable staff.

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

BAF number	Concerning	Lead exec	Raw score	Mitigated score (Current score)	Target score
61	Major incident and external environmental impact on the organisation (COVID-19)	David Noyes	20	20 External / 8 internal ↓ / 16 overall↓ (previously 20)	12
63	Indirect Commercial Relationships	Helen Ives	20	16 External / 6 Internal / 16 overall↔	12
55	Workforce Sustainability	Helen Ives	20	16 External / 6 Internal↓ / 12 overall↓ (previously 16)	9
58	Future organisational function	Sue Harriman	20	12↔	6
59	Business as Usual - Demand and Capacity	David Noyes & Suzannah Rosenburg	16	12↔	6
57	Quality Governance, Safety and Professional Standards	Jackie Ardley	16	12 ↔	6
65	Covid-19 Recovery and re-set	Sue Harriman	16	12 (new)	9 - by end Q4, 6 - by Q3 21/22

All risks have been updated in consideration of impact for Covid-19. New risks have been incorporated within the BAF as follows:

- BAF#65 regarding recovery and re-set (mitigated score 12)
- BAF#66 regarding Partnerships (mitigated score 9)

The full BAF is presented to the Confidential Board.

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

Wheelchairs Link to BAF #63 – Indirect Commercial Relationship Risks

We were recently informed by Southampton City Clinical Commissioning Group that following a fully competitive tendering exercise for the Wheelchair Service across Southampton and South West Hampshire, that the new contract has been let to Millbrook Healthcare Limited (the current provider), commencing 1st April 2021. We were engaged in the tender process throughout to ensure our experiences help to inform the revised service

specification and shape the new service model, including via an engagement survey and participation in a healthcare professionals' workshop. We will continue to engage and work with Millbrook Healthcare throughout the mobilisation period to ensure the best possible outcomes for our patients.

Southampton Systems update

Link to BAF#59 – BAU Demand and Capacity

As previously reported, the Covid- 19 crisis has provided an opportunity to accelerate cross organisational collaboration within the Southampton /South-West System. Daily system calls have now reduced to 3 per week, with one being dedicated to system-reset. We have collectively developed a system restoration plan, focussing on the next few months, whilst being mindful of the risk of a potential second wave. The system continues to work closely together, using the framework of priorities agreed by the Hampshire and Isle of Wight Integrated Care System (HIOW ICS) on longer term recovery plans.

Whole system capacity

We have been monitoring activity levels via a shared business intelligence performance and activity dashboard and have started to see an increase in activity within the Emergence Department and within elective areas. In response, we have taken whole system capacity decisions, jointly and in collaboration, allowing for coordinated bed capacity in the community. Bed occupancy in both the Acute and across the community is around 70%; demand for rehabilitation and reablement is growing, and we continue to examine both the risk of managing increasingly complex post-Covid-19 patients in the community and options to extend our 'home first' care capability.

We reacted swiftly by generating additional bed capacity in the system at the Adelaide Health Centre (AHC) and we created the opportunity to utilise the wards at Royal South Hants (RSH) Hospital for patients who needed support with breathing (with the wards at the RSH having a piped oxygen supply). Thankfully, the size and scale of the crisis locally was not as first envisaged and so we have converted Fanshawe ward at the RSH back to its original purpose of step down rehabilitation and are using the opportunity created to complete capital improvement works, modernising and enhancing the patient experience in Lower Brambles. Two areas comprising of single rooms at the AHC have been used for inpatient rehabilitation admissions and we plan to revert the site to its original purpose whilst retaining the ability to reconfigure the facility in the event of another extreme crisis.

Community nursing

We have sustained our community nursing support in the city throughout with a focus on supporting patients in most need of support for example those with palliative care needs, insulin and catheters etc. Our integrated (with city council) community rehab and reablement teams have, and continue, to operate an effective central admission avoidance/early supported discharge hub in the city.

Primary care, podiatry and Musculo-skeletal Services (MSK)

We have continued to deliver urgent interventions and remote consultations and are planning to restore podiatry and GP services from the first floor of AHC from mid-July with MSK services returning to the site in early August (they have been delivered from our Stoneham facility for the duration). We have continued to operate the Portswood site of our GP surgery, in partnership with our PCN colleagues from St Mary's surgery, as a Covid-19-cold site, while the Nicholstown surgery site is providing the GP hot- Covid-19 site for the city, currently under our partners from SPCL.

Children's services

C&F West are similarly starting to reconfigure services with a clear emphasis on the vital role school nurses will play at the present time. Service are also planning how to execute the forthcoming immunisation/vaccination round in the context of necessarily restricted access to schools, school buildings, and distancing/PPE requirements. As a consequence of the pandemic, we are anticipating a rise in Child and Adolescence Mental Health Service (CAMHS) referrals – as such we are already implementing learning from the Covid-19 period and will implement a more flexible pathway to the right level of intervention following group work and assessment of

clients.

Southampton Care Group

Having set out our priorities for the future in terms of recovery across the Care Group on 7 May, the Trust has conducted a series of focus forums which have endorsed our approach, which are playing well into the system plans.

County services update Link to BAF#59 – BAU Demand and Capacity

Specialist Dental Services

Our specialist dental services, having provided clinics for emergency dental treatment across the county during the peak of the crises, are now extending the service offer and are able to see a limited number of priority cases (vulnerable patients). We have even been able to do a very limited number of General Anaesthetic sessions and have more planned. As this is an aerosol generating process the service has to be very careful indeed and recovery is likely to take some time. Although we are able to monitor, triage and prioritise patients on our waiting lists, it is unfortunately inevitable that we are seeing a growth in waiting lists in this area, given the very restricted capacity we are currently able to deploy.

Sexual Health Services

Our sexual health services have sustained the ability to respond to urgent referrals throughout, and are now in the process of returning to a more recognisably normal service while retaining measures that proved effective via phone or remote consultations. The first few months of service delivery on the Isle of Wight have gone well with the new team inducted and operating under Solent policies and governance.

Portsmouth and South-East Hampshire (PSEH) Systems update Link to BAF#59 – BAU Demand and Capacity

PSEH Integrated Care Partnership (ICP) has shown itself to be a well-functioning system with a good level of trust and co-operation. In response to the pandemic, daily system calls were implemented from the middle of March which have only recently reduced to 3 times a week. The system has been Opel 1 (green) status since the pause on elective work in late March to ensure there was sufficient bedded capacity at Portsmouth Hospitals NHS Trust (PHT) in preparation for the anticipated peak in demand from the pandemic. PHT's plans to restart elective work will increase occupancy. Community bed occupancy across Southern Health NHS Foundation Trust & Solent has remained low with an average of 60 - 70% occupancy. However, demand for home based rehabilitation and reablement services (PRRT for Solent and IIC for Southern) is now returning to pre Covid levels.

The PSEH collective target for 3 hour discharges and a medically fit for discharge list of less than 30 is only being partially achieved and remains a challenge for all partners.

Work has now begun to reset the Integrated Care Partnership (ICP) work programme with the identification of 3 strategic objectives; Patient Flow, Place Based Care and Health Communities which will have a number of cross cutting workstreams e.g. mental health, children & families.

All partners are committed to taking the learning from Covid-19, in terms of collaborative behaviours, more effective ways of working and high impact service changes that need to be retained.

Mental Health Services

Mental Health services in the City have continued with remote consultations where possible and face to face as necessary. In partnership with Southern Health, Solent rapidly mobilised a mental health Emergency Department redirection service based at St James in preparation for the expected pandemic peak in April. Early learning from this service change suggests this pathway delivers a better experience for patients and has been identified as one of the High Impact Changes for the PSEH ICP.

Mental Health demand is now rising back to pre Covid-19 levels with increased acuity presentations for admission to our wards. Hampshire and Isle of Wight (HIOW) Integrated Care System (ICS) is leading a task & finish group on modelling for a potential mental health surge and there are active discussions between Solent and Southern to develop contingency plans across our Mental Health inpatient services to cope with future demand.

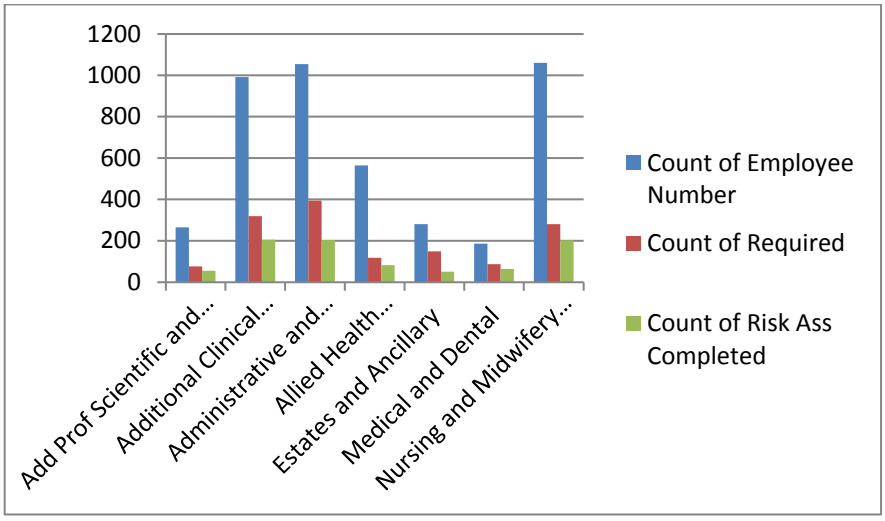
Appendix 1– Covid 19 Risk Assessments for "higher risk" colleagues

The Department of Health and Social Care (DHSC) and NHS England and Improvement (NHSI) have asked all NHS employers to complete Covid-19 Risk Assessments for staff where it is known the risk of an adverse outcome of Covid-19 is greatest. This includes people who are Black, Asian or Minority Ethnic, men, those with a long-term condition, white people aged over 60 and people who are pregnant. A target of 100% completion has been set for 31 July 2020. The Chief People Officer is Solent's Senior Responsible Officer for completion of risk assessments.

As at 24th July 2020, the Trust's performance against target stands at 70% of all willing and available "higher risk" staff with a good number of risk assessments still underway locally in departments. 50 additional risk assessments have been received since the data below was compiled and we expect to see a number more received in our Occupational Health department each day between 27 and 31 July 2020, when our progress will be reported to DHSC and NHSI.

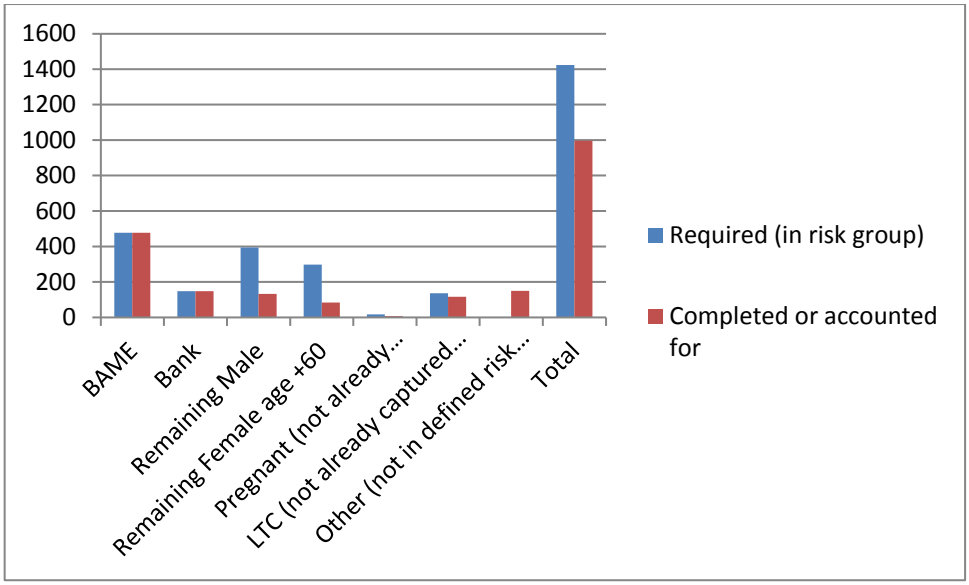
When taking into account our total BAME population we have received completed risk assessments for 80% of BAME staff. Some have exercised their right not to complete a risk assessment and others are absent from work and unable to complete a risk assessment for legitimate reasons such as maternity or adoption leave and/or other non-Covid related absence. As a group BAME colleagues are considered to be at greater risk of an adverse outcome upon contracting Covid 19 and we have contacted all staff a number of times as well as writing to each at their homes. As at 24th July 2020 we are confident that we have risk assessed 100% of BAME staff who are willing and available to be risk assessed.

Risk assessments completed by staff group:



Please find results for all higher risk categories as at 24th July 2020 below. Staff are segmented to ensure we do not duplicate results i.e. a member of staff could be BAME, male, aged over 60 and have a long term condition. We have therefore created a hierarchy to reflect this.

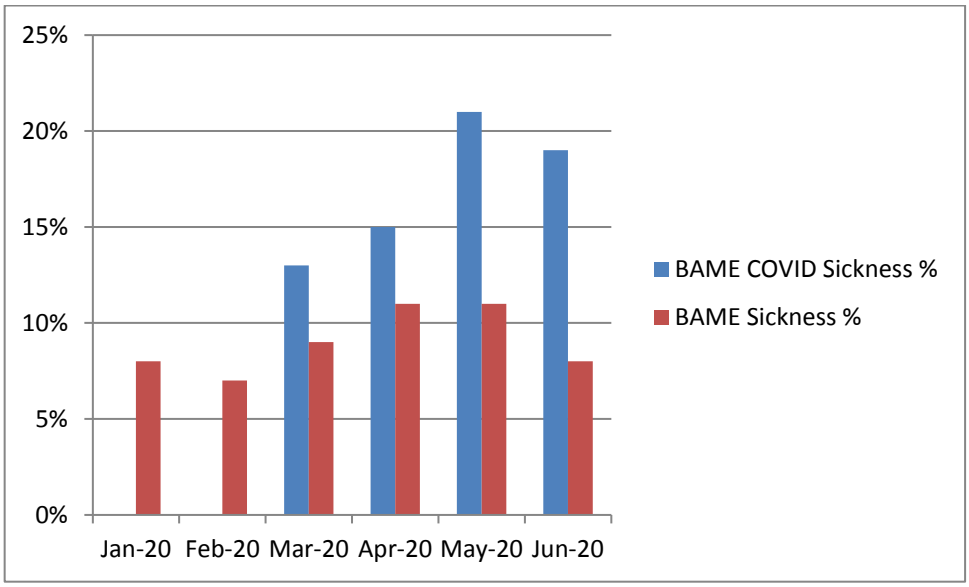
Risk assessments received for all "high risk" staff groups as at 24th July 2020:



We have completed risk assessments for 100% of newly qualified, bank and returning staff (NHS campaign to bring qualified staff back into practice to support the national response to Covid 19). We have put in place arrangements to ensure we can undertake due diligence for agency staff.

We have been monitoring the prevalence of Covid 19 sickness throughout and can confirm that our BAME colleagues' sickness absence to Covid is 10% higher than sickness for other reasons (as a percentage of total sickness absence for staff of all ethnicities).

Our BAME staff population is 10.8% of all staff, including our bank staff.
BAME staff sickness absence usually runs at 10% or below as a proportion of all sickness, but sickness absence due to Covid saw a doubling of BAME staff sickness absence as a proportion of all Covid sickness absence. This reinforces the need for completion of risk assessments to ensure that high risk colleagues are not placed in higher risk roles or areas and have access to appropriate and/ or enhanced measures where considered necessary.



Board and Committee Cover Sheet

Item No.	9

Presentation to	*In Public Board Meeting*			
Title of Paper	Trust Board Performance Report – April 2020			
Purpose of the Paper	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.			
Author(s)	Alasdair Snell	Executive Sponsor	Andrew Strevens	
Date of Paper	24/07/2020	Committees/Groups previously presented	TMT	
Action Required	For decision?	N	For assurance?	Y
Recommendation	*The Board is asked to:* • *Receive the report*			

For presentation to Board and its 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: Sufficient assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

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1.1 Operational Performance Dashboard

Month: Jun-20

	Indicator Description	2019/20 Actual (equivilent period)	Internal / External	Threshold	Current Performance	Capability	Variance
Community / Mental Health	Accepted Referrals (in month)	22,094			12,806	?	
	Attended Contacts (in month)	98,802			80,982	F	
	Discharged Referrals (in month)	19,968			10,539	F	
Community / Mental Health	DNA'd Appointments (in month)		I	8%	3.0%	P	
	Rapid Response 2 hour compliance - Portsmouth		E	90%	90%	?	
	Rapid Response 2 hour compliance - Southampton		E	90%	100%	P	
Inpatients	Occupancy Rate (in month) - Community Wards		I	92%	57%	?	
	DTOC Rate (in month) - Community Wards		E	4.5%	5.4%	?	
	Occupancy Rate (in month) - Mental Health Wards		I	85%	54%	?	
	DTOC Rate (in month) - Mental Health Wards		I	4.5%	13.2%	?	
Performance	Waiting List Size - RTT (month end)		I	1,071	524	?	
	Referral to First Appt < 18 weeks		I	95%	89%	?	
	Referral to First Appt < 52 weeks		I	100%	100%	P	

Performance Hotspots

High Priority

- COVID-19 Impact
- 6 Week Diagnostic Target Compliance
- Special Care Dentistry GA Waiting Times
- COVID-19 Operational Recovery

Improving / Positive

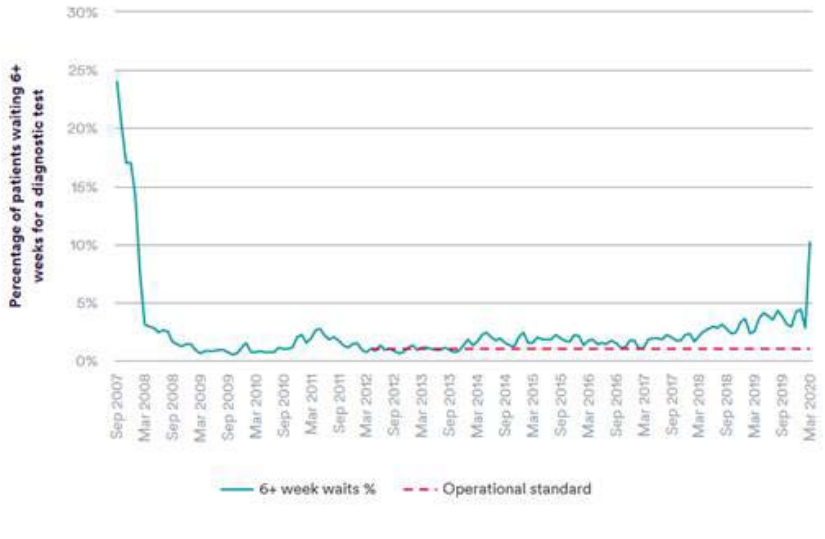
- Clinical Supervision Reported Compliance
- Statutory and Mandatory Training Compliance
- CAMHS National Access Target Performance

1.2 Performance Subcommittee Exceptions

During the Trust's response to COVID-19, a new joint Performance Subcommittee was introduced to cover all Care Groups, replacing the previous structure which reviewed Portsmouth Care Group separately from Southampton and County Wide Care Groups. This has proved beneficial in sharing learning across the Trust and therefore will remain in place moving forwards.

6 Week Diagnostic Target

Between December 2019 and April 2020, the average compliance for patients waiting 6 weeks or less for a diagnostic test was 99% for Solent. However, in May 2020, the performance dropped to its lowest point to date, at 65%. Due to the impact of COVID-19, many diagnostics clinics were cancelled by our third party provider, resulting in this significant increase in breaches. Although the national data hasn't been publicised yet, the NHS England data in March indicates that this is was a growing national issue with performance at 89.8% (see below), the lowest performance in over 10 years. We understand that national waiting time targets have been challenging also for our partner providers across the Hampshire and Isle of Wight system, with comparable performance to Solent reported within the STP.



Source: NHS England, Diagnostic Waiting Times and Activity

The Trust has recorded this issue on the risk register, and it is being monitored through the Performance Governance framework for assurance. We are working with our third-party partners to clinically triage and prioritise patients in the interim period whilst capacity is restored to normal levels.

Clinical Supervision and Statutory and Mandatory Training

In the previous M1 Performance Report to Board, we highlighted the initial increase in clinical supervision within 6 weeks performance had increased from 40% to 55%. After implementing a central bespoke tool that enables our clinical workforce to both record and report supervision compliance quickly and simply, clinical supervision compliance has increased by over 20% to 77%, as at July 23, 2020.

Performance and compliance will continue to be encouraged and monitored through the Performance and Quality Governance frameworks with a change in focus to embed the recording of clinical supervision into the normal working culture for clinicians. As a Trust we are confident appropriate supervision is taking place, however the challenge has been around the recording of it in a centralised way.

The Business Intelligence Team have improved the internal Statutory and Mandatory Training compliance reporting process, enabling staff to access the training matrix daily with up-to-date records. This has meant staff are able to actively monitor their compliance rate. Consequently, the Trust have increased the compliance levels from 78% as reported in the M1 Performance Report up to 91% as at July 23, 2020. This is a significant improvement that we aim to maintain and improve upon through the year, noting its continued importance during the current pandemic.

General Anaesthetic Waiting Times for Special Care Dental Services

Concerns regarding the general anaesthetic (GA) activity within the Special Care Dental Service continue and are reflected by the Trust's top service line risk, with a score of 20. The Dental service line have been managing long waiting lists for some time due to lack of available theatre space within the local system to meet the demand, however as a result of COVID-19, and the cessation of all non-urgent surgical activity, the waiting lists have currently been frozen. As a consequence, we expect to start seeing deterioration in the 18 week local waiting time target for the service in the coming months. There is also a growing backlog of patients awaiting triage, some of whom will require a GA, as well as a likely increase in referrals once routine activity begins again within General Dental Practices. Without an increase in theatre capacity, which will be challenging due to the COVID-19 pressures on our acute partners, the service will be unable to bring the waiting list down to a manageable level. The service is actively exploring innovative alternatives to help increase capacity to reduce the growing waiting lists.

COVID-19 Operational Recovery

Solent is actively working with our STP partner organisations currently to plan how to safely increase service capacity across both the trust and other providers. Careful analyses are being undertaken to map demand, acuity and capacity to do this as quickly as safely as possible. One such innovation is being launched in Solent by the end of July whereby every service in the trust will be able to access their respective waiting lists centrally, to enable oversight, triage and prioritisation using contemporary data than the previous monthly reports at a higher level. This should quickly help increase our clinicians' autonomy and responsiveness to the impact of the pandemic and improve patient outcomes.

CAMHS National Access Target Performance

Historically, due to significant demand on Solent's two CAMHS, it has been challenging to meet the increasing national access target whereby an additional 70,000 children with a diagnosable Mental Health condition receive treatment from an NHS-funded community MH service. For Solent in 2019/20, this meant that 34% of this service user group needed to be met in which Southampton CAMHS achieved 48% and Portsmouth just fell short by 0.9%. However, in 2020/21, the target has increased to 35% and current performance for both cities is significantly exceeding the targets, with Southampton currently forecasting an impressive 93% and Portsmouth at 54%, based on performance YTD after two months. Whilst we would expect this forecast to drop with seasonal variation and a predicted surge in referrals as a result of lockdown, Solent will need to consider between prioritising within existing resource or securing additional resource. This will be the same choice necessary for many of our clinical services across the organisation.

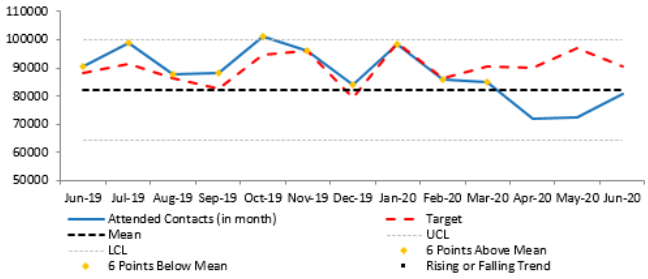
Local Performance (Operational Performance Dashboard, section 1.1)

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:

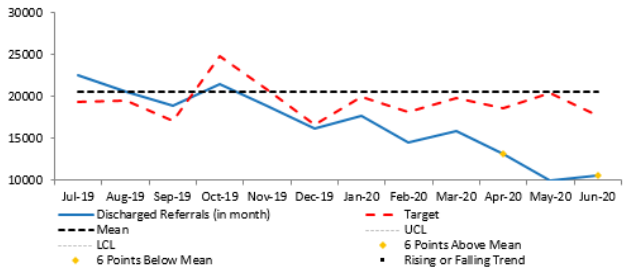
Attended Contacts (in month)

The number of attended contacts has been highlighted on the capability rating this month, following 6 consecutive months below the same period last year. January and February 2020 were just 0.3% and 0.2% lower than 2019, however the number of contacts from March 2020 onwards has declined significantly as a direct result of the cessation of some routine activity due to COVID-19. It is expected that activity will begin to increase over the coming months as services stand back up some routine patient activities.



Discharged Referrals (in month)

The number of discharged referrals in month has been flagged as a 'Fail' against the capability rating this month again as the number of discharges per month has been consecutively lower than the previous year for the past 9 months. The lower levels of discharged patients within the past 4 months are an indication of the reduced routine caseload management processes than services usually undertake, as a result of the focus on urgent referrals and the COVID-19 response.



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

Nothing to note.

1.3 NHS Improvement Single Oversight Framework

Month: Jun-20

	Indicator Description	Internal / External Threshold	Threshold	Current Performance	Capability	Variance
Quality of Care Indicators						
Organisational Health	Staff sickness (rolling 12 months)	I	4%	5.2%	F	
	Staff turnover (rolling 12 months)	I	14%	12.9%	?	
	Staff Friends & Family Test - % Recommended Employer	I	80%	*	*	*
	Proportion of Temporary Staff (in month)	I	6%	6.2%	?	
Caring	Written Complaints	I	15	13	?	
	Staff Friends & Family Test - % Recommended Care	I	80%	*	*	*
	Mixed Sex Accommodation Breaches	E	0	0	P	
	Community Friends & Family Test - % positive	E	95%	97.4%	P	
	Mental Health Friends & Family Test - % positive	E	95%	97.4%	?	
Effective	Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	E	95%	100.0%	P	
	% clients in settled accommodation	I	59%	74.2%	P	L
	% clients in employment	E	5%	5.0%	?	
Safe	Occurrence of any Never Event	E	0	0	P	
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	0	?	
	VTE Risk Assessment	E	95%	92%	?	
	Clostridium Difficile - variance from plan	E	0	0	P	
	Clostridium Difficile - infection rate	E	0	0	P	
	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%	89.3%		
Maximum 6-week wait for diagnostic procedures	E	99%	79.0%		
Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0		
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50%	73.0%		
Data Quality Maturity Index (DQMI) - MHSDS dataset score	E	95%	91.8%*		
Improving Access to Psychological Therapies (IAPT)					
- Proportion of people completing treatment moving to recovery	E	50%	53.3%		
- Waiting time to begin treatment - within 6 weeks	E	75%	100.0%		
- Waiting time to begin treatment - within 18 weeks	E	95%	100.0%		

Use of Resources Score					
Use of Resources Score	E	2	2		

* Data collection paused during COVID-19 pandemic response
** Data reported 3 months in arrears due to NHS Digital publication timescales

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

1.4 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 1.3):

Staff Sickness

The staff sickness indicator shows that without significant intervention, the target will not be achieved. COVID-19 has seen the Trust's sickness levels continued to rise to a peak of 5.3% during May 2020, although this has subsequently reduced to 5.2% in June 2020. Further narrative on Workforce metrics can be found in the Workforce Dashboard Commentary (section 4.1).

Percentage of Clients in Settled Accommodation

The settled accommodation metric looks at the stability of the client cohort utilising our Mental Health services. This metric has been highlighted this month as a significant cause for concern as there has been a downward trend in performance over the past 6 months; however it is worth noting that the target continues to be achieved. This is currently being reviewed by the Service Line to identify whether this decline in performance it is a true reflection of their client cohort.

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

Clostridium Difficile (C.Diff) - variance from plan

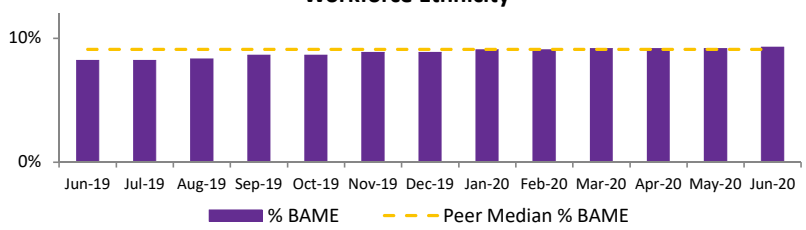
Clostridium Difficile (C.Diff) – infection rate

The C.Diff indicators have triggered a 'pass' on the capability rating this month as a result of no cases being identified with Solent for the past 6 months, which is positive for the Trust.

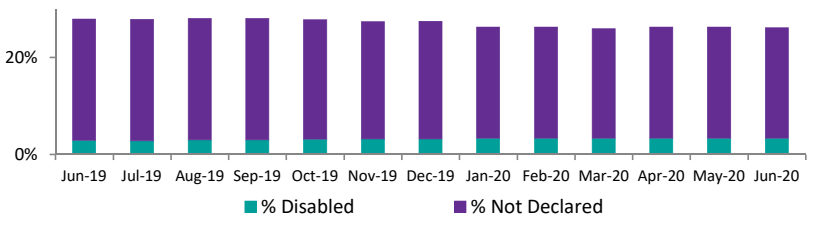
2.1 Workforce Integrated Performance Report — Month: Jun-20

Planning

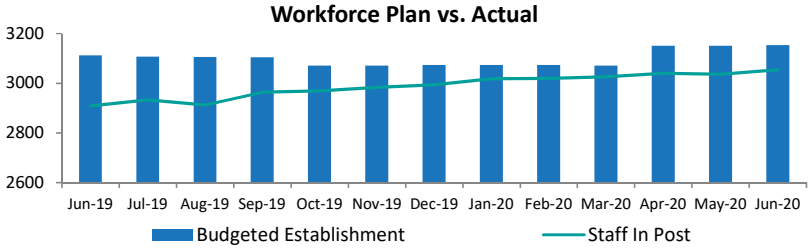
WRES



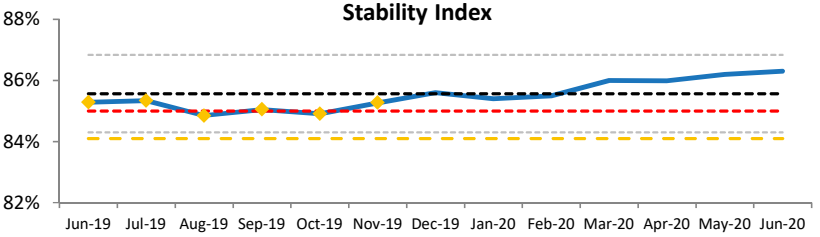
WDES



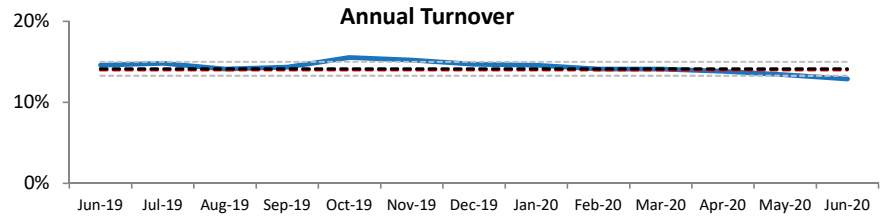
Actual vs. Planned

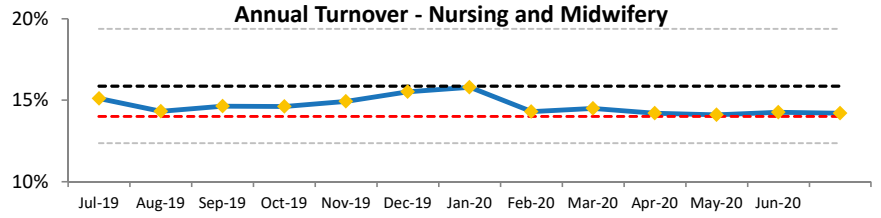


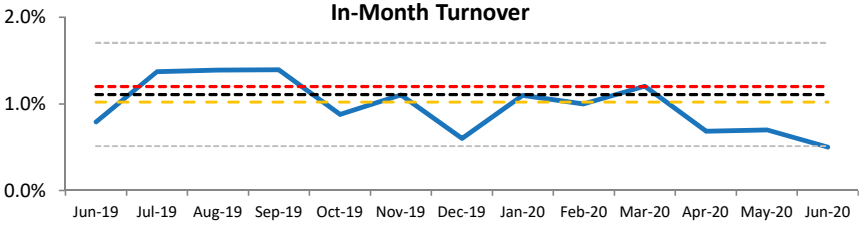
Stability Index



Turnover







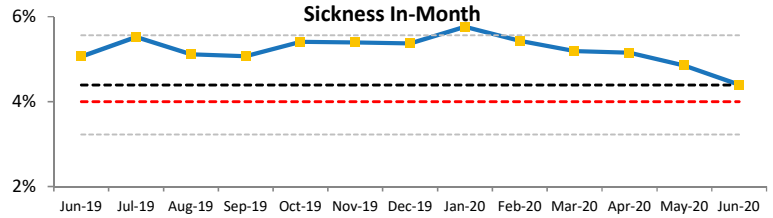
Overall, our Full Time Equivalent (FTE) in post for June is ahead of the workforce plan, however this is based upon temporary budget establishment as COVID has delayed completion of the 2020/21 establishment. Stability and turnover have reduced in recent months and in turn this has improved the vacancy rate. The reasons for this are threefold; a piece of work undertaken to improve retention in Nursing has been successful, the budgeted establishment has been reducing across 2019/20 resulting in a smaller vacancy gap and in the shorter term we also recognise the impact of COVID on the job market. Evidence suggests that people are not changing roles as frequently as they might due to unusual circumstances and the uncertain future of the economy. A specific issue in relation to retention in AMH was added to the risk register and actions agreed at the last WOD Committee, as well as a number of leadership support interventions taking place in that area.

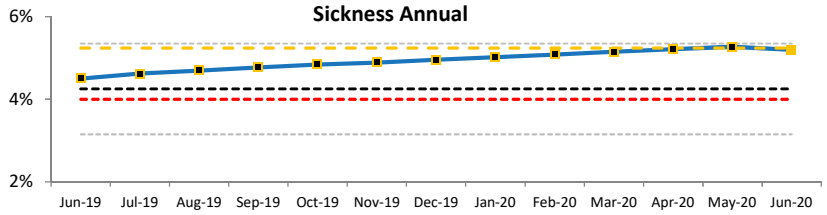
Deployment

Month: Jun-20

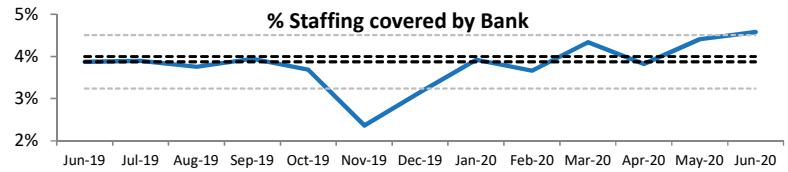
Key: Data | Target | Mean | Upper / Lower Control Limit | 6 Points Above/Below Mean | Rising/ Falling Trend (6 points) | Peer Median

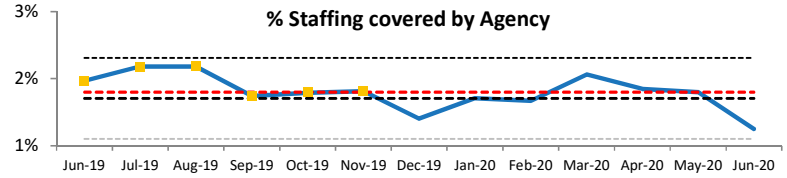
Sickness

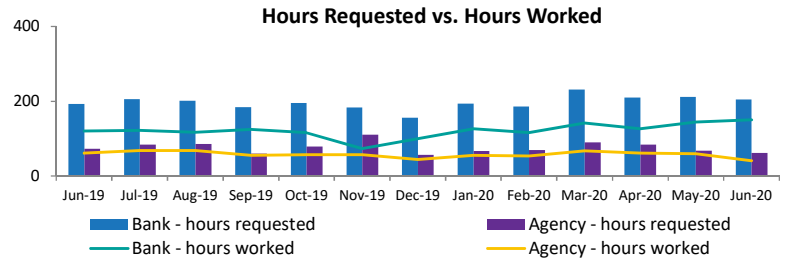




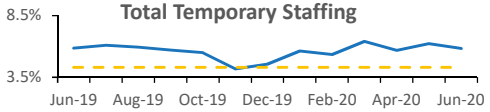
Bank & Agency







In Month Cost: Bank - £323354 Agency - £141463



Rostering

Current Position: 1/ 4

There was a 1% increase in sickness absence year on year to May 2020. This increase is noticed from December 2019 onwards and has ranged from 0.7% increase to a peak of 0.9% in April and May 2020 as a result of COVID outbreak. Sickness levels reduced in June 2020 in line with seasonal expectation. Trend analysis reveals a number of hotspot areas which have been provided with additional support. COVID related sickness will not be recognised for the purpose of formal sickness management. Mental health related absence is a specific area of focus for our Wellbeing Practitioner team. A range of health and wellbeing support packages have been put in place as part of our response to COVID, some of which we will continue to provide and support our move into the reset and recovery phase of our pandemic plan.

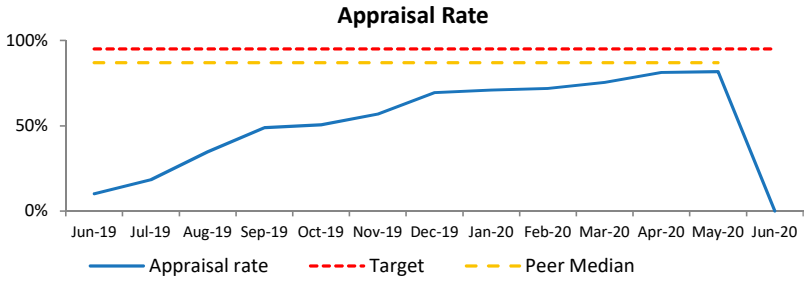
The additional staffing for May 2020 is 5.2%, with 1% coming from Agency staff. Solent Bank continues to perform well and recruited a number of additional temporary staff to provide capacity during our COVID response. We have not had to fully utilise this capacity but are working with individuals to keep them engaged in the event of a second surge and to support a reduction in agency usage where possible. The collaborative bank project has been delayed in the wake of COVID-19; implementation will impact business continuity plans. This was mitigated during COVID by engaging with NHSP to provide a rapid response solution. We will review our use of collaborative bank as part of our ongoing workforce optimisation work.

Additional Rostering support was provided to services to manage the increase in workload created by additional staffing and a number of redeployments, during COVID. We remain at 1 out of 4 against the national attainments. We have received an internal audit report regarding our overall rostering capability and effectiveness, with actions agreed to be delivered in September 2020. Work is progressing on implementation of e-job planning. This will help us attain a level 2 in rostering.

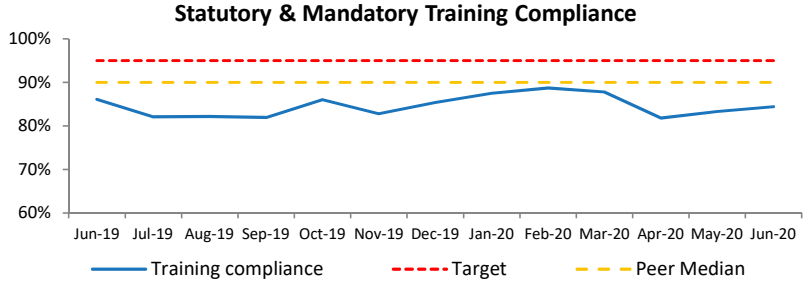
Development

Month: Jun-20

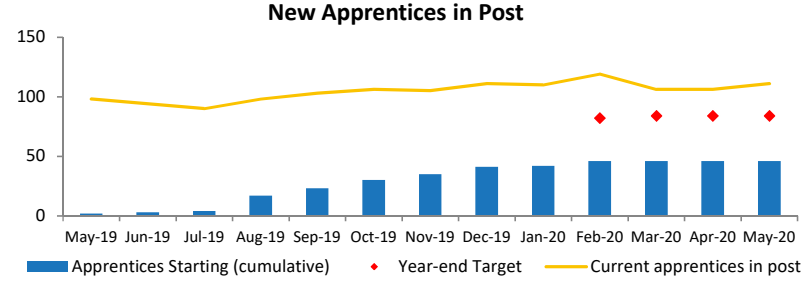
Appraisals



Stat & Mand Training



Apprentices



Engagement

Friends and Family Test

Percentage of Staff who would recommend Solent as an Employer

71%

Q2 2019/20

Staff Survey

Percentage of Staff who would recommend Solent as an Employer

69%

2019/20

The statutory and mandatory training rate in June 20 was 84% against a target of 90%. Training compliance is discussed at PRMs, with the e-learning system cited as an obstacle to success and progress to procure and implement a new system was delayed as we focused on our response to COVID. Reporting of training has moved onto PowerBI which enables managers to monitor their teams performance in real time. 700 sessions of upskilling training were completed between March and June 2020, these were undertaken via a combination of face to face and virtual environments. Appraisals for 2020/21 were paused at the outset of the pandemic but have been re-started with a focus on wellbeing in June with a view to full completion by November 2020. The requirement to provide evidence of completion of 2019/20 appraisal objectives to ensure staff move to their next pay step point has been deferred until 2021/22. Work to implement Manager Self Service in October 2020 will support the implementation of this change, ensuring staff can record appraisals effectively.

A procurement exercise for a new Learning Management System (LMS) has re-started, with implementation due to commence in late 2020 and a go-live planned for April 2021. This will be a significant boost for staff morale, and will strengthen our learning and development infrastructure. An Apprenticeship Academy model is planned to be in place in 2021 and we aim to increase the number of apprentices to 5% above target; we will be seeking to utilise apprenticeships as a structured pathway into the Trust and for career development. This pipeline will also support the succession planning and talent management components of our workforce plans.

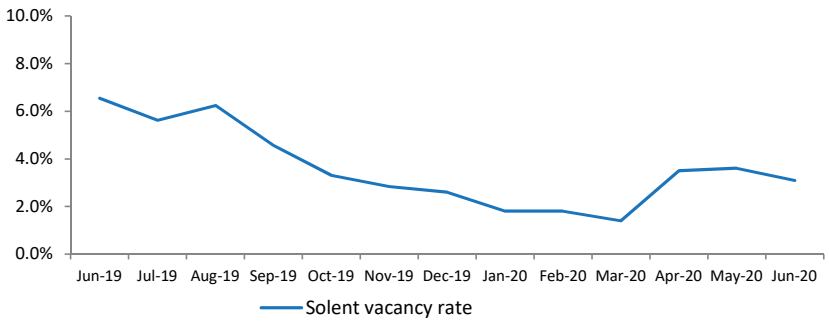
Staff survey results, with national benchmarking, are now being made available to services and we are sharing the analysis more widely across the Trust. Services will be encouraged to create local action plans from their results.

Acquisition

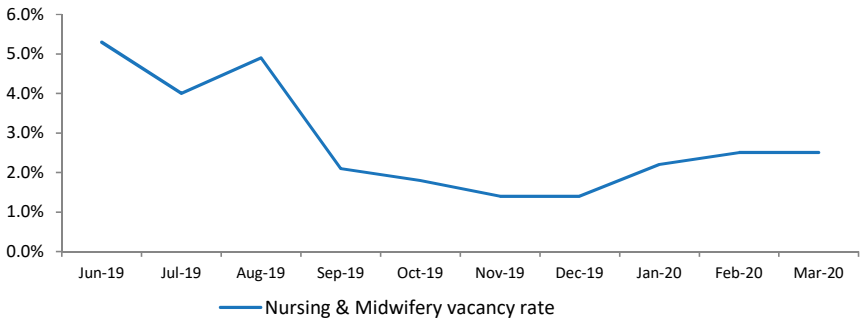
Month: Jun-20

Vacancy Rate

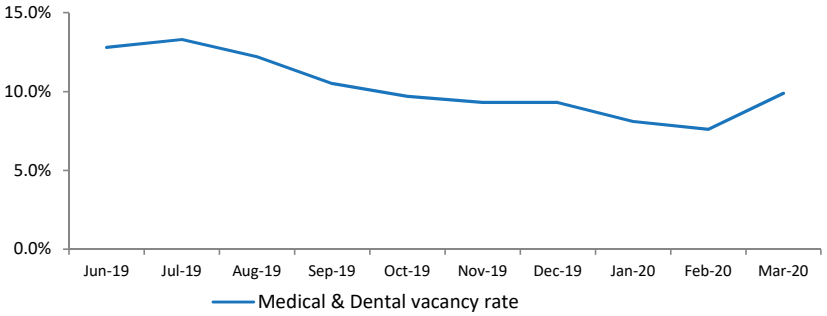
All Staff



Nursing & Midwifery



Medical and Dental



The vacancy rate for June 2020 was 3.1% (based upon 2019/20 budget), showing continued improvement. This is due to a combination of effective recruitment and retention campaigns and the planned reduction in workforce through the year.

Due to the impact of COVID-19, permenant budgets were not allocated to individual service lines or occupational groups. We are able to report against the Trust wide position, as above. We have no adverse turnover rates and are therefore not concerned over growing vacancy rates.

There are pockets across the Trust with higher vacancy rates, such as our Mental Health services with a vacancy rate in excess of 10%. Mitigations are in place (including block booked Agency staff) and detailed in the risk appraisal presented to WOD Committee earlier in 2020. Work continues to fill posts and critical roles in these areas across the Trust.

Leadership and Culture

Month: Jun-20

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' was due to take place on 16 March, followed by the Annual Apprenticeship Awards. However, this has been postponed in the wake of COVID-19 and the need to refocus staff into emergency planning and preparedness. These events will be rescheduled to later in 2020.
Work is underway on the procurement of a new LMS with two systems being demonstrated by providers from our procurement framework. To ensure a collaborative process, these sessions will be attended by staff from across the Trust to ensure that whichever system is selected is fit for purpose and user friendly. It is expected we will implement the new LMS in April 2021.
Work on Improving People Practices continues with the POD team, utilising manager and staff forums to ensure that all areas or gaps are picked up and will be addressed in the delivery of this programme.

Engagement

Solent NHS Trust has been named joint best performer in the Health Service Journal (HSJ) top 5 Mental Health and LD Trusts in relation to whether people said they would be happy with the standard of care at their organisation should a family or friend need treatment. Our response rate was the highest we have ever achieved at 63%, 2149 people completed the survey which is a 4% increase from 2018. Compared to other combined Community, Mental Health and Learning Disability Trusts, we scored better than average in 10 out of the 11 themes, and amongst the top scoring overall in 5 out of the 11 themes. We have shared service level analysis during the 1st week of July so that each area can create local action plans for improvements. We expect to utilise PowerBI tools in future which should significantly reduce the time required to analyse our results and provide meaningful information to our services, allowing more time to determine the actions which will provide most value for staff and implement those actions.

Leadership

The research we commissioned on the 'State of the Nation' review which is an independent look at our values, leadership and culture was reported at the March Workforce & OD (WOD) Committee.
Our Leading with Heart programme attracted the Award for Excellence in Professional Practice by the Division of Occupational Psychology, for our team who worked closely to develop the programme.
We are now taking our next step to offer our middle management community a Leading with Heart intervention, with session being scheduled for these cohorts.

Inclusion

We continue to work towards our Inclusion Objectives. Work continues across the D&I and POD teams to turn the data we have into intelligence and create meaningful interventions in the coming year to bring about positive change. In the next 6 months we will create a deep dive of the reporting of our diversity data, the impact of this in our understanding of the data and what our approach to people practice are, with this having been highlighted in previous WRES returns.
We will continue to bring focus to special events and months. COVID-19 has highlighted a number of inequalities for our staff in relation to ethnicity, long term conditions and age. We are piloting an initiative to support managers and staff to positively approach observations and disclosures as a result of the recent heightened awareness of the lived experience of our BAME staff. Roger Kline, an eminent authority on diversity is sharing his research in the context of Solent WRES performance to our Board and Senior Leaders during w/c 6 July 2020.

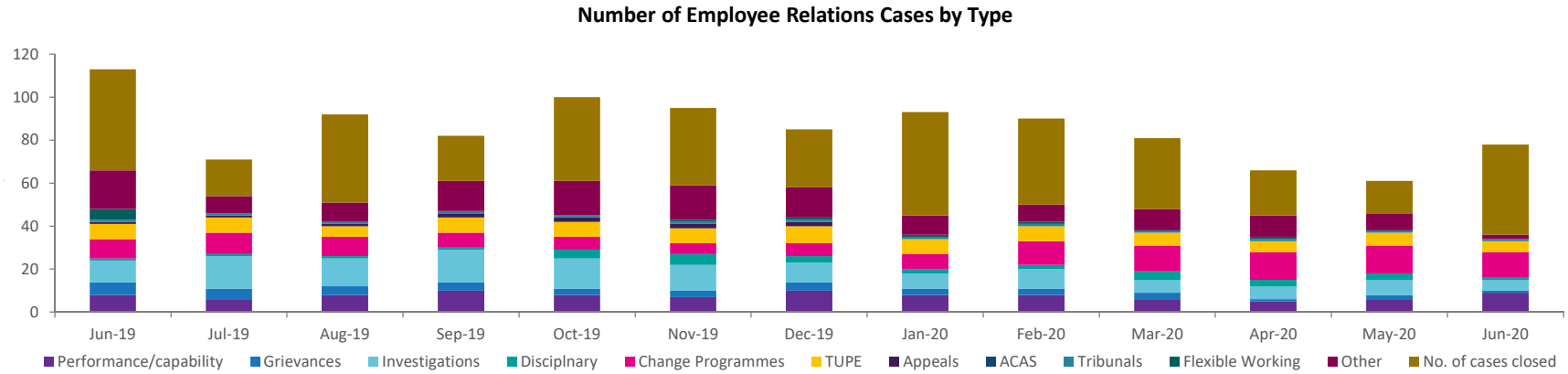
Wellbeing

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. A number of additional wellbeing interventions have been made available for staff during our response to COVID-19, these have been well received and it is expected that we will want to continue to provide some of these interventions as we seek to return to our new normal.
Although resource heavy, our teams have been piloting schemes in some teams to provide intensive support and have followed up 3 months later, with a plan to follow up again at 6 months post intervention, to see if they are still being utilised and are as effective. Results from the 3 month stage are promising and show sustained improvement.

Change and Employee Relations

Month: Jun-20

Employee Relations



Across the year we have seen a decrease in the overall Employee Relations (ER) cases from June 2019 to June 2020 with 87 cases currently being managed by the team as at 30 June 2020 (19 on hold due to COVID . We are managing a number of complex cases and have 15 cases of organisational change (3 on hold) and 6 TUPE projects (1 on hold). We will be working with Trade Unions to start to move forward on the cases on hold for the benefit of staff involved.

Since December, a People Management Action Forum has been operating, providing an opportunity for plurality in decision making and exploration of a wide range of options for managing employment relations issue whilst maintaining a person centred approach. This forum has been successful and has seen discussions held on a range of suspension and dismissal processes.

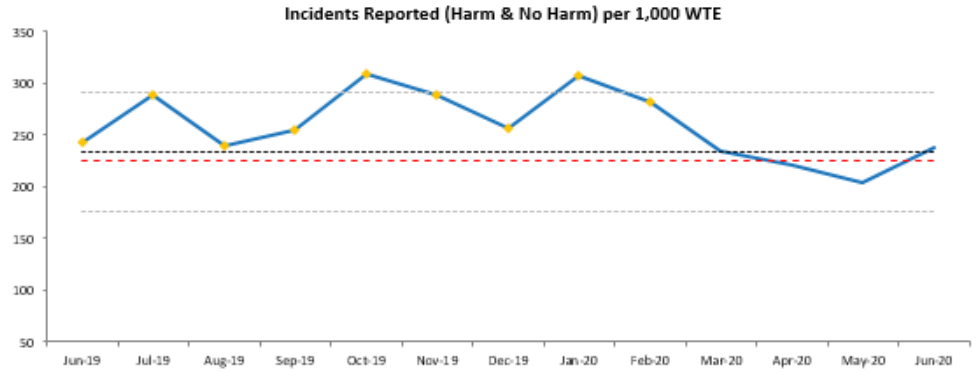
In the context of policy reviews, we are part way through a review of current polices to place people at the centre of our response and to focus on promoting informal resolution. We are currently reviving our work to establish a Just Culture, through a leadership development and manager skills programme. This programme will ensure that those involved in ER cases are appropriately equipped with the right skills to reflect Solent's values when handling challenging circumstances.
The complex cases we manage are overseen by case managers assigned independently and where necessary, involve legal support. Lessons learnt from cases are compiled and we will take action to reflect them in practice moving forward, where appropriate.

3.1 Quality Performance Dashboard

Month: Jun-20

Safe

Incident Reporting Rates



YTD	Moderate & Above Incidents	
2020-21	71	
2019-20	58	▲ 22.4%

YTD	Serious Incidents (SI) Raised	
2020-21	2	
2019-20	16	▼ 87.5%

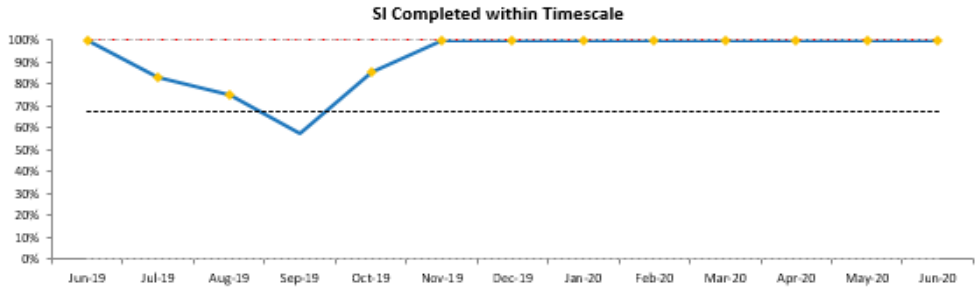
YTD	Physical/Verbal Assaults to Staff	
2020-21	132	
2019-20	197	▼ 33.0%

Narrative

The drop below the mean and benchmark for May is reflective of the reduction in services during the COVID 19 Pandemic. The reduction has been raised at care group performance review meetings. The increase in moderate incidents is attributed to a rise of Pressure Ulcers developing in Solent Care, Adults Portsmouth and Adults Southampton are analysing the increase.

Effective

SI Investigation and Closure

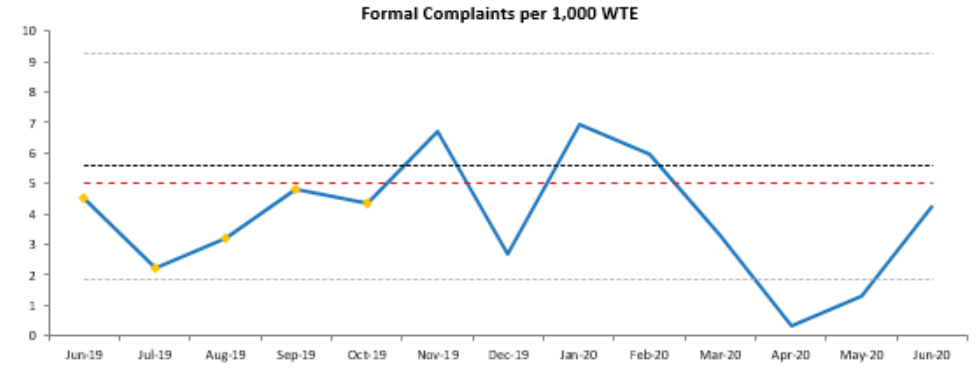


Narrative

The Quality and Safety Team continue to work with services to maintain 100% compliance.

Experience

Formal Complaint Rate



YTD	Complaints Received	
2020-21	18	
2019-20	43	▼ 58.1%

Complaints Closed to Timescale	
Target	Actual
80%	50%

YTD	Unsolicited Plaudits	
2020-21	231	
2019-20	336	▼ 31.3%

Narrative

The low number of complaints and plaudits received in May, is attributed to the reduction in services and the public adhering to the national message ' protect the NHS' during the COVID 19 Pandemic. The number of formal complaints received in June is comparable to number of complaints received in June 2019, indicating that some services have restarted with the easing of lockdown. At the start of lockdown each complaint was reviewed and closed if possible however a number were put on hold in line with national complaint guidance following a discussion with the complainant.

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

During May and June, we have continued to engage with the CQC on all relevant matters. We have not yet been informed of a new date for the inspection that was planned prior to the pandemic.

As reported previously a robust Quality Improvement Assessment (QIA) process was implemented at the beginning of the COVID-19 pandemic which sought to review every process and clinical delivery change by an expert panel chaired by the CMO/CNO. This process has worked well and is now transitioning towards the review of changes around recovery, and determining which changes adopted during COVID-19 may need to be retained.

In addition, changes were made to our Quality Improvement and Risk (QIR) Group which are as follows:

- Access to QIR was made available via electronic meeting routes (MS Teams) to reduce travel time and face to face contact for participants.
- Deep-dive activity was suspended during COVID-19 to support a refocus of workload for clinical staff.
- Escalation reports were moved to a monthly cycle and revised to include COVID-19 quality related items.
- Many subgroups providing written reports to QIR were moved to verbal updates by exception.
- Some reports were agreed to be delayed and will be heard at QIR later in the year.

As we are now moving into the recovery phase these arrangements are being reviewed and a paper will be discussed at August QIR to agree which aspects will be retained and which changes will be adopted in response to learning during the pandemic.

The Infection Prevention & Control, (IPC), team have continued to support the organisation to ensure national guidance is interpreted and implemented appropriately across the Trust. A summary of their activity is as follows:

- Continue to deliver FFP3 fit testing and IPC training to new and existing staff.
- The team are reintroducing business as usual surveillance, and it has been agreed to increase hand hygiene observational audit to once a month as opposed to a 6-monthly check for inpatient areas and clinics.
- The hand hygiene competencies will be changed to include both clinical and non-clinical staff and will be increased to 6-monthly, from an annual check for clinical staff and 3 yearly for non-clinical staff.
- In May 2020 the Chief Nurse of England wrote to the Chief Nurses of NHS organisations asking them to complete the Infection Prevention & Control Board Assurance Framework. This has been completed and has been discussed at Infection Prevention & Control group, considered at each of the service line governance meetings and has been discussed at the Trust Board in June 2020. As a result, changes have been made to strengthen the mitigations in place and will be presented back to Board in August 2020. The draft response has been provided to NHSE/I as required and to the CQC who will be considering this as part of their inspection regime in future.
- Provided guidance to Solent's community hospital sites to ensure staff and patients are being kept safe with the introduction of masks in clinical areas and where office space is not

COVID secure.

- In this reporting period the team have continued to visit clinical areas to undertake spot checks and to support teams to identify and mange infection outbreaks. There have not been any infection outbreaks during this reporting period.

We are delighted to confirm that we will be working with the University of Southampton to implement and evaluate the Creating Learning Environments for Compassionate Care (CLECC) intervention. This approach has been trialled in acute hospital settings and the purpose of this project is to assess if the intervention is transferrable to other settings such as Mental Health Services. The work has been commissioned by the Chief Nursing Officer (CNO) of England and is an exciting opportunity for Solent's Mental Health Services to participate in national research and to influence the development of evidence-based practice. The project is planned to commence during July 2020.

The Solent NHS Trust hydrotherapy service and PHT Critical Care Team have been confirmed as finalists in the National Patient Safety Awards 2020 in the category of Clinical Governance & Risk Management. The submission was based on the work undertaken for a patient who was ventilated and had Gillian Barrie Syndrome and was enabled to access the hydrotherapy pool as part of his recovery. The submission focused on themes around innovation of care, team and patient involvement in the risk assessment /documentation and dissemination of our work nationally. The service lead, Claire Jeffries, is now required to film a 15-minute presentation and send to the judging panel over the next few weeks and a virtual ceremony for the announcement of winners will be held in November 2020.

During the COVID pandemic the safeguarding team developed an electronic training package which included a workbook to be completed by participants to support staff to maintain safeguarding competence. This work was subsequently shared on the NHS Futures platform and the National Head of Safeguarding has acknowledged the excellent work of the team and there has been significant interest from other organisations to adapt our work for their own use.

In June 2020 NHSE/I highlighted our integrated Learning Disability Team as an area of outstanding practice in supporting people with a Learning Disability during lockdown.

Diversity and Inclusion

The outbreak of COVID-19 has had a significant impact on Diversity and Inclusion work. Local, regional and national links have been made and sustained, in order to learn from others and prevent work being duplicated within individual trusts. A Solent Diversity and Inclusion response has been designed in partnership with other colleagues, including the BAME resource group and Occupational Health. This has five main sections: Equality Analysis; protection of BAME staff; BAME health awareness; data, research and evidence and listening and engaging with BAME staff and the local community. This document is updated weekly by the leads for the relevant sections and then signed off at Director and Board level.

In addition, we have held regular zoom sessions with BAME staff, through the staff resource groups and strategically led by Sue Harriman, Chief Executive Officer and Jackie Ardley, Chief Nurse. The recent PHE Health Inequalities report and Black Lives Matter movement was discussed openly during several open Solent zoom sessions. The Trust Board and senior leadership team had the privilege of a personalised Q&A with Roger Kline, author of the Snowy White Peaks in the NHS.

Community Engagement and Experience

We are pleased to confirm that we have finalised our first Community Engagement newsletter, within which we have outlined our aspirations for community engagement, alongside sharing details of our partnerships with local people, groups and organisations' to help us achieve our ambition of developing local services with local people.

Freedom to Speak Up

The National Guardian's Office published its annual Freedom to Speak Up Index report in July 2020. We are delighted that for the second year in a row, the Trust is the best performing combined mental health, learning disability and community trust in the country. We also had the second highest FTSU index score nationally – again for the second successive year.

The report states, there is a very strong correlation between Trusts that have a positive speaking up culture and Trusts that are rated highest by the CQC. We believe that creating this culture really provides us with solid foundations for us to move from 'good' to 'outstanding' in our CQC ratings.

Following some recent changes within the Chief Nurse Directorate, we are in the process of appointing a new Freedom to Speak Up Lead Guardian. There has been a significant level of interest in the post and following a competitive selection process at the beginning of July we are very pleased to confirm we have appointed to the position. Further details will follow in due course.

Enhanced Health in Care Homes

In light of the COVID-19 pandemic, and the devastating impact this had on our older and vulnerable population, especially within the care home environment, Solent NHS Trust has committed to work in collaboration with Southampton City CCG and partner organisations as well as our own specialist teams to devise a programme of resources and support to enhance the knowledge and skills of care home staff, with the sole aim to improve the care and experience of their residents and staff.

The engagement and willingness of Solent teams has been outstanding, recognising how together we can enhance the care residents receive, not only to improve their wellbeing but also to support a reduction in conveyances to secondary care thereby reducing pressure on the wider system. The teams currently involved are Podiatry, Tissue Viability, Diabetes and Dentistry along with other partners bringing together a programme of work which will be delivered via different forums across Southampton City.

Complaints Update

In May and June 2020 the Trust received a total of 17 formal complaints. This is an increase from the last two month period, and although complaints received in May continued to be below the normal parameters, the rate of complaints received in June returned to near average. The complaints by service line are in the table below:

Service Line	May 2020	June 2020
Adults Portsmouth	1	0
Adults Southampton	0	3
Children's Services	1	3
Primary Care	0	2
Sexual Health	0	0
Adult Mental Health	1	5
SPA	0	0

Special Care Dentistry	1	0
Corporate	0	0
Infrastructure	0	0
Total	**4**	**13**

The usual complaints process for new complaints was reinstated on the 1 July. Paused complaints were also reopened on this date. Local Resolution meetings are part of this process and the PALS and Complaints team have encouraged services to consider whether these meetings can take place via apps (Zoom/MS Teams). Service concerns continue to be responded to in the usual way, in order to resolve issues quickly.

The increase in complaints received during June correlates with the easing of COVID-19 lockdown. All complaints relate to current care rather than complaints for concerns that occurred during the initial lockdown period. The main complaint themes relate to clinical care (11) communication (3) staff attitude (1) and further complaints relating to confidentiality (Children's Services) and general procedures (Adults Southampton).

The Adult Mental Health Service received the most complaints over the last two months. In response, the PALS and Complaints team instigated weekly meetings with the service to review on-going complaints. The team also have bi-weekly complaint reviews with the Head of Quality and Professions and the Associate Director of Quality & Governance to escalate any concerns.

Two service concerns were escalated to formal complaints during this period, at the request of the complainant, one for Adult Mental Health Service and one for Primary Care.

The team received a total of 37 service concerns this period, the lowest over a two month period since April 2019. Children's Services received the highest (15) with the majority relating to communication (6) including concerns around letters, reports and referrals. The majority of Primary Care concerns relate to GP Surgeries (6 out of 8) and include concerns regarding prescriptions and the ability to contact surgery and make appointments.

One piece of professional feedback was received in May relating to the Crisis Resolution Service and was resolved within 30 days.

The team closed a total of 10 complaints during this period; one of these escalated to a High Risk Incident investigation (Adult Mental Health) and one a Serious Incident investigation (Children's Services). Two of the closed complaints were reopened due to unresolved issues and remain on-going; both were initially received in March and are for the Adults Southampton and Mental Health service lines. This demonstrates the level of scrutiny undertaken and the flexibility to respond when new information becomes available as part of the process. At the end of June, the team have 19 on-going complaints requiring responses.

The PHSO announced they will be continuing with any existing healthcare complaints and taking on new complaints as of 1 July 2020. The Trust currently has no cases open with the PHSO.

Incident Updates

The changes to incident reporting introduced in March, in response to the COVID-19 pandemic, remained in place for May and June. Feedback from staff on the new, streamlined, incident report

form has been positive. However, the incident hotline, set up to allow staff to report incidents over the phone, has had little use and so this has been stepped down at present.

The trend, identified in the last report, of fewer incidents being reported compared with previous years, continued in May and June. However, June's figure of 714 is comparable to 2018 and is just 6% lower than the same period in 2019. The volume and percentage of incidents categorised as Minor in May and June this year is significantly lower than the same months in 2019, and the number of incidents graded Moderate has increase compared to last year, indicating that the most serious incidents continue to be reported.

There were three High Risk Incidents declared in May and June. One involved an information governance breach in Children's Services. The second occurred in the Adults Portsmouth service line relating to equipment and an information governance breach. The third involved the death of a patient receiving care from the Adult Southampton service line, where learning was identified around communication between teams. Once the investigations are complete the learning from all three will be shared at the Serious Incident/Learning from Deaths panel.

The number of expected and unexpected deaths reported in May and June is higher than in both 2018 and 2019, despite the reduction in overall incidents. There were 164 deaths reported in 2020 compared with 143 and 119 during 2019 and 2018 respectively. Of these, 15 were reported to be COVID-19 related, 10 expected and 5 unexpected. None of these were inpatients with Solent at the time of their death.

The review of incidents reported as COVID-19 related, continued throughout May and into June. No trends or concerns were noted.

Serious Incident (SI) Update

During May and June, two Serious Incident investigations were declared. Both incidents occurred within Children's Services. One related to missed opportunities for the timely referral of a patient with a suspected eating disorder. The second was an information governance breach concerning a child in foster care.

The outcomes and learning from these investigations will be shared and discussed at the Serious Incident and Learning from Deaths panels in July and August. These investigations are the first to be written using the Incident Reporting System (Ulysses).

The themes and learning identified will be reported in the Learning from Deaths quarterly report including SI's, Incidents and Patient Safety. Extensions were requested and granted by the CCG's for three Serious Incidents in May and June, due to difficulties in completing the reports as a result of COVID-19. One of these has now been submitted to the CCG with the other two due at the end of July. Except for the 3 where extensions were granted, all serious incident reports have been submitted within the agreed timeframes during May and June.

Friends and Family Test (FFT)

In response to the COVID-19 pandemic, the reporting requirement for the new FFT has been suspended until September 2020, however services have continued to capture and report patient feedback during this time. The FFT figures for May and June remain low with 232 responses being received. This has improved slightly since April where 127 responses were received. A summary of the feedback received during April – June is detailed below:

Month	Number of responses	'Recommend'	'Neither Recommend/Not Recommend' or 'Don't know'	'Not Recommend'	Themes from 'Not Recommend'
April-June 2020	468	456	8	4	Mainly related to patients noting that they did not want a specific clinician to retire 1 response related to issues around access and attitude within the Adults Southampton Community Nursing Service.

In quarter 1, a total of 468 FFT responses were received with just 4 people saying they 'would not recommend'. The main source of feedback received was via paper surveys, specifically the iStatement survey which incorporates the FFT question.

During the COVID-19 pandemic, feedback received has continued to be supportive and positive for services across the Trust including the following free text comments:

- *Reassuring, supportive and encouraging staff who provide confidence*
- *Patients felt listened to by staff*
- *Excellent, efficient care*
- *Polite, friendly and professional staff*

4.1 Chief Finance Officer Commentary

Month 3 Results

The Trust is reporting an in-month and YTD adjusted breakeven position, although the underlying deficit is £200k, compared to a shadow budget YTD deficit of £1,032k. The deficit is expected to be recovered from NHS E via the top up mechanism implemented in response to COVID-19.

Due to the reduced levels of services provided across many service lines, the actual spend is lower than the shadow budgets. More normal levels of spend are expected as services reset.

COVID-19 Expenditure

The Trust has incurred additional revenue and capital expenditure as a result of COVID-19. In quarter 1, revenue expenditure linked to COVID-19 was £3.3m and included expenditure on additional staffing, ICT equipment and software to enable working from home, estates maintenance and repairs costs, as well as costs to support additional capacity in wards, 'Grab and Go' food bags for frontline staff and additional PPE.

Capital projects to support COVID-19 total £1.4m covering work from March to June. £1.0m was spent on increasing bed capacity at Adelaide Health Centre in Southampton and Hamble House on St James Hospital site. This has resulted in an additional 88 beds. £0.2m has been invested in ICT devices to allow staff to work from home.

Capital

Capital projects activity focussed on COVID-19 mobilisation in April and May with most other projects progressing at a slower pace than originally anticipated. There are several large estates projects expected to gather momentum in the coming months. ICT projects were also impacted by COVID-19 as enabling home working became top priority. The Windows 10 and Office 365 project is back on track and progressing well.

Cash

The cash balance was £29.3m at 30 June. This is circa £14.0m higher than at 2019-20 cash levels due to changes to the NHS payment mechanism, where NHSE and CCG block payments and the top up supplement are received one month in advance.

Aged Debt

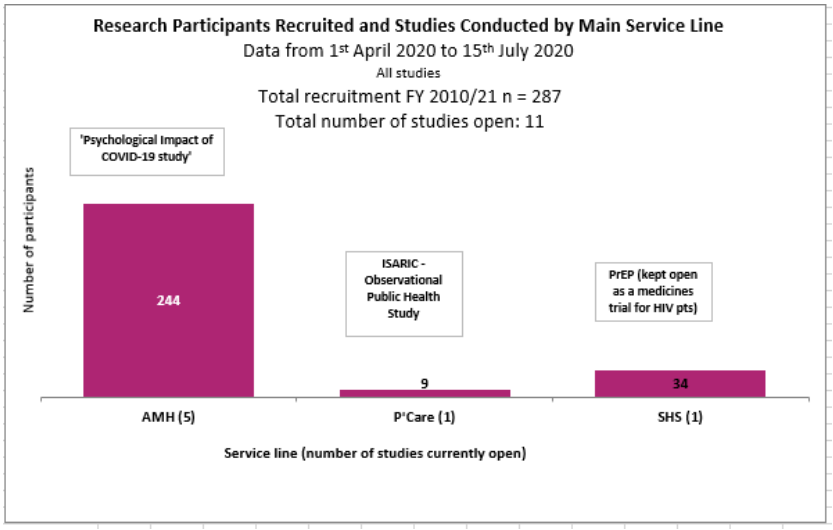
The Trust's total debt was £3.2m at the end of June. 91+ day overdue debt at the end of month was £0.5m with £0.3m bad debt provision made against it.

5.1 Research and Improvement Commentary

Research

At the start of lockdown, almost all of our open studies were suspended. We were asked by the National Institute for Health Research to prioritise any urgent Public Health England COVID-19 research. There have been few studies suitable for community organisations to date, however we have a number in planning and are running some online. The research team have been supporting the vaccine development trials with UHS, and co-ordinating local studies. Performance monitoring of numbers recruited to trials has temporarily ceased.

We currently have 11 studies open.



Clinical Effectiveness & QI

Completion against audit and evaluation plans

	Local Projects 2020/21		
	Number on Plan	**Completed projects**	**Completion rate**
Adults Portsmouth	20	0	0
Adults Southampton	43	3	7%
Child & Family	48	2	4%
Mental Health	26	0	0%
Primary Care - GP	2	0	0%
Primary Care - MPP	48	5	10%
Sexual Health	24	1	4%
Special Care Dental	18	1	6%
Totals	**229**	**12**	**5%**

Clinical Effectiveness

- Aspirational plans from the trust-wide Improvement planning session conducted in January 2020 has led to 229 local audits and evaluations being planned across the trust for the year.
- 15 reports have been received so far. Five of these evidence specific improvements.
- New trust-wide audit toolkits for documentation and mental capacity audits are in development.
- All national audits were halted initially during COVID though we are recommencing mental health audits for prescribing (POMH) and psychosis (NCAP), with more national audits set to open soon.
- National audit reports have been distributed to service lines and will be discussed at service line audit meetings.
- A number of COVID specific audits have been conducted including the use of effective use of antibiotics in Dentistry and COVID screening prior to face to face contacts in Podiatry.
- In addition to trust-wide evaluations commissioned by the Academy, six service specific evaluations have been agreed looking at remote consultation for individuals (Sexual Health Service) and group interventions (Child and Family, Pain Team). An evaluation of COVID rehabilitation post-ITU for COVID has been agreed for Adults Southampton.

NICE

- Services continue to review new NICE guidance though specific attention has been drawn to COVID rapid guidance with summaries being produced for guidance most relevant to our settings.

Quality Improvement (QI)

- A new, remote, Zoom based training programme has been developed. Four sessions have been provided to date training. 25 staff as well as 2 bespoke team sessions for Child and Family and Admiral Nursing.
- A further 3 cohorts of QI training are planned for the remainder of the year, with 6 sessions per cohort.
- The SolNet QI site has been developed to include better tracking of projects, wider selection of resources and a significant collection of project summaries.

Workshop Programme

- Academy staff and NHS Elect have put together a series of 10 remote interactive workshops addressing key research and improvement topics over the next three months, with approximately 15 workshops planned for the rest of the financial year.
- Workshop sessions will be accompanied by a range of resources and videos.

6.1 NHS Provider Licence – Self Certification 2020/21 – July 2020

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 quoracy as well as any recommendations made following Internal Auditors (or other external review). All NED positions are substantively filled. We currently have an interim Medical Director in post with the permanent Medical Director commencing in August 2020.

The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting. We continue to regularly consider and monitor our governance processes in light of the ongoing National COVID-19 situation.

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

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

For 2020/21 all providers will be supported to produce a breakeven position, with all reasonable expenditure reimbursed. Full year financial guidance has not been finalised, although confirmation has been received that the measures implemented for months 1-4 will be extended into month 5.

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.

We continue to regularly consider and monitor our governance processes in light of the ongoing National COVID-19 situation.

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 – All NED positions are substantively filled. We currently have an interim Medical Director in post with the permanent Chief Medical Officer commencing in August 2020.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 10.1

Board and Committee Cover Sheet

Item No.	10.1

Presentation to	Trust Board			
Title of Paper	Emergency Planning Resilience and Response to Covid-19			
Purpose of the Paper	The aim of this paper is to provide insight and assurance to the Board on the Trust response and processes to the Covid-19 pandemic (to date) from the emergency planning, resilience and response (EPRR) team command and control perspective.			
Author(s)	Elaine Peachey		Executive Sponsor	David Noyes
Date of Paper	2/7/20		Committees/Groups previously presented	
Summary of key issues/messages	To provide an oversight of the EPRR operational response including the command and control, information flows, business continuity planning and use, recovery and reset and how learning is captured and used in forward planning.			
Action Required	For decision?	N	For assurance?	Y
Recommendation	That the board are assured of the EPRR response to the Covid-19 situation and that it is effective and appropriate in order to continue to support the organisation and the health community			

For presentation to Board and its 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								

Item 10.2

Solent NHS Trust

Emergency Planning Resilience and Response to Covid-19

(Major incident 2020)

July 2020

Aim

The aim of this paper is to provide insight and assurance to the Board on the Trust response and processes to the Covid-19 pandemic (to date) from the emergency planning, resilience and response (EPRR) team command and control perspective.

Background

On 31 December 2019, WHO was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus (2019-nCoV) was subsequently identified from patient samples. On 30 January 2020, the World Health Organisation Emergency Committee agreed that the outbreak now meets the criteria for a Public Health Emergency of International Concern. 31 January 2020 the first two cases of COVID-19 were identified in the UK and the NHS remained on alert for a possible emergency response and began planning.

HIOW declared that the first two cases had now been identified in the area and by 10 March there were nine confirmed cases, one in IOW, eight in Hampshire. 12 March it was announced that we were to move from the 'contain' phase to the 'delay' phase and the Chief Medical Officer raised UK risk level from Moderate to High. On 18 March a national major incident was declared.

The outbreak of covid-19 was first named on January 7 2020 when it was known to be a worldwide outbreak of the disease. We were aware that the novel virus had emerged and was very different from current or recently circulating virus strains. There was and still is, sustained human to human transmission and the novelty of the strain means that there is little or no immunity in the population which allows the virus to spread rapidly among humans and in general terms makes the virus likely to be more virulent than other infectious diseases.

The Accountable Emergency Officer (AEO), instigated our Trust preparation and response via setting up the incident co-ordination centre (ICC) and supporting team on 10th March, to review the situation, and start to both compile readiness reports and disseminate information. Following the declaration of a major national incident across the country on 18th March 18, these meetings became formal 'gold' command and control meetings.

Command and Control

The EPRR lead worked proactively with the Accountable Emergency Officer (AEO) throughout the incident. The AEO was, and still is the Incident Commander for the majority of the timeline supported by the other executive directors.

The incident co-ordination centre (ICC) was sent up (virtually) from February 12 with daily sitreps that were collected from all services and reported regionally with any issues affecting services. Week commencing March 17 and directly in response to the changing picture nationally, the virtual ICC commenced dial in three times a day (9.00, 12.00, 1800) on Monday, Wednesday and Friday.

The week commencing March 23 these meetings changed to daily meetings twice a day (11.00 and 16.30) five days per week in response to the predicted peak in the virus. At weekends the 'gold' calls commenced on March 28 once per day at 10.00am and these meetings continue to date.

As locally we appeared to have moved beyond the peak and there were no issues identified on May 18 the decision was taken to reduce the weekday meetings to three days per week again on Monday, Wednesday and Friday. Further improvements in the impacts of covid-19 meant that we were able to reduce further these calls to Monday and Friday only at 11.00am on May 26 and these continue to date.

Both the timings and the number of days that the gold meetings occur remain under constant review and are flexed in response to any changes and to take account of staff welfare going forward at an appropriate level.

During gold meetings situation reports from all services were discussed and actioned and information was shared across the organisation by the incident director. Gold command meetings facilitated the organisation to:

- Apply a level of authority in order to centrally manage resources
- Make rapid progress to Integrate services to both configure a response to manage the predicted size and shape of anticipated demand and continue to provide essential patient care
- Recognise and share good practice
- Have a shared understanding of the challenges
- Jointly identify solutions to issues
- Share changes in all guidance and national information

The Gold command meetings followed the EPRR framework with a standardised agenda including all possible areas that may be affected such as staffing, PPE, safety, care provision. The attendance list included the AEO and executives, EPRR representative, decision loggist, minute taker and senior representation from all service lines and corporate services. Both the attendance and the frequency of the meetings remained under constant review. In order to prevent burnout, as soon as the peak passed, the meetings were changed to three times a week for the full team and then further reduced to twice a week. At the weekends the on call leads dialled in to the incident on call director and updated with any issues identified, these calls continue.

The AEO also attends the Hampshire IOW Health and Social Care cell which is part of the local resilience forum. The meetings were initially twice weekly however more recently these meetings have reduced to once a week.

Information flow

Data and information was vital to the support to and the assurance from the organisation during the response and we used a number of ways to achieve this through the gold command meetings using the communications team and the various methods of communication such as social media, national media and the allocation of specific projects as they were required.

The Business Intelligence dashboard, rapidly formulated by the Performance team, provided an online tool with visualisation of Solent NHS data giving access to multiple data sets and a one stop shop for clinical, workforce, finance and quality data. This provided a strong, high level, command support tool for Gold. The early implementation of this system was very successful and is an integral part of the organisation particularly the Covid-19 response.

Business continuity

In 2017, as part of our annual winter planning, we challenged ourselves to think through in significant detail the operational infrastructure, equipment, financial and workforce implications of generating additional system capacity in the event of an extremely challenging winter. The plan was compiled with the involvement of key services and priority services looked at how additional capacity could be supported.

The contingency plans included a risk based, prioritised (RAG) list of services and the capability/capacity that the trust could mobilise in the event of an extreme set of circumstances over and above normal system business continuity. While that winter (thankfully) didn't present such an extreme challenge as we had prepared for, the conceptual work and principles we had applied certainly proved invaluable in configuring our response to Covid-19. The contingency plans we had created in 2017 had been incorporated into Trust business continuity plans and hence embedded in service response planning, which we judge was of great benefit in implementing a very similar response for covid-19.

At the start of the covid-19 outbreak services, in early March, given the predicted infection rates and evidence from the experience in other well developed European countries, we asked each of our service lines to review their business continuity plans against assumptions of a reduction of 20%, 30% and up to 50% of their staff. While (to date) we haven't seen impact as high as 50%, in the first few weeks in several areas we did approach 30% absence, and so again this proved to be very worthwhile planning.

Recovery and reset

While the incident remains live, and of course the situation is still dynamic, the Trust identified in week 2 that we would need to plan for post incident recovery and learning. Accordingly a small team was established to do just this, and this has proved of great benefit as we are starting to implement recovery actions now.

Learning

Continuous improvement is facilitated by a well-managed and monitored learning process across the organisation which is an integral part of EPRR in response to an incident. During the Covid-19 pandemic lessons have been captured and converted into actions to ensure improvement.

Conclusion

The impact of Covid-19 locally and nationally has been genuinely unprecedented. However, as an organisation we have always taken a planning approach of planning for the worst. As the board are aware, last year the Trust achieved full compliance against the NHS England EPRR assurance framework which meant that we were in a strong position to adapt or use existing plans throughout the response and on to the recovery phase. Clearly, no plan ever really covers all the bases, but our processes, conceptual approach and ability to implement and adapt plans has served us well.

The internal 'Gold command' has retained a strong command and control structure enabling internal staff to escalate issues and then receive information and direction.

Services have used their business continuity plans effectively particularly in the early days when they needed to identify which services could be stopped and which if any could be scaled down or made available in a different way.

It is clear that, despite the huge challenges and the often very dynamic nature of the crises, Solent NHS trust's EPRR framework and arrangements have held up well during this incident. There will, of course, be lessons learnt, and we will continue to seek to improve and review our plans during the recovery phase.

Item 11.1

NHS Solent NHS Trust

Board and Committee Cover Sheet

Item No.	11.1

Presentation to	Trust Board		
Title of Paper	Infection prevention and control board assurance framework		
Purpose of the Paper	The purpose of this paper if to provide assurance that the Trust is working in line with national guidance and meeting the quality standards required.		
Author(s)	Angela Anderson, Associate Nurse Director	Executive Sponsor	Jackie Ardley, Chief Nurse
Date of Paper	23 July 2020	Committees/Groups previously presented	Infection prevention & Control Group (IPCG), QIR & Trust Board
Summary of key issues/messages	In May 2020 the Chief Nurse of England (CNO) published the Infection prevention and control board assurance framework and the SE regional team have asked all Trusts to complete a self-assessment against the framework in order to assure the Board that measures taken and practice within the organisation are in line with current guidance. This paper was presented to Board in June 2020 and influenced by the learning from the discussion at Board has been updated to provide the required level of assurance. For ease the areas which have been updated are highlighted in yellow. This paper offers the Board comprehensive assurance on the current position and the plans to ensure we continue to improve.		
Action Required	For decision?	N	For assurance? Y
Recommendation	The Board are asked to: • Consider the information provided and to triangulate this alongside other information received through Workforce & Organisational Development (WOD) and Quality Assurance • Note the establishment of the project group to lead on this area of work and to support the work of this group.		

For presentation to Board and its 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							

Publications approval reference: 001559

Item 11.2

Infection prevention and control board assurance framework

4 May 2020, Version 1

(Version 2 – Solent)

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	The organisation follows the national guidance in relation to Infection Prevention and Control. Individual services have systems and processes in place to risk assess patients at the front door and outcomes of risk assessment are recorded in the patient records In our inpatient areas all new admissions are swabbed and isolated. In our older person's mental health ward, we have established a cohort area in a corridor where all rooms are ensuite Inpatient areas have completed risk assessments and have provided written information for visitors. Some areas have introduced visitor contact sheets Services have implemented local processes to support staff such as the decision-making tree introduced in the CAMHs team which identifies if a face to face home visit is required or if the consultation can be	Practice varies across services therefore it is necessary to review existing standard operating procedure (SOP) in order to produce a single SOP for staff to ensure a consistent approach where this is appropriate. There are no current audits in place to demonstrate compliance with requirements	Monthly Infection Prevention and control meetings have been introduced and services are required to provide updates in relation to all aspects of IPC in their area An IPC assurance project has been established which will support services to develop assurance processes for now and the long-term future National guidance is available to all staff via the Trust intranet Expert infection, prevention and control (IPC) advice is available to services.

	completed remotely. In our mental health community services consultations are carried out remotely where possible and where home visits are required patients are called in advance to establish if they have symptoms. All staff have access to PPE in the home All clinic activity that is due to be restarted will be have a full risk assessment conducted in collaboration with estates. Specialist dental services have clear pathways of care in place across all sites		Clear written guidance available to mental health clinical areas
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	All in patient wards have systems and processes to isolate and cohort nurse. Patients are only moved when clinically indicated. Infection prevention and Control team provide advice and support in line with the Trust isolation policy and PHE guidance.	No gaps in assurance	National guidance is available via Trust intranet There is access to the full suite of Trust IPC policies IPC team provide advice and support where required and review practice against all relevant guidance
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	The Trust follows the national guidance in relation to the discharge of patients. All inpatient areas swab patients prior to discharge to care homes, in line with guidance	Not all areas provide written guidance in the form of a SOP for staff The pathway followed in OPMH is unclear and will be reviewed	All national guidance has been shared with the relevant inpatient areas for reference. IPC team provide advice and support to services
• patients and staff are protected with PPE,	PPE stocks are monitored through our procurement team and is used in line with national guidance	No audits have been completed yet which would demonstrate staff are adhering to the	IPC team carry out spot checks and visits, escalation of non-

as per the PHE national guidance	Daily communication system is in place which and the Trust operates a Gold Command system where staff can escalate issues of concern which includes availability of PPE The Head of IPC interprets all national guidance in conjunction with the Director Infection Prevention & Control (DIPC) There is a PPE hub in both cities which is used to ensure services always have enough PPE available including at weekends Videos have been provided to staff which demonstrate how to safely 'Don & Doff' PPE The IPC team regularly attend wards and community teams, linking into skills slots and providing advice. They have also visited clinical and non-clinical environments to provide specific advice in relation to cleaning, patient flow and guidance on use of PPE	appropriate use of PPE, donning and doffing.	adherence is reported, and poor practice is highlighted and addressed with individuals/teams The IPC team provide advice and support directly to services Don and Doff videos have been made available to staff Staff have access to the Trust IPC policies
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The Trust emergency planning lead and our Head of IPC review all guidance and any changes are signed off by the Chief Nurse/DIPC and CMO. Updated guidance is communicated to staff across the Trust via the Gold Command system and the daily staff communications Head of IPC has been member of the Heads of Quality & Professions (HQPs) daily call where queries are answered, and new information/guidance shared. In addition, dental service receives updates from PHE directly and from Chief Dental Officer (England)	No gaps in assurance	Systems in place to escalate where guidance changes rapidly or there are concerns around compliance or dispute. Gold command and Head of Quality & Professions (HQPs) calls also used to address concerns. The Head of IPC attends regular meetings with the HQPs to update and answer queries. Zoom calls with Head of IPC & CN/CEO are

	Regular Zoom calls for all staff have been held by the Head of IPC and the CEO and/or the DIPC Bespoke update training provided to teams by the IPC team as requested A QIA process is completed where there is a need to consider guidance which may be conflicting, for example the difference in relation resuscitation and AGPs between PHE & the Resus Council. Guidance specific to mental health also comes via the Mental health Forum, RCPsych, NAPICU and other sources. This is reviewed with the IPC team to ensure messages are consistent or adapted such as the NAPICU guidance on risks associated with wearing plastic aprons when placing a patient into seclusion		provided regularly for frontline staff to ask questions Bespoke update training sessions provided to teams by IPC team
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Full briefing provided in the Chief nurse report to Board and the Q3 & Q4 IPC report taken through usual governance routes Service lines report and escalate concerns up through quality improvement and risk group and via Gold Command where required/appropriate Members of the executive Board are always present on the Gold Command Calls	The BAF includes an overarching risk associated with Covid which the Board are sighted on. Local governance processes within service lines and through IPC group will continue to consider, record and mitigate risks as they arise	Daily access to executive Directors for escalation of risks and concerns
• risks are reflected in risk registers and the Board Assurance Framework where	There is a risk identified on the BAF relating to Covid and its impact on services	No specific risks identified on the risk register, at service line or Trust level. This will be reviewed by service lines and the IPC	Daily access to executive Directors for escalation of risks and concerns

appropriate		team	
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Services have continued with planned programme of screening. IPC team presence continues in the ward areas The team are linked into the hospital microbiologist who provides advice and guidance where requested as well as alerting the team of any concerns.	The link advisor role needs to be reviewed and strengthened in some areas to ensure more robust governance and assurance	Daily results to IPC team from the lab which enables the team to follow up patients identified Wards are following policies and notifying the IPC team of findings if required Work is underway to review the role description for link advisors and an additional 28 link advisors have been trained in the past month with more planned Services have introduced additional audits, for example of mattress, chair audits. These are required to be reported through local governance frameworks Adults services Portsmouth have established a local matron's forum with the Head of Quality and Professions which will focus on quality issues

			and risks, including IPC as a standard agenda item Services has introduced
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	The organisations compliance with IPC statutory and mandatory training at the end of March 2020 was 93% All teams caring for patients have had access to training. An upskilling programme which included infection prevention & control has been delivered to new and redeployed staff across the organisation All staff in mental health services assigned to work in isolation corridors, rooms within inpatients and within the assessment unit have had IPC training and the clinical matron is visible to the teams and available to provide advice and support to the teams	There is a lack of confidence in the application of theory to practice due to training being delivered predominantly online. There is also a lack of confidence in the effectiveness of the current cascade systems	National guidance provided and followed Access to the suite of local IPC policies and procedures Regular zoom meetings for staff to discuss IPC practice and guidance provided as well as IPC team delivering face to face sessions as part of the upskilling programme. The team also provided adhoc sessions to clinical teams as requested Spot checks carried out by IPC team on clinical visits and concerns addressed as they arise Services have introduced additional

			cleaning regimes for each area and have produced lists of equipment which needs to be cleaned
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	Each clinical area has designated cleaners, and all have been trained to ensure they are undertaking appropriate cleaning procedures. There are cleaning schedules in place for all areas and staff have access to the appropriate PPE for the task they are undertaking Individual competency assessments are in place for all Facilities management (FM) staff	Monitoring that staff are using the correct PPE in all circumstances There is less assurance in relation to some of our services which are delivered in buildings outside of the Trust estate such as the substance misuse service	National guidance available to all staff including the supervisors of cleaning staff Trust policies, including decontamination policy, are available to all staff IPC team have provided adhoc/bespoke training to cleaning staff Audits are undertaken by FM supervisors and any concerns managed or escalated as appropriate IPC team have provided substance misuse service with specific advice on cleaning schedules between patient visits.
• decontamination and terminal decontamination of	National guidance has been implemented across the Trust The IPC are in regular contact with the	The team may not always be aware of products being brought directly to the ward areas which	Access to Trust IPC policies, including

isolation rooms or cohort areas is carried out in line with PHE and other national guidance	housekeeping/cleaning teams and all products have a COSHH assessment completed by the Health & Safety Officer All new products being introduced are reviewed by the IPC team and the H&S officer to ensure they meet the required standards in line with national and local guidance/policy Dental team clean surgery between patients and facilities team deep clean at the end of each day	is a risk	decontamination policy for all staff Additional cleaning is provided where there have been any risks identified Cleaning checklists have been introduced. A trial of services using ATP equipment locally is underway to assess impact and will be rolled out if effective
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Considering Covid, increased frequency of cleaning has been implemented across all Solent sites in line with national guidance. For non-Solent sites we have increased the frequency of cleaning where we manage the cleaning service All areas have cleaning schedules in place, and these are reviewed where requested by IPC or matron's/clinical managers	It is not clear if services provided on non-Solent sites have had an increase in frequency of cleaning The recent ATP scores raise concerns regarding the effectiveness of the cleaning regimes	Where there are concerns raised regarding the standard of cleaning the issues are raised directly with the team and concerns escalated through normal channels Where issues are raised to the premises manager our FM manager will undertake an audit and co-ordinate increased cleaning frequencies where necessary Following national guidance and local policy relating to cleaning, IPC

			and H&S team providing additional support to patients and staff in relation to understanding personal and environmental hygiene needs FM leads report into the IPC group on standards achieved
• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	FM staff order, receive and distribute the linen stock Linen is stored in line with local policy and national guidance. The Trust has not had any identified cases of cross infection in clinical areas at this time	There are no audits to demonstrate adherence with guidance	FM staff undertake checks when receiving and distributing linen and escalate concerns where required so that action can be taken immediately Matrons undertake quality rounds and have not identified any risks currently
• single use items are used where possible and according to Single Use Policy	National guidance is followed and where changes in guidance these have been communicated to staff. Face mask and goggles where appropriate have been used for sessional use in line with guidance System implemented to ensure any home produced and non-standard equipment donated to services are checked by H&S and	Nil noted	HSE guidance followed, Checks by H&S and IPC PPE hub aware to contact H&S and IPC to check equipment Standard precautions policy available for staff to refer to

	IPC before releasing for use		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	National guidance and local policies are in place and followed to support safe decontamination of equipment.	Initially the usual audit schedule was halted, however this has been reinstated so that assurance is provided Currently ATP scores have raised concerns regarding the effectiveness of cleaning and actions are in place to address	Spot checks are carried out by IPC team, ensuring information and single use and decontamination products are made available to people as the guidance is changed and updated
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	Trust systems and processes are in place and follow normal governance routes with issues or concerns raised through medicines management committee Dental prescribing at triage in accordance with Faculty of General Dental Practices (FGDP) recommended guidelines published by Scottish Dental Clinical Effectiveness Programme (SDCEP)	None identified, however there is a risk of increased use of antibiotics	Continue surveillance and monitor Audit currently underway in dental services
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	Usual reporting systems and processes remain in place and reported through IPC Q3 & Q4 IPC reports to QIR and full summary in CN report to June Board	Nil identified	Incident report monitoring Governance reporting
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	The wards have implemented national guidance with some variation around end of life care, allowing visits in those circumstances. Visitor guidance has been reviewed regularly and remains in line with national guidance Services have included specific wording in their appointment letters explaining what actions patients and their carers need to take when attending clinical appointments, e.g. children's services letters to parents Dental urgent care pathway restricts numbers attending clinics to minimum, waiting area is patient's car	None identified	Some areas have visitor's policies and posters are available through our communication team with regular communications to staff which guidance has been updated
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	National guidance is followed, and patients are, where possible nursed in single rooms or in cohort bays The hospital sites have implemented the national guidance for patients and staff in relation to wearing of masks As services are reintroduced a manager's checklist for services has been developed to guide managers and staff in ensuring best practice is followed	There have been instances where the restricted visiting guidance has not been adhered to	Guidance and updates communicated to staff Where possible healthcare workers are not shared across wards Visiting is restricted in line with guidance and information has been provided in writing to patients and families/carers as well as being made available on our Trust internet site.

• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Links to all national guidance and information are provided on both the public facing internet and the Trust intranet and includes some easy read versions. The integrated learning disability team have a full range of easy read information for service users.	Links are not always up to date where guidance is changed rapidly or where services have altered their delivery methods	Services have been directly in contact with existing and newly patients referred.
• infection status is communicated to the receiving organisations or department when a possible or confirmed COVID-19 patient needs to be moved	As part of the transfer of care/discharge process services inform the receiving area a patient's Covid status in line with guidance Patients transferred in an emergency in mental health services have infectious status communicated via emergency ambulance or as part of transfer process internally. Patients being discharged into an alternative care setting, such as a nursing home, have a swab completed prior to discharge to confirm infection status on discharge	This may not be implemented consistently across the Trust with possible variance in how this is recorded	Full up to date clinical history and presentation of the patient is provided as part of the discharge process A template has been added to SystmOne to record patient Covid status on admission with daily update as part of daily ward round
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with	All services have adapted the guidance to work for their clinical environment, for example up to 14 days self-isolation if they are high clinical risk. Community nursing teams conduct pre-visit questionnaire to identify patients or families that have suspected/confirmed Covid	Unclear how the guidance is interpreted and applied across all services when considering service restart	QIA process in place to support decision making IPC advice available to all services a manager's checklist for services has been developed to guide

possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection	In specialist dental services patients have swabs taken 72 hours prior to their appointment. Services such as child and family screen children and families on the phone before being seen for a face to face appointment using a set of consistent screening questions The mental health assessment unit has an isolation room available should this be required for a symptomatic patient that requires an urgent assessment that cannot be facilitated in another way Dental triage and urgent care pathway in place. Patients requiring GA are asked to isolate for 14 days isolation and have a swab at 72 hours pre op		managers and staff in ensuring best practice is followed
• patients with suspected COVID-19 are tested promptly	National guidance is followed, on admission if direct from community the staff take a swab & isolate the patient. If the patient is a direct admission from acute hospital if not tested on or before discharge the ward staff will complete a swab and isolate the patient. In both cases the patient will remain isolated until swab result is received. If an individual present with symptoms to our non-inpatient areas the staff will direct them to the appropriate help	Lack of evidence that there are sufficiently robust systems in place as part of the restart	Incident reporting and monitoring system National guidance available to staff Swab testing SOP available
• patients that test negative but display or go on to develop symptoms of COVID-	National guidance is followed and where indicated patients re-tested All patients transferred into the wards are	No gaps in assurance	IPC team available to advise and support clinical decision making

19 are segregated and promptly re-tested	isolated in single rooms for a minimum of 48hrs post transfer		
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	National guidance in place. Where patients arrive unexpectedly and are symptomatic staff will direct them to the appropriate help In community services patients receive a telephone call prior to their appointment to undertake a risk assessment Where possible across all services routine appointments are carried out via remote consultation. Home visits continue where indicated for example, via depot clinics and home treatment in mental health services	There is no formal SOP in place to guide staff where we start to reopen services	A system is in place where urgent work is being carried out, patients are required to wait outside of the building or in their cars until their appointment time to reduce the risks

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	A programme of clinical updates has been implemented across the organisation Bespoke training, upskilling programmes and induction have been implemented for both bank and substantive staff new to the organisation and for those who have not worked clinically for a period Compliance is above 93% at end of March 2020 for infection control across all services – clinical and non-clinical. Estates & facilities staff and care agencies staff have all had additional and bespoke training sessions provided to ensure they are familiar with the most current guidance	No gaps identified	IPC team available for advice and support Daily updates to all staff via communications systems Verbal conversations being had with contractors to ensure they are aware of expectations

• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	National guidance followed and local IPC policies in place Staff have had access to the upskilling programme and IPC team have delivered bespoke training where requested. A Trust 'don & doff' video, one for inpatients and one for what to do in a patient's home were produced and are available to staff	No audit of appropriate use of PPE has been completed New staff and re-deployed staff accessed the training whereas existing staff didn't necessarily have the same training so may not be fully up to date	Spot checks by IPC team Monitoring incidents reported Staff feedback
• a record of staff training is maintained	A central record of staff statutory and mandatory training is kept Attendance at upskilling and adhoc training is recorded	Lack of confidence that all adhoc training sessions are recorded and available for review	No mitigations
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	The CAS alert was reviewed by the Head of IPC, Head of Procurement and the H&S lead and guidance issued to staff The Trust introduced a PPE stock monitoring system in early April so that services who were running low could be restocked. This was monitored at the daily Gold Command call and actions taken to identify where potential stocks were low. Staff have access to the PPE hub 7 days a week to replenish stocks so that they were maintained at safe levels	No gaps identified	H&S and IPC have reviewed all information and provided guidance in line with alert Procurement team fully linked into national and regional calls and escalated issues through Gold Command as required Mutual aid across services and partners in place to reduce the risk of essential PPE not being available
• any incidents relating to the re-use of PPE are monitored and	All incidents are reported and monitored within normal governance arrangements. Any concerns regarding PPE are raised through Gold command or directly with IPC and action taken immediately to address the issues	No gaps identified	Incidents of concern are escalated and if required an incident review meeting is undertaken

appropriate action taken	During this time there have been no incidents reported relating to the need to re-use PPE in the Trust		
• adherence to PHE national guidance on the use of PPE is regularly audited	National guidance and local policies are in place to support best practice	No formal audits in place.	Spot checks are carried out by IPC team who challenge any inappropriate use of PPE in a clinical setting Any misuse of PPE identified on social media is addressed directly with the matron and clinical lead for the area and the posts removed The Chief Nurse, Associate Nurse Director, Heads of Quality & Professions regularly visit clinical areas and if any inappropriate use of PPE identified this will be addressed Matron's address any concerns as part of their quality reviews
• staff regularly undertake hand hygiene and observe standard	Annual hand hygiene competency is completed by all clinical staff in ward and community settings.	No gaps identified	Following discussion at IPC group it has been agreed that hand hygiene audits will be

infection control precautions	Hand hygiene observational audits (bare below the elbow etc) are also completed on the ward twice per year. Information and guidance are available in the clinical settings		completed for all staff, clinical and non-clinical every 6 months. Due to current situation where staff are not currently in the workplace arrangements are in place to undertake a virtual assessment with a face to face assessment to be completed on return It has also been agreed that the hand hygiene observational audit will change to be undertaken monthly in our in-patient wards
• staff understand the requirements for uniform laundering where this is not provided for on site	The uniform policy has been updated to reflect national guidance Zoom calls undertaken with staff who were anxious about wearing own clothes in clinical setting Changes and national guidance and Trust policy communicated through normal channels to all staff	Lack of familiarity with the policy particularly by staff who don't usually wear uniform	Where possible staff have access to shower facilities and staff changing areas. Lockers and dirty laundry bags have been made available to staff Continued focus on uniform requirements and updates through comms team Advice and support provided where indicated by the IPC team and the

			senior nurses across the organisation
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	The Occupational Health (OH) team provides advice and support to staff and have introduced extended hours of availability during this crisis. Regular comms sent to staff via daily message, including updates and changes to guidance Good systems and processes in place to share the information with staff. Good OH support and advice backed up by IPC advice if required. The Power BI system provides data on the number of staff that are self-isolating/positive/working from home	Unable to demonstrate how well people understand	Advice and support from manager are available to staff OH, and IPC team available to advise where required
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Trust isolation policy and national guidance followed. All wards currently in use have single rooms. Where necessary and appropriate patients can be cohort nursed	Limited access to shower and toilet facilities for patients in some facilities. Limited access to hand washing facilities for staff in some clinical settings outside of patient rooms	Provide hand sanitiser outside the rooms, have access to shower facilities close by and patients are isolated to their rooms with facilities brought into their rooms, e.g. use of commodes
• areas used to cohort patients with suspected or confirmed COVID-19	Staff where possible use sessional PPE in line with national guidance. Cleaning schedules are in place and cleaning staff have access to appropriate PPE	Need assurance that all products being used are compliant and have been checked by IPC and H&S lead	H&S and IPC team are checking products when they are made aware of new ones being

are compliant with the environmental requirements set out in the current PHE national guidance			introduced
• Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	All infective patients are managed in line with Trust policy and IPC team provide clinical visits and advice and support. Where indicated an RCA is completed to identify and share learning for improvement, including learning from excellence	No gaps identified	Incident reporting systems Reporting system between microbiology team and IPC
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	The IPC team provided training for community testers and ward staff who were undertaking swabs. Train the trainer approach taken so that ward staff always have staff who can swab. If there is a gap the IPC team complete the swab	No clear approach to competency assessment and recording in place including training records	Incident reporting monitoring Community testing SOP in place Ward testing SOP in place
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	The national guidance has informed practice in relation to staff and patient testing	There have been incidents where the national guidance has not been followed	Incident reporting and monitoring IPC feedback when being contacted for advice and support Escalation of variation in practice
• screening for other potential infections takes place	The Trust continues to work to current Trust policy	Nil noted	No mitigating actions

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	There is a full suite of policies in place for staff. Regular spot checks and planned audits are in place. IPC team visit clinical areas where and when an alert organism is identified All national guidance relating to Covid is available to staff and updated and reviewed regularly	No gaps identified	No mitigating actions
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	All guidance is reviewed by the emergency planning lead and the Head of IPC. There is a daily update system in place and any changes to guidance are sent via this route. The Head of IPC has been holding at least weekly Zoom sessions for all staff to access The clinical teams use a range of methods to proactively respond to changes in guidance for example when the changes in CPR guidance was made the mental heal teams arranged a conference call with the clinical team, the Chief Nurse and the Chief Medical Officer	No gaps identified	Incident reporting SOPs Urgent Care Pathways Guidance available on SolNet Spot checks and eyes on
• all clinical waste related to confirmed or suspected	Trust policies are available for staff to support their practice and have been updated in May 2020 to reflect the changes to waste disposal	No gaps in assurance	Spot checks incident reporting and patient feedback

COVID-19 cases is handled, stored and managed in accordance with current national guidance	in the community. There is regular comms provided including update's for safe disposal in clinical and community environment and patients' homes		
• PPE stock is appropriately stored and accessible to staff who require it	There is a stock monitoring system in place to ensure teams do not run out. There is a PPE hub in two key sites for staff to access should stocks be running low, including availability at weekends	No audits available to demonstrate that PPE is stored appropriately in the clinical areas	Physical checks before PPE being used. Reporting defects to H&S and IPC, as well as Procurement
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	National guidance is followed Risk assessment supported by OH are completed to inform decisions. Regular welfare checks are completed by managers and the OH team. Occupational Health information and updates are included in the daily communications. In response to the PHE reports in relation to the disproportionate impact of Covid-19 in BAME communities regular Zoom meetings with BAME staff taken place and will continue. Members of the executive, particularly the Chief Executive Officer and Chief Nurse attend these and have open Q&A sessions. The BAME resource group have influenced the development of the risk assessment forms	Lack of clarity for risk assessment has on occasions resulted in delays of support to carry out these assessments	Staff at risk have been supported to work from home or been redeployed to a non-patient facing role Risk assessments for BAME, all men, people over 60 and high-risk staff are being completed across the organisation

	which have been implemented. They have also been influential in leading the discussion around Black Lives Matters, helping colleagues and leaders across the organisation to understand their experiences and challenges faced. Services have used technology to maintain contact with staff using zoom or teams. This includes staff who are shielding/working from home In mental health they have also maintained contact as an MDT and team managers keep in close contact with staff Covid secure work environments based on risk assessment have been identified across the Trust		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	All staff requiring FFP3 have been Fit tested and training for Fit testing was been provided by the IPC/EiPs teams	Records of training are not complete Lack of assurance that agreed system to approve staff for Fit testing	System for agreeing who should be tested agreed Incident reporting and monitoring
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	The Trust monitors staff sickness/absence as part of normal Trust governance Occupational health provides regular health and wellbeing checks to all those self-isolating/shielding Any concerns are escalated through Gold command and with managers where appropriate	No gaps identified	Staff have access to a suite of Health and wellbeing resources Managers have access to OH advice and support Staff are encouraged to take annual leave, take

			regular breaks. The importance of keeping hydrated and eating well are also reinforced The Trust has focussed on the importance of clinical supervision during this time and has seen a steady increase across the organisation
• staff that test positive have adequate information and support to aid their recovery and return to work.	National guidance is followed, and information is provided consistently through occupational health and with support and advice from IPC where this is appropriate	No gaps identified	Support from OH, consistency from manager

Item 12.1

Board and Committee Cover Sheet

Item No.	12.1

Presentation to	Trust In Public Board			
Title of Paper	Workforce and OD (WOD) Exception Report			
Purpose of the Paper	To summarise the business transacted at the Workforce and OD (WOD) Committee held on 21st May 2020			
Author(s)	Helen Ives, Chief People Officer	Executive Sponsor	Mike Watts, Non-Executive Director	
Date of Paper	June 2020	Committees/Groups previously presented	---	
Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked: • To note the report			

For presentation to Board and its 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 Trust In Public 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)							

Summary of business transacted:

Review of Governance

A full overview and discussion of Workforce & OD Committee governance; outlining the work that has been progressed or postponed during COVID-19 and the emergency and refocused efforts that Solent have made towards this. Risks and issues were noted and the Committee agreed that appropriate actions have been taken; also that recovery planning and reporting will provide assurance against all areas highlighted.

People & OD COVID-19 Response

A full account was given of the workforce & OD activity undertaken to support people, respond to the pandemic, and manage risk. Together with the review of governance, the Committee felt sufficiently assured.

Key matters from the discussion included:

- COVID-19 sickness absence levels, noting that these have now steadied out
- Occupational health risk assessment incorporating risk factors for long-term conditions, disability, BAME, age, gender, pregnancy and those shielding
- RIDDOR reportable events and governance through incident reviews and health & safety
- Integrated physical and mental health and wellbeing response
- Staff testing capacity and outcomes
- Internal communications response (putting people first) including freedom to speak up and staff resource groups; alongside public information messaging and reputation management
- PR opportunities to highlight the important of community and mental healthcare
- Full briefing on items normally taken at People & OD Group, which had been stood down, including:
    - Resourcing
    - Training and development
    - Upskilling
    - Deployment and redeployment
    - Workforce optimisation
- Proactive workforce support to care homes across the system, creating an end-to-end solution for contracting, coordination and deployment
- Additional support to managers, enabling them to be compassionate and person-centred and to help manage a new virtual workforce
- Postponement of work in response to internal audit on e-rostering. Noting, however, that e-rostering support during COVID-19 has been intensive and successful (with additional resources aligned to services)
- National pause on workforce and business planning has necessitated a common-sense approach to workforce planning based on last year's figures
- Progress on Adult Mental Health (AMH) workforce planning slowed but a full update was received on the recovery plan. The recruitment of new consultants is critical and must be monitored closely, recognising the very significant market pressures

- Wessex Deanery have been provided with a full report on quality of education placements for trainees. Reports from trainees are generally positive and no concerns have been raised. Placements due to be restarted from September 2020 (depending on COVID-19

People & OD Recovery Plan

An early outline of the People & OD approach to recovery planning was shared, which is linked to the Trust-wide recovery planning. There are key areas:

- When we might restart the operations and programmes of People Services to their full extent
- What the OD learning and response is trust-wide, including aspects such as how research and act on innovation and how we continue to strengthen culture and behaviour
- Development of the new People & OD strategy to underpin our trust-wide strategy
- Working in partnership across the STP/ICS to progress system priorities

Decisions made at the meeting:

Amendments to the objectives of the Committee were included in the governance paper. These were approved.

The proposed scores for internal and external risks for workforce sustainability on the BAF were agreed, noting that this is a live document and that some further COVID-19 details could be added.

The themes from the roundtable discussion on organisational effectiveness will be fed into the Recovery Programme and also shared through appropriate channels for the forthcoming discussion on strategy development (a slide deck to be shared on this separately).

Recommendations:

The Committee recommended that the exceptional work of all services working together be noted at the next Board meeting, recognising the people, leadership, culture and values of Solent.

Other risks to highlight (not previously mentioned):

There were no other risks to note.

Board and Committee Cover Sheet

Item No.	12.2

Presentation to	Trust In Public Board			
Title of Paper	Workforce and OD Committee Exception Report			
Purpose of the Paper	To summarise the business transacted at the Workforce and OD (WOD) Committee held on 16th July 2020			
Author(s)	Helen Ives, Chief People Officer	Executive Sponsor	Mike Watts, Non-Executive Director	
Date of Paper	July 2020	Committees/Groups previously presented	----	
Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked: • To note the report			

For presentation to Board and its 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 Trust In Public 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)							

Summary of business transacted:

- Workforce Performance & Sustainability Report. Differences brought about by COVID-19 were noted, including the pause on normal workforce planning processes. The Committee agreed there was sufficient assurance.
- Appraisal of operating risks and internal audit recommendations. The action plan for the red audit result on e-rostering was discussed. COVID-19 has had a significant impact on progress due to diversion of resources elsewhere. The Committee felt there was limited assurance and asked for a more detailed plan and timescales to be presented at the next Audit & Risk Committee meeting.
- Board Assurance Framework (BAF). The Committee agreed with the changes in score proposed. The overall risk score has reduced from 16 to 12 due to a decrease in the internal risk scoring, brought about by lower levels of turnover and absence.
- STP/ICS Workforce & OD Programme. A verbal update on the Recovery Programme was provided. In addition, the Committee received papers on the system work that Solent have been leading to support care homes in Portsmouth & South East Hampshire and a system-wide MOU for long-term staff sharing. The Committee praised the innovation being led by Solent.
- Diversity and Inclusion. An update was provided by the Associate Director for Diversity & Inclusion and the forthcoming Annual Report to Board was signposted. The Committee requested greater assurance on data and the Chief Nurse confirmed this was an integral part of the report and improvement plan. The Committee agreed there was sufficient assurance.
- Review of COVID-19 risks, issues and response. A detailed update was provided on Occupational Health, including: risk assessments for BAME, health conditions, pregnant women, men and those aged 60 and over. Compliance targets were discussed alongside reporting requirements. Support is being offered from staff resource groups, occupational health and managers and this was noted as particularly important in order to manage anxiety around risk. The Committee commended the cross-functional approach taken by teams in the Trust and agreed there was sufficient assurance.
- Reset & Recovery for People & OD Services. The Committee reviewed the approach taken to determining priorities for recovery and agreed there was sufficient assurance.
- Recovery of Employee Relations Caseload. The recovery plan for paused cases was discussed (noting the Improving People Practices principles from Dido Harding) and the Committee was sufficiently assured.
- Adult Mental Health Workforce Plan. The Committee noted the good progress on the plan and they were sufficiently assured.
- Output from Organisational Effectiveness Discussion. The Committee accepted the recommendation to defer this report to enable the Chief People Officer to discuss further with the Executive in the first instance.

The Committee was observed by Geraldine Strathdee, Non-Executive Director, Community Health Partnership. She was asked for her reflections on the Committee and commented that it was an example of good practice.

Key items for escalation to the Board are:

- Greater scrutiny at Board level of e-rostering improvement (see below recommendation)
- Recognition of COVID-19 impact on groups with protected characteristics, including gender, ethnicity, age and disability and visibility of risk assessment compliance. Reporting on risk assessment compliance will be shared at Board through the CEO Report.

Decisions made at the meeting:

No decisions were made at the meeting.

Recommendations:

The Committee recommended that the Audit & Risk Committee seek further assurance in the form of detailed timescales for e-rostering improvements. It was also recommended that key metrics be included in the Workforce Sustainability & Performance report for Board.

Other risks to highlight (not previously mentioned)

There were no other risks to note.

Item 14

Solent NHS Trust

Board and Committee Cover Sheet

Item No.	14

Presentation to	In Public Board			
Title of Paper	Mental Health Act Scrutiny Committee Exception Report			
Purpose of the Paper	To summarise the business transacted at the Mental Health Act Scrutiny Committee held on 20th July 2020.			
Author(s)	Sam Stirling, Corporate Affairs Administrator	Executive Sponsor	Thoreya Swage, Non-Executive Director (Committee Chair) Jackie Ardley, Chief Nurse	
Date of Paper	21/07/2020	Committees/Groups previously presented	-.-	
Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked: • To note the report from the Committee			

For presentation to Board and its 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 In Public 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							

Summary of business transacted:

- The Committee noted that there were no open **Internal Audit Recommendations** to report in relation to Mental Health.
- The Mental Health Act and Mental Capacity Act Lead took comments on the **Mental Health Act Report**.
    - The Committee were informed of removal of Deprivation of Liberty (DoLs) data within the report, following update of the Committee Terms of Reference (ToR). It was confirmed that DoLs would be reported to the Mental Health Act Governance Group going forward.
    - The Use of s132 was reviewed and it was agreed to provide appropriate assurance to the Quality Improvement and Risk (QIR) Group and Quality Assurance Committee.
    - Extensive discussions were held regarding the process for informal admissions and capacity to consent. Remote working, training and recording was considered and it was agreed to complete a full deep dive and report the findings to the next meeting.
    - The Committee reviewed the impact of Covid-19, including s2 assessments and management on inpatient wards. It was confirmed that the Coronavirus Act had not been implemented and assured of appropriate escalation if required.
    - Clarity regarding wording for the Use of CTOs was agreed.
- Standard scrutiny of the **Restraint and Seclusion Assurance Report** took place. The Committee noted the report and that episodes of seclusion and restraint had been reviewed and considered, to ensure that cases were appropriate and lawful.
    - It was confirmed that a deep dive into prone restraints was taking place.
- The **Committee Annual Report** (appendix 1) was presented and amendments highlighted. It was agreed to review the Committee Objectives for 2020-2021 with the new Chief Medical Officer when in post and approve virtually.
- Updates to the Committee **ToR** were highlighted, including removal of reference to DoLs and changes to Committee membership.
- The Mental Health Act and Mental Capacity Act Lead informed of plans to update and strengthen processes for **Associate Hospital Managers**.
- The Committee noted that there were no new risks to report in relation to the **Board Assurance Framework (BAF)**.
- **Any Other Business**- It was noted that the new DoLs (LPS) would be introduced in April 2022.

Appendix 1 – Committee Annual Report

Mental Health Act Scrutiny Committee Annual Report 2019-20

Introduction

The Mental Health Act Scrutiny Committee (MHASC) is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference (ToR) and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2020.

Meetings

During 2019-20 the following meetings were held:

- 30th May 2019
- 22nd August 2019
- 14th November 2019
- 23rd March 2020

Membership & Attendance

Attendance by members is outlined as follows:

NAME	30th May 2019	22nd August 2019	14th November 2019	23rd March 2020	% attendance	Notes
Mick Tutt – Chair Non Executive Director	P	P	P		100%	*Retired end of January 2020*
Thoreya Swage- Chair Non Executive Director				p	100%	*Joined the Trust Feb 2020*
Catherine Mason Trust Chair	P	P	A	P	75%	
Jon Pittam Non Executive Director	P	P	P	P	100%	
Francis Davis Non Executive Director	A				0%	*Resigned June 2019*
Jackie Ardley Chief Nurse	P	A	P	P	75%	
David Noyes COO – Southampton & County Wide Services	A	A	A	A	0%	
Dr Dan Meron Chief Medical Officer	P	P			100%	*Left the Trust December 2019*
Jonathan Prosser Interim Medical Director				P	100%	*Interim from December 2019*
Sarah Austin Chief Operating Officer, Portsmouth	A	A	P	A	25%	
Suzannah Rosenberg Deputy COO, Portsmouth			P	P	100%	

P= Present A= Apologies

Terms of Reference
The ToR are undergoing extensive review and rigorous consultation, taking into consideration recommendations from the PWC MHASC internal audit and comparative review of other such Committees in similar Trusts.

Status against the achievement of the Committee's Objectives

Objectives for 2019-20	Year end position
To continue to utilise the Mental Health Act lead Report as a main vehicle for scrutinising compliance with the expectations of the Act	*Agenda planned accordingly for every meeting*
To continue the scrutiny of the use of seclusion and restraint	*This is a standing item for reports provided in addition to the main MHA report.*
To continue the scrutiny of the application of DoLs, across the Trust	*Received at every meeting within the Lead Report.*
To receive further advice on the provision of appropriate oversight of the outcomes from MCA & MHA training	*On-going - Reviewed regularly based on changes in legislation*
To continue the process of reflective training sessions for Associate Hospital Managers	*On-going- processes currently being reviewed*
To continue formal reviews/appraisals for AHM	*On-going- processes currently being reviewed*
To continue to advocate for a choice of venues for community hearings	*On-going as venues change*
To consider further scrutiny of the reasons for non-attendance (by those detained) at hearings	*Discussed in Monitoring the MHA meeting*
To seek further options to understand the views of people detained, generally	*Discussed in Monitoring the MHA meeting*
To seek assurance in relation to the progress of actions associated with the PWC MHASC internal audit.	*Included on the agenda and report providing overview of open audit actions provided accordingly.*

Summary of business conducted in year

- The majority of business conducted at the meetings was through the Mental Health Act Scrutiny Report co-ordinated by the MCA&MHA Lead, with contributions from relevant clinical and service leads and seclusion reviews.
- The report included an executive summary which highlighted key issues and guided committee members to more detail within the body of the document, as well as appendixes where necessary.
- Each meeting received a Restraint and Seclusion Assurance report for noting.
- The May 2019 Committee approved the Committee's Annual Report for onward reporting to the Board.

- The Committee received an update on the progress of PWC internal audit recommendations in August and November 2019.
- An overview of updated Deprivation of Liberty Guidance was provided to the August Committee. Considerations of the implications for the Trust were held.
- Reappointments of AHMs were reported at the August 2019 Committee. A summary report regarding the AHM recruitment and selection process was provided to the November 2019 meeting.
- The November 2019 meeting received an overview of Pan-Hampshire data and it was agreed to continue providing data until the May 2020 meeting when context to the meeting could be fully considered.
- The Mid-Year Review of Objectives were presented to the November 2019 meeting and agreed.
- The Committee noted update regarding the number of 48 hour discharges following letter from HM Courts & Tribunal Service.
- Exception reports of the MHASC were presented to the Board following each meeting.
- Training sessions were provided during Part B of the meeting and psychiatrists as well as Executive Directors and other management colleagues were invited to attend, if the training was considered to be of value. The following training sessions were provided:
    - Solent MIND- March 2019
    - Brain Injury- April 2019
    - MH Training Legal update (Paul Barber)- May 2019
    - Information Governance

Objectives for 2020-21

- To continue to support developments of AHMs

Further objectives to be agreed following discussion with the new Chief Medical Officer

Conclusion

The Committee has complied with its Terms of Reference.

Report Author(s)	Thoreya Swage, Non-Executive Director and Mental Health Act Scrutiny Committee Chair Sam Stirling, Corporate Affairs Administrator

Item 15

Board and Committee Cover Sheet

Item No.	15

Presentation to	In Public Board			
Title of Paper	Audit and Risk Committee Exception Report			
Purpose of the Paper	To summarise the business transacted at the Audit and Risk Committee held on 19th June 2020.			
Author(s)	Sam Stirling, Corporate Affairs Administrator	Executive Sponsor	Andrew Strevens, Chief Finance Officer Jon Pittam, Non-Executive Director (Committee Chair)	
Date of Paper	17/07/2020	Committees/Groups previously presented	----	
Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked: • To note the report from the Committee			

For presentation to Board and its 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 requirement to consider **Going Concern** basis of accounting as part of the year end audit process and revised arrangements were shared, including a cash flow statement for the next eighteen months. The Committee agreed with the assessment provided.
- The Chief Finance Officer presented the **Annual Accounts (including the Letter of Recommendation)** and the Committee recommended onward approval to the Trust Board.
- Ernest & Young provided a comprehensive overview of the **Annual Results report for the year ended March 2020 including the Audit Plan**. The Committee noted the anticipated unqualified audit opinion on the financial statements and an unqualified value for money conclusion and recommended the report for Trust Board approval.
- The Trusts' internal auditors, PwC presented the **Internal Audit Annual Report (including Head of Internal Audit Opinion)**. The report was confirmed to be consistent to previous years with the achievement of an audit opinion of 'generally satisfactory with some improvements required', reflecting the proportion of medium and high risk recommendations in the audit reports. The report was received and approval by Trust Board was recommended.
- The Committee recommended the **Draft Annual Report and Annual Governance Statement** and agreed that there were no significant issues in relation to the financial statements of 2019/20, operations or compliance raised by the Audit and Risk Committee during the year.
- The Chief Nurse presented the **Quality Account** and it was agreed to recommend approval to the Board.
- The Chief Finance Officer presented reports outlining **Single Tender Waivers** processed, **Losses and Special Payments** and **SFI Breeches** since the last meeting. The rationales for these were provided- which were noted by the Committee.
- PwC presented the **Internal Audit 2019/20 Progress Report**- a summary of further progress against the 2019/20 audit plan was provided:
  Since the February 2020 Audit and Risk Committee, the following internal audit reports have been finalised:
    - Key Financial Systems
    - Medicine Management
    - E-Rostering
    - Risk Management

  The Chief Finance Officer confirmed internal monitoring of final management responses. The Committee noted progress and received the report.
- The Counter Fraud Team presented the **Counter Fraud Progress Report** and the **Counter Fraud Annual Report**- which were noted by the Committee. The Counter Fraud Team also provided an overview of the **Provider Fraud Risk and type and Fraud, Bribery and Corruption Annual Work plan for 2020/21**- which was approved by the Committee.
- The **Clinical Audit Annual Report** and **Clinical Audit Annual Plan- Six Monthly Review** were noted and discussions were held regarding changes expected in light of Covid-19.
- An **Update on external reviews / (un)announced visits** was provided.
- The Chief Executive Officer acknowledged this meeting as the final year end Audit Committee for Jon Pittam (Committee Chair) and noted formal thanks for exceptional chairmanship and knowledge during his time as a Non-Executive Director.

Decisions made at the meeting:

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

Recommendations:

The following reports were recommended to the Trust Board for approval:

- Annual Accounts 2019/20
- Annual Results Report for the year ended March 2020
- Internal Audit Annual Report and Head of Internal Audit Opinion
- Draft Annual Report and Annual Governance Statement
- Quality Account

Other risks to highlight (not previously mentioned):

There are no risks to highlight.

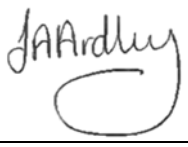
Item 16.1

Board and Committee Cover Sheet

Item No.	16.1

Presentation to	Trust In Public Board			
Title of Paper	Quality Assurance Committee Exception Report			
Purpose of the Paper	To summarise the business transacted at the Quality Assurance Committee held on 21st May 2020.			
Author(s)	Sam Stirling, Corporate Affairs Administrator	Executive Sponsor	Thoreya Swage, Non-Executive Director (Committee Chair) Jackie Ardley, Chief Nurse	
Date of Paper	May 2020	Committees/Groups previously presented	-.-	
Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked: • To note the report from the Committee			

For presentation to Board and its 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 Trust In Public 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 **format** of this and future Committee meetings, in light of Covid-19.
- There was no **Freedom to Speak Up Concerns** or **Urgent Matters of Safety** to report.
- Regarding **Partnership governance arrangements**, discussions were held regarding risk management across the system.
-
- The Committee **noted** the following reports presented:
    - **Freedom to Speak Up 6 Monthly Report (including Covid-19 update) -** No issues were raised.
    - **Quality Account-** the Committee discussed potential amendments to future iterations to ensure accessibility.
    - **Exception Report from the Quality Improvement and Risk (QIR) Group and Chief Operating Officers-**Key updates were provided from the Southampton and Portsmouth Care Group and exceptions arising from the Quality Improvement and Risk Group.
    - **Annual Governance Statement (final draft) -** It was highlighted that final amendments would be made outside of the meeting in preparation for sign off.
    - **BAF Consideration and oversight of risks-** Relevant risks were reviewed, particularly in light of Covid-19.

- A verbal update was provided regarding exceptions arising from the **Ethics Panel.** An overview of key topics was provided and it was confirmed that considerations were being held in relation to outputs and learning from the group.
- The Committee received a verbal update on **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items).** It was confirmed that there had been no indication provided regarding dates for CQC visits and confirmed that open, honest dialogue (particularly regarding programme of work since Covid-19) would continue.
- Discussions were held regarding **Mental Health Services.** The Committee noted report received regarding the **Mental Health Act 1983 under the Covid-19 Pandemic.**
- The Committee **reflected** on hard work of staff within the Trust and the importance of monitoring staff wellbeing during this time.

Item 16.2

Board and Committee Cover Sheet

Item No.	16.2

Presentation to	Trust In Public Board			
Title of Paper	Quality Assurance Committee Exception Report			
Purpose of the Paper	To summarise the business transacted at the Quality Assurance Committee held on 20th July 2020.			
Author(s)	Sam Stirling, Corporate Affairs Administrator	Executive Sponsor	Thoreya Swage, Non-Executive Director (Committee Chair) Jackie Ardley, Chief Nurse	
Date of Paper	July 2020	Committees/Groups previously presented	-.-	
Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked: • To note the report from the Committee			

For presentation to Board and its 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 Trust In Public 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)							

Summary of business transacted:

- There were no **Urgent Matters of Safety** to report. The Chief Nurse provided an update on **Freedom to Speak Up** including positive staff survey results and Freedom to Speak Up Guardian changes.
- There were no matters to raise in relation to **Partnership governance arrangements**.
- The Committee **noted** the following reports presented:
    - **Quarter 4 Learning from Deaths, including SIs and incidents (formally Patient Safety Report)**-Strong reporting culture was acknowledged and an overview of incidents for this quarter was provided.
    - **Learning Disability Strategy Update**- the Committee commended the work taking place across service lines and discussed effects of Covid-19.
    - **Quarter 4 Experience of Care Report (patient experience, complaints & community engagement)** – full discussions were held and the Committee were briefed on the introduction of the 'Community Conversations' programme since Covid-19.
    - **Wheelchairs Update Report**- the Millbrook tender was debated and assurance of full monitoring provided.
    - **Exception Report from the Quality Improvement and Risk (QIR) Group and Chief Operating Officers-** Key updates were provided from the Southampton and Portsmouth Care Group and exceptions arising from the Quality Improvement and Risk Group. The Committee also recommended the **Safe Staffing Report** (item 17.3) to the Board for noting.
    - **Quarter 4 Safeguarding Report**- issues in relation to Covid-19 were discussed. On-going work to ensure training compliance was confirmed.
    - **BAF Consideration and oversight of risks-** Relevant risks were reviewed by the Committee.
- The following **Annual Reports** were recommended to the Board for noting:
    - **Infection Prevention & Control Annual Report** (item 17.4)
    - **Safeguarding Annual Report** (item 17.5)
- The Committee received a verbal update on **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items).**
- The Chief Medical Officer presented the **Ethics Panel Exception Report** and on-going challenges identifying methods for implementing learning outputs.
- The Chair provided key highlights from the **Mental Health Act Scrutiny Committee**.
- Minor amendments to the **Committee Annual Report** (appendix 1) were noted. It was agreed that JA consider 2020-2021 objectives and seek virtual approval outside of the meeting.

Appendix 1- Quality Assurance Committee Annual Report

Quality Assurance Committee Annual Report 2019-2020

Introduction

The Quality Assurance Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference (ToR) and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2020.

Meetings

During 2019-2020 the following meetings were held:

• 23rd May 2019	• 21st November 2019
• 18th July 2019	• 23rd January 2020
• 19th September 2019	• 23rd March 2020

Membership & Attendance

Attendance by members is outlined as follows:

NAME	Meetings						% attendance	
	23rd May 2019	18th July 2019	19th September 2019	21st November 2019	**23rd January 2020**	23rd March 2020		
Mick Tutt – Chair * Non Executive Director	P	P	P	P	P		100%	*Retired at the end of January 2020*
Thoreya Swage- Chair * Non Executive Director						P	100%	*Joined the Trust in February 2020*
Mike Watts Non Executive Director	P	P	P	P	P	P	100%	
Francis Davis* Non Executive Director	A						0%	*Resigned from the Trust in June 2019*
Stephanie Elsy Non Executive Director				A	P	P	67%	*Member from November 2019*
Sue Harriman Chief Executive Officer	P	A	P	A	A	P	50%	
Or **Andrew Strevens** Deputy Chief Executive Officer & Chief Finance Officer	P	P	A	A	P	A	50%	
Jackie Ardley Chief Nurse	p	A	P	P	P	P	83%	
Sarah Austin Chief Operating Officer	P	A	P	A	P	A	50%	
or **Suzannah Rosenberg** Deputy Chief Operating Officer		P	P	P	P	P	100%	
Dan Meron Chief Medical Officer	P	P	A	A			50%	*Left the Trust in December 2019*
Jonathan Prosser Interim Medical Director					P	P	100%	*Interim Medical Director from December 2019*
David Noyes Chief Operating Officer	P	P	P	A	P	P	83%	

Rachel Cheal Associate Director of Corporate Affairs and Company Secretary	P	P	P	P	P	P	100%	

P= Present A= Apologies

ToR

An annual review of the ToR was completed in July 2019. The Committee then reconsidered the ToR in March 2020 comparatively with other local Trusts and to reflect the recommendations of Internal Auditors, PwC following an internal audit to review the effectiveness of the assurance process. It was during this review that the Committee was renamed to the Quality Assurance Committee.

Status against the achievement of the Committee's Objectives

Objectives	Year end
Any urgent matters of safety, or Freedom to Speak-Up concerns will be reported to the committee, at the commencement of each meeting. The Freedom to Speak-Up lead will have an open invitation to attend all meetings and will be invited to present a formal written report on a 6-monthly basis.	*Standing agenda item included at each meeting. The Freedom to Speak Up Lead receives an open invitation to attend each meeting (which is held on a bi-monthly basis) and provides a 6-monthly update report.*
Exception reports from the COOs and the Chair of QIR will be received at each meeting.	*It was agreed at the March 2020 meeting to revert to 3 separate reports for the COOs and QIR Exception Report. This change is yet to occur due to adjustments made to agendas in light of Covid-19.*
A series of 'deep dives' into specific areas of Governance and Regulatory Compliance, according to a planned programme of activity, will be received at each meeting.	*Agenda planned accordingly*
Other reports will be received following agreement by the Chair, CMO and CN.	*On going*

Summary of business conducted in year

Highlights of the main business conducted by the Committee for the period April 2019 to and including March 2020 are summarised as follows;

- An update on urgent matters of safety and any issues associated with Freedom to Speak Up (F2SU) were noted at each meeting. A full six monthly F2SU report was received in November 2019 (with an annual report presented to Audit and Risk Committee). The Committee also received a F2SU Self-Review report in November 2019.
- At the July 2019 Committee a change in the Trust Policy ratification process was noted. It was confirmed that policies would now be ratified by the Trust Management Team Meeting.
- An update on the Board Assurance Framework (BAF) was provided to each meeting for members to consider the mitigations and agree assurance that risks were being actively managed and escalated.
- Following the August 2019 Audit & Risk Committee, it was agreed that audit recommendations were overseen by respective Board committees. The Committee received two reports in September 2019 and November 2019, however agreed appropriateness of reporting to the Quality Improvement and Risk (QIR) Group (with updates provided through the escalation report).
- The draft Quality Account was shared and endorsed by the Committee in March 2020.
- A progress update in relation to the Learning Disablity Strategy was provided following Trust

Board approval at the March 2020 meeting.

- At the March 2020 Committee, an escalation report was received (following presentation at QIR) regarding issues with service provision by NHS Property Services at Solent occupied sites.
- A report to provide assurance of actions taken as a result of the adrenaline auto-injector shortage was provided at the March 2020 meeting.
- Following review of the ToR, it was agreed to include a Mental Health Act Scrutiny Committee update at each meeting to ensure aligned approach and oversight between the Committees. A verbal update was provided to each meeting from January 2020.
- The Committee received the following quarterly reports:
    - Regulatory Compliance Update (including CQC matters, visits & any NHSE/I items)
    - Learning from Deaths including SIs and Incidents (formally patient safety report)
    - Experience of Care (Patient Experience/Complaints & Community Engagement)
    - Safeguarding
    - Risk Analysis- between QIR and Assurance & Operational Risk Register- consideration of quality and patient safety related risks
    - Safe Staffing
- The Committee received the following annual reports:
    - Academy of Research & Improvement Annual Report 2018/19 (May 2019)
    - Patient Experience Annual Report 2018/19 (July 2019)
    - Safeguarding Annual Report (July 2019)
    - Infection Prevention Control Annual Report (July 2019 & November 2019- *revised*)
    - Complaints Annual Report (September 2019)
- Each meeting agreed items for escalation to the Board and items for cascading to services.
- A Committee exception report was presented to the Board following each meeting.

Objectives for 2020-2021

To be confirmed and circulated for virtual approval by Quality Assurance Committee members

Conclusion

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

Report Author(s)	• Thoreya Swage, Non-Executive Director and Quality Assurance Committee Chair • Sam Stirling, Corporate Affairs Administrator

Safe Staffing Report, 1 December-31 May 2020

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, including the actions taken in response to Covid-19 pandemic.

- The Board is asked to endorse the action being taken to maintain and monitor safe staffing levels across the organisation.

Background

The Trust is required, as outlined in the National Quality Board Guidance (NQB), 2016, to report to Board on safe nurse staffing every Six months. In its guidance the NQB set out 10 expectations and a framework within which organisations and staff should make decisions about safe staffing and emphasises the requirement for NHS provider Boards to be accountable for ensuring that their organisation has the right skills in place for safe, sustainable and productive staffing. The expectations are set out below:

Expectation One	**Expectation Two**	**Expectation Three**
Right Staff	**Right Skill**	**Right Place & Time**
• Evidence based workforce planning • Professional Judgement • Compare staffing with peers	• Mandatory training development and education • Working with the Multi-disciplinary team • Recruitment and retention	• Productive workforce and eliminating waste • Efficient deployment and flexibility • Efficient employment and minimise agency

This report covers the time period December 2019 to May 2020. 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 refocussed these meetings to maximise the opportunity for sustained improvement and sharing of learning. A summary of themes from each meeting will continue to be submitted 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 were a critical component of our planning in response to the Covid-19 pandemic particularly in relation to the setting up of additional bed capacity.

In the first 3 months of this reporting period the position in relation to reliance on temporary staffing in some service areas, particularly across mental Health services, remained a concern and continued to be monitored and strategies planned to reduce reliance on bank and agency solutions.

There continue to be challenges with effective roster management across all teams and as a result the safe staffing meeting will from June 2020 concentrate on four key elements:

- Roster approvals within timescale
- Net hours balance position
- Bank & Agency usage
- Annual leave/unavailability

The actions identified to address the issues reported previously have had some impact with improvements seen in some areas in relation to roster approvals. This position will continue to be monitored and when sustained improvements are seen it will be possible to add additional matrix.

As reported previously it has been agreed to trial the newly available acuity and dependency tool for mental health inpatient services. Due to the pandemic the implementation has been delayed but will be taken forward from July 2020 and will be monitored through the safe staffing meetings.

A priority from the last reporting period was to identify the Red flag incidents for each area to include on the safe staffing dashboard. The service lines have been considering this and will be proposing their red flags for agreement at the July safe staffing meetings.

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 the ward level data is 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.

Over this reporting period in the main the data shows that staffing levels were either on or above plan. In the first three months where services were below plan this in the main was due to short notice sickness/absence or periods when new staff were on induction so were supernumerary and therefore not counted in the numbers. On these occasions clinical judgement determined if temporary staffing was required and where indicated gaps were filled either by moving staff flexibly

across clinical areas, staff undertaking overtime shifts or use of bank or agency. The key priority remained 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.

In the latter three months of this period there is marked difference in the data with some areas appearing to be significantly under plan. This was a direct result of the impact of Covid-19 and the actions needed to release capacity to accept patients into the wards. Some wards, using risk assessment, discharged patients to create capacity, for example Fanshawe ward in April was under plan on registered and care staff on days and under on care staff for nights. However, for a significant part of the month Fanshawe had at times fewer than 5 patients admitted which meant that the number of staff required to cover shifts was greatly reduced for a period. This was a similar position for Jubilee and Spinnaker where additional beds were stepped up, but the bed occupancy was reduced so staffing levels were also reduced.

In the case of Lower Brambles in April the ward reduced its occupancy and had a high number of staff off sick with Covid-19 or shielding/self-isolating. The patient's numbers were also significantly reduced, therefore fewer staff were required which explains the reduced fill rate for April. During this time an Infection prevention & Control (IPC) review was undertaken and it was agreed that the ward was not a suitable environment to receive Covid positive or suspected Covid patients. Therefore, it was agreed to close Lower Brambles for a period and to step up 17 beds in the Adelaide ward, a new facility which provided the system with increased bed capacity.

During late March and April facilities were identified which could be converted to create additional bed capacity to manage the expected surge in cases. The additional capacity was created in Jubilee house, Spinnaker ward, Hamble House (New facility) and Adelaide health centre (converted from GP/Outpatient facility). In line with the safe staffing framework a structured approach to modelling the staffing requirements was completed building in a level of risk assessment to allow for the unknown elements of what staff may be faced with as the surge happened. All additional bed capacity and the staffing model were taken through a QIA process lead by the Chief Nurse and Chief Medical officer and all sites were visited by the Chief Nurse before becoming operational. Except for Adelaide ward none of the additional bed capacity has needed to be utilised but the plans remain in place and will be refreshed should a second surge occur.

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 of 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/Cause Group	Assault - Non-Physical	Assault - Physical	Medication Errors	Pressure Ulcers	Slips, Trips, Falls	Grand Total
COVID19 Adelaide	0	0	2	1	1	**4**
Fanshawe Ward (RSH)	3	3	14	28	30	**78**
Jubilee House Continuing Care (JUBH)	0	1	13	10	13	**37**
Lower Brambles Ward (RSH)	0	0	8	13	13	**34**
Snowdon Ward (WCH)	0	2	17	1	23	**43**
Spinnaker Ward (SMH)	0	1	25	23	27	**76**
The Kite Unit (WCH)	13	30	7	0	11	**61**
The Limes (LIMES)	5	54	45	0	124	**228**
The Orchards Acute -	7	28	140	0	3	**178**

Hawthorn (OCSJ)						
The Orchards PICU - Maples (OCSJ)	33	87	33	0	1	**154**
Grand Total	**61**	**206**	**304**	**76**	**246**	**893**

The review of incident data shows a further increase in the numbers of incidents in comparison to the previous period where 793 incidents were reported. The most notable increase is in the reports of physical assault and a further increase in the numbers of medication errors. There has also been a slight increase in the reports of pressure damage, but further exploration of these incidents confirms that these have occurred outside of Solent care. The concerns relating to this have been escalated as part of system discussions. This reporting period has seen a reduction in the numbers of reported slips, trips and falls.

The highest levels of medications errors continue to be in the acute metal health wards, specifically Hawthorns which has seen a more than 50% increase. Following the detailed review referenced in the previous report and the actions taken as a result this has not affected the level of improvement required. A deep dive is being completed currently and will be reported through Quality Improvement & Risk (QIR) group. However early indications do not link these errors to safe staffing. There has also been a rise in medication errors noted within Spinnaker ward and this is being reviewed currently as there may be a correlation between this increase and the current vacancies and reliance on temporary staff.

Table 2 below summaries the complaints and services concerns received and the themes by in-patient ward for December – May 2020:

Ward	Complaints	Service Concerns	Themes
Fanshawe Ward (RSH)	1	0	The theme identified in the formal complaint related to clinical treatment.
Jubilee House Continuing Care (JUBH)	2	0	The themes identified in the formal complaints raised to the trust relates to attitude of staff and clinical treatment.
Lower Brambles Ward (RSH)	1	1	The theme identified relates to attitude of nursing staff; patient did not feel listened to. The service concern related to a loss of personal property and a wallet.
Snowdon Ward (WCH)	0	1	The service concern related to communication and information around the patient's discharge from the ward, which caused some confusion.
Spinnaker Ward (SMH)	0	2	One of the service concerns related to missing dentures and a lack of communication re discharge planning. The other related to clinical treatment and staff attitude.
The Kite Unit (WCH)	0	1	A patient's parents were concerned that an out of area transfer of care would be detrimental to the patients care, as they

			would not be able to visit.
The Limes (LIMES)	4	2	The themes identified in the formal complaints raised to the trust relates to clinical treatment and communication issues The service concerns related to loss of property and communication (inaccurate information was provided in a report).
The Orchards Acute - Hawthorn (OCSJ)	2	4	The theme identified relates to clinical treatment and the family being unhappy with the care provided to the patient. The service concerns raised to the trust were around communication & clinical treatment.
The Orchards PICU - Maples (OCSJ)	0	2	The service concerns raised to the trust involved clinical treatment & communication.
Total	10	13	

During the reporting period there has been a significant increase in the number of formal complaints received, 10 compared to 3 in the previous reporting period. The areas which has received the most complaints is The Limes, with 4 formal complaints and 2 service concerns, having had no complaints or service concerns reported in the previous 6 months and Hawthorns which had 2 formal complaints and 4 service concerns. The numbers of service concerns have remained broadly similar with a slight increase from 9 to 13 in this timeframe and continuing to show an upward trend. The recurring theme in both complaints and service concerns continues to be staff attitude and communication in relation to clinical treatment.

Considering the incident data and complaints data alongside the unify 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 and/or have had significantly reduced bed occupancy. 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 demand and capacity tool developed by community nursing service in Southampton is currently under review with some refining and updating of the information required. This work will be shared with the Portsmouth team with a view to having a consistent approach across the organisation.

During the Covid-19 pandemic the teams completed a caseload review and where safe to do so discharged patients while continuing to support those at highest risk. The teams also supported the inpatient areas with some staff being redeployed for a period. Both teams are currently reporting good morale at present, but some individuals have found the redeployment and adjustments to current service model difficult. Concerns raised are being followed up at present.

Children's services were heavily involved in supporting services through redeployment of staff to the inpatient wards. The team continue to have difficulty recruiting to the matron role in the Portsmouth CCN team and will be reviewing the current approach to identify what could be done differently to support successful recruitment.

The team have recently completed a capacity/demand assessment for staffing in special schools and this has highlighted a potential risk in relation to safe staffing levels. The teams have met to explore alternative models and will be discussing solutions regarding this with commissioners in advance of the new term in September.

As a result of the pandemic recent modelling has identified that there will be a backlog in immunisations and in order to catch up the Child and Family School Aged Immunisation programme will require approximately an additional 25 WTE staff. This additional number considers the backlog and the need to deliver the required numbers of vaccinations safely in line with enhanced PPE requirements and social distancing due to COVID. There are plans to redeploy some members of staff from within the service line, but this will still leave a significant gap between the requirement and existing capacity. Work is underway to consider possible solutions.

Primary care services continue to experience challenges in the recruitment and training for Podiatry as well as seeing an escalating challenge around the ability to recruit psychologists to work within the Pain programme. To address this the team are keen to work with colleagues across the Solent footprint to explore the possibility of developing training roles that span the breadth of opportunities that the Trust can offer in relation to psychology to help grow and develop our own. This work will be taken forward in the coming months.

The primary care team face ongoing challenges in relation to recruitment and retention of their Advanced Nurse Practitioners. This mainly relates to the ability to meet the competitive salaries offered in non-Solent GP practices. Discussions are continuing in order to seek a solution which supports the retention of these key clinical staff.

Specialist Dental services have continued to provide a reduced service during the Covid pandemic but are currently increasing activity as restrictions are lifted.

Sexual health services continue to recruit band 5 nurses and provide an extensive training programme through their training hub which supports individuals to develop the required competencies to progress to a band 6 role in the future.

In the last six months the team have reviewed the structure and have put in place a development programme for the band 6-7 including introducing development posts, this has been well received by those that were successful in the roles. They have also introduced a leadership programme for staff between band 5-7.

The Sexual Assault Referral Centre (SARC) staffing levels is an ongoing risk which is on the service line risk register. The team have successfully recruited 3 SOE's but due to COVID their training has been delayed, but it is hoped that they will be able to complete practical training in July. There is a current vacancy in the crisis worker team and one staff member is off work because of family member shielding. The team aim to recruit to the vacancy as well as recruiting to the bank but to mitigate the current risk colleagues in sexual health have been redeployed to SARC to support the crisis worker rota.

Bank and Agency Usage

Demand for Bank has remained static over the last 6-month period.

Community Nursing in Southampton have seen a significant increase in demand over the past 3 months with a 50% increase in agency usage due to vacancies within the services. Focus has been on the scrutiny of rosters and staffing levels, the implementation of a successful recruitment project, including recruitment fairs and university open days for nursing students.

Community Portsmouth has seen continued reduction in demand over the past 6 months which is attributed to a recruitment focus the team have undertaken. Improved numbers of Bank Community nurses have helped to significantly reduce the need for off framework agencies nurses.

Demand remains high within Adult Mental Health. This continues to be attributed to high levels of vacancies. Work has been undertaken by service to addresses the long-term recruitment plan and the introduction of B4 MH practitioners, and focused recruitment remains in place. There has been a slight reduction in demand over the past 2 months which can be attributed to recent RMN recruitment.

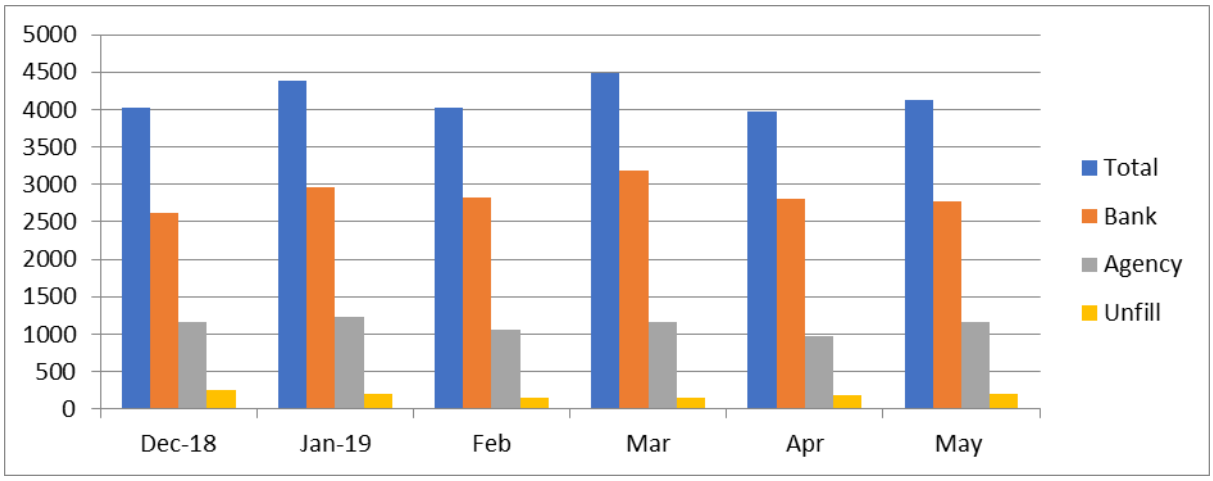
At the beginning of the year Spinnaker saw a large increase in bank requirements due to the opening of additional beds that also required cover 24/7 during this period.

Adults Southampton clinical areas have remained at a static level due to continued nurse vacancies across areas.

The below table highlights level of Bank & Agency requests for clinical areas for Dec 2018 – May 2019

Clinical Dec 18 - May 19	Req	Bank	%	Agency	%	Unfilled	%
AMH SERVICES	6351	3860	61%	2267	35%	224	4%
PORTSMOUTH ADULT SVS	4069	2069	51%	1612	40%	388	9%
PORTSMOUTH CHILDREN SVS	673	673	100%				
SOUTHAMPTON ADULT SVS	4094	2477	60.50%	1245	30.50%	372	9%
PRIMARY CARE	1423	1405	99%			18	1%
SOUTHAMPTON CHILDREN SVS	1132	1132	100%				
DENTAL SERVICES	796	343	43%	453	57%		
SEXUAL HEALTH SERVICES	186	180	97%			6	3%
TOTALS	18724	12139	65.00%	5577	30.00%	1008	5%

This table 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. The Trust turnover has not reduced further since the last report, but work continues to ensure a downward trend is achieved and sustained. Concern remains regarding the ongoing challenges in both recruiting and retaining staff, although some areas are experiencing positive responses to job adverts which may be due to the number of people who have returned to the NMC register as a result of the pandemic as well as the positive coverage of the NHS during this time.

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 needs of service users/patients.

The work on agreeing the appropriate acuity and dependency tool for services will continue including learning from the national safe staffing programme. The change of focus in the safe staffing meetings will support sustained improvement in roster management and performance across the organisation.

Key Priorities for the next six months:

- To embed the new approach to safe staffing meetings
- To achieve sustained improvement on key aspects of roster management
- To agree the Red flag/safe staffing dashboard that service lines have proposed, and which reflect the NQB guidance requirements
- Implement a safe staffing standard operating procedure (SOP)

Board Recommendation

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

Appendix 1

Ward Name	Dec-19				Jan-20				Feb-20			
	Day Fill Rate		Night Fill Rate		Day Fill Rate		Night Fill Rate		Day Fill Rate		Night Fill Rate	
	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff
ADS Snowdon Ward	99%	100%	102%	100%	101%	95%	95%	100%	100%	110%	100%	98%
ADS The Kite Unit	102%	131%	200%	172%	101%	103%	105%	147%	103%	99%	101%	152%
ADS Lower Brambles Ward	99%	98%	100%	100%	99%	99%	100%	100%	100%	100%	100%	100%
ADS Fanshawe Ward	100%	97%	100%	100%	100%	99%	98%	101%	100%	100%	100%	98%
MHS Brooker	85%	103%	94%	99%	95%	99%	96%	96%	94%	101%	92%	98%
MHS The Orchards Acute - Hawthorn	89%	139%	91%	159%	90%	159%	92%	185%	95%	167%	87%	190%
MHS The Orchards PICU - Maples	97%	130%	100%	135%	94%	145%	95%	153%	86%	112%	97%	110%
ADP Spinnaker Ward	103%	108%	100%	104%	100%	102%	102%	131%	97%	110%	100%	214%
ADP Jubilee Hse Contnu Care	98%	123%	125%	161%	99%	123%	102%	190%	101%	102%	100%	207%

Ward Name	Mar-20				Apr-20				May-20			
	Day Fill Rate		Night Fill Rate		Day Fill Rate		Night Fill Rate		Day Fill Rate		Night Fill Rate	
	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff
ADS Snowdon Ward	106%	105%	101%	104%	114%	104%	97%	109%	127%	113%	95%	94%
ADS The Kite Unit	100%	107%	100%	173%	106%	86%	101%	151%	95%	98%	100%	161%
ADS Lower Brambles Ward	100%	100%	100%	100%	52%	63%	60%	56%				
ADS Fanshawe Ward	100%	105%	100%	108%	83%	74%	93%	65%	106%	144%	126%	128%
MHS Brooker	92%	103%	91%	99%	105%	108%	96%	112%	107%	122%	98%	129%
MHS The Orchards Acute - Hawthorn	89%	172%	92%	205%	96%	163%	93%	196%	95%	180%	96%	223%
MHS The Orchards PICU - Maples	92%	142%	96%	167%	97%	119%	93%	118%	99%	124%	93%	124%
ADP Spinnaker Ward	91%	100%	99%	191%	97%	114%	98%	115%	102%	101%	105%	124%
ADP Jubilee Hse Contnu Care	112%	95%	102%	177%	111%	89%	89%	89%	105%	69%	75%	55%

NHS
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NHS Trust

SOLENT NHS TRUST

Infection Prevention Team Annual Report 2019 - 2020

Jackie Ardley
Chief Nurse,
Director of Infection Prevention

Bethany Carter
Head of Infection and Prevention

Contents of Infection Prevention Team Annual Report 2019-2020

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SOLENT NHS TRUST INFECTION PREVENTION TEAM ANNUAL REPORT 2019-2020

OVERVIEW

Message from Jackie Ardley, Chief Nurse and Director of Infection Prevention

"I am really proud of the leadership and role the Infection Prevention (IP) Team have provided in Solent. The team has gone above and beyond professionalism in their approach to the ever changing world of Covid-19."

The IP Team began planning and preparing Solent's response to meet the challenges of Covid-19 for patients and staff in January 2020.

Since January, the team has worked differently to meet the challenges a period of sustained transmission due to a global health pandemic has brought.

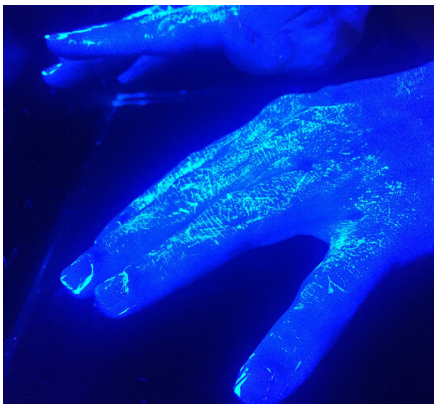
One such example of different practice has involved the process of empowering staff across the Trust in correct usage of PPE.

Overview of 2019-2020

The first 3 quarters of 2019-2020

The IP Team continued to monitor surveillance of infections, conduct Trust wide audits, develop and review policies, provide education and support to all staff.

For quarter 4, the normal schedule of audits have not been completed due to the demands from addressing Covid-19



Staff have been supported to adhere to standards of infection prevention

The IP Team collaborated with Solent's Sexual Health team to identify, implement and evaluate the application of a disinfectant for use on specific equipment by this team

Highlights of the year from the IP Team

Support

We have provided FIT testing sessions to Solent Staff and staff in nursing/care homes.
We have adapted our ways of teaching by improvising with hand hygiene to introduce paint and gloves to demonstrate correct doffing of gloves.
We have visited a wide variety of clinical areas in which Solent staff work such as child health clinics to support staff to practise safely.
PLACE - we have supported this important aspect of co-production in Solent for patients.
We have worked collaboratively with IP colleagues across Trusts to promote infection prevention.
We have provided guidance for the commissioning of new buildings and clinical areas.
We have shared knowledge obtained from external study days on Sepsis for example with our Link Advisors to support their role.

Liaison

We have liaised with matrons to provide regular IP skill slots across AMH and OPMH clinical sites.
We have worked with the homeless health care team, training non-clinical staff to support clients with hygiene and when to seek advice from health colleagues.
We have supported newly qualified nurses at induction and built early relationships with them.

Changing practice

We have changed practice to reduce risk to staff and patients such as the introduction of Nasal Naloxone and the provision of a waiting area for TB patients.

IPT ACTIVITY IN NUMBERS

SURVEILLANCE

MRSA/CDI

AUDITS

1.MRSA Screening
2.Antibiotic Prescribing
3.Dental Audit
4.Hand Hygiene
5.Environmental Audit

EDUCATION

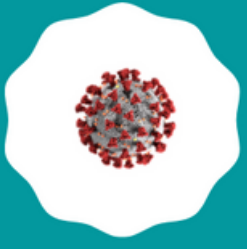
Policies
Review of; MRSA, Decontamination, Hand Hygiene, Standard precautions, Management of Diarrhoea and Vomiting, Urinary Catheter. CJD and Isolation Policy were due for full review.

LINK ADVISORS

1.Numbers - 155 link advisors
2.Training & Workshops - 5 workshops and 2 train the trainer courses (22 new LA trained).

WARD/COMMUNITY VISITS

Regular intervals – some planned, some unplanned.



COVID-19

1.Zoom meeting support.
2.Responding to PHE guidance.
3.Upskilling for staff.
4.FIT testing.
5.Problem solving.
6.Liaison within trust.

Jackie Ardley
Chief Nurse, Director of Infection Prevention

Angela Anderson
Associate Nurse Director

Bethany Carter
Head of Infection Prevention

Debbie Larkins
Infection Prevention Nurse Specialist

Jen Killeen
Infection Prevention Project Lead

Lorraine Harradine
Infection Prevention Practitioner

Lorraine Brown
Infection Prevention Support Worker

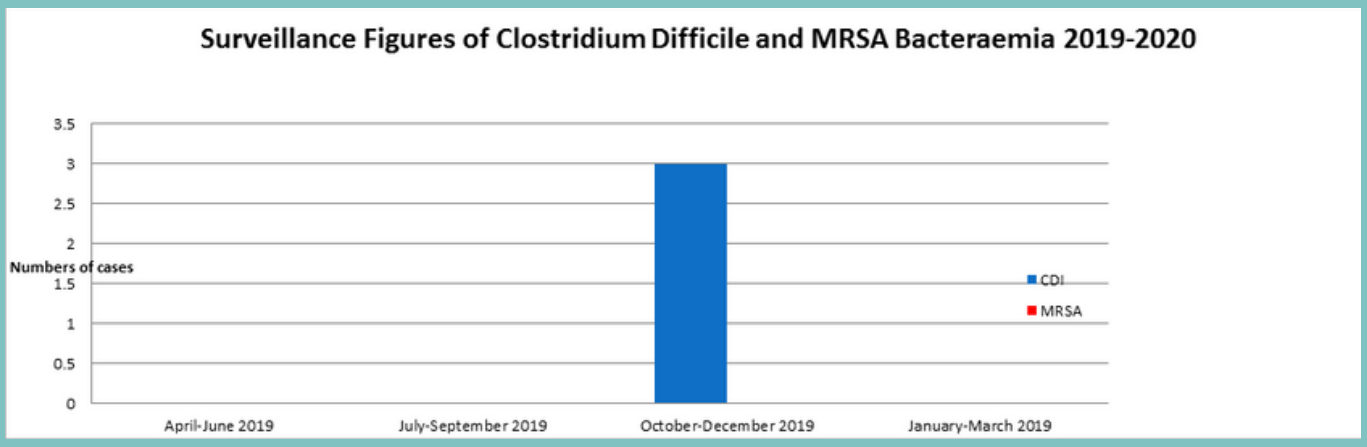
Amy Bowers
Infection Prevention Practitioner

Nicola Barker
Infection Prevention Team Administrator

During the Covid-19 Pandemic, Ann Bishop and Sally Shillaker supported the Team throughout this period

Surveillance

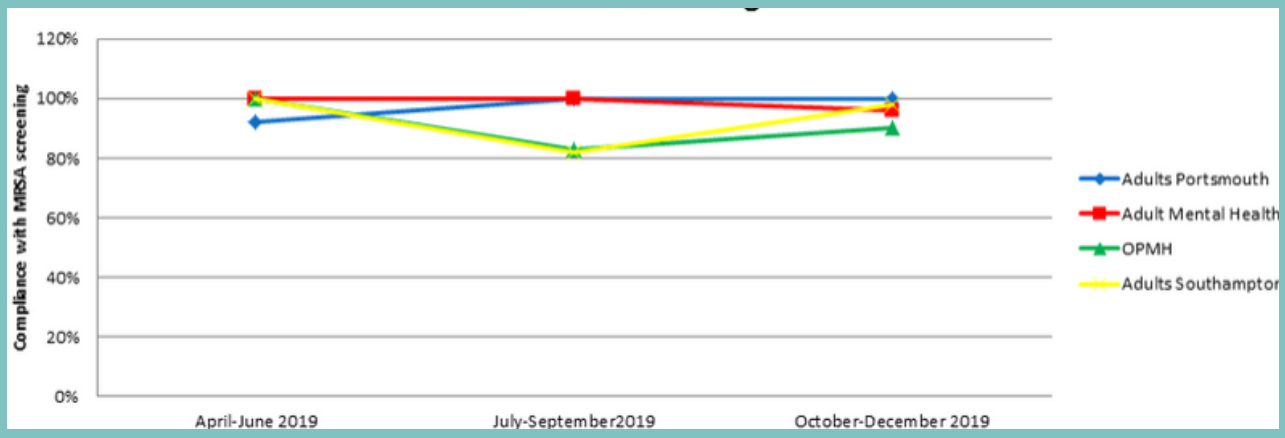
The IP Team monitor for cases of MRSA Bacteraemia and Clostridium Difficile



This graph illustrates that Solent NHS Trust had no cases of MRSA blood stream infection during the year April 2019-2020. However, there were 3 cases of Clostridium Difficile (CDI) in Quarter 3. Learning has been shared with the teams involved in these cases. The main conclusion is that communication with IP Team needs to be prompter and this is now subject to monitoring. There was no evidence of onward transmission to other patients in these inpatient areas.
It is worth all Solent staff working in inpatient areas developing a vigilance for signs of CDI.

Audit

Audits were conducted for Quarters 1-3 on MRSA screening and compliance within Solent is illustrated below.



A date is chosen within each quarter and audited. A dip in compliance was seen for Quarter 2 for OPMH and Adults Southampton, however compliance improved at Quarter 3. Results are shared with clinical teams and strategies considered to enhance compliance if necessary.

Antimicrobial treatment prescribing audit

This audit encompasses all systemic antimicrobial treatment prescribing on Solent NHS Trust wards. The aim of this audit is to monitor if local guidelines and guidance from the Department of Health are being adhered to in order to ensure that prescribing of antibiotics is safe and effective.

Six out of seven prescriptions audited were compliant with the guidelines, with one exception. An action plan has been written for the ward pharmacist to feedback to medical colleagues reminders about prescribing guidelines to address this.

There was generally good compliance of all standards. Compliance with Standard 3 (duration of antibiotic indicated) has fallen since the last audit and 3 prescriptions did not have a duration/course length indicated on the drug chart. An action plan has been written for the ward pharmacist to feedback to medical colleagues reminders about correct documentation on drug charts.

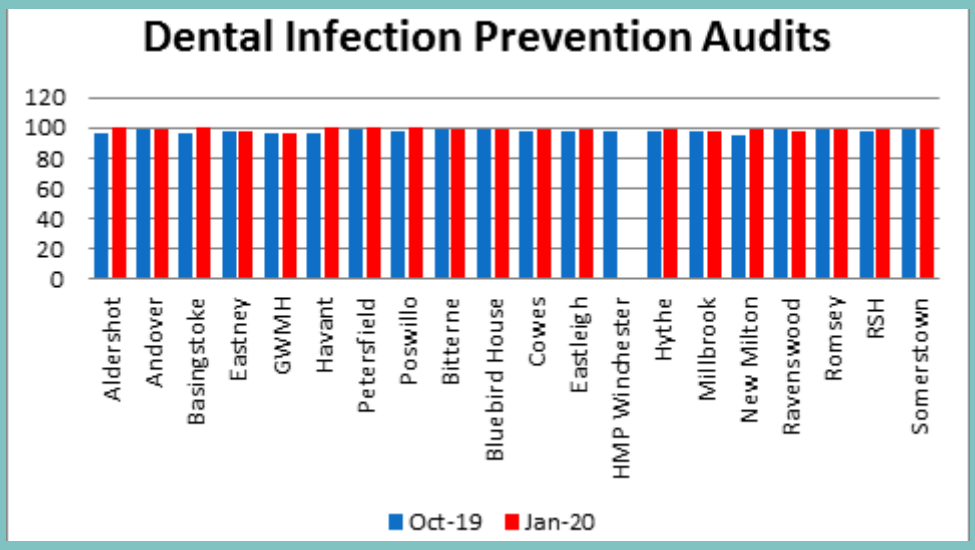
It should be noted that there were very few antimicrobial prescriptions during this audit cycle, and it is therefore difficult to draw conclusions from such a small set of data. Due to Covid-19, it has not been possible to conduct the audit scheduled for January 2020.

Dental Infection Prevention Audit

2 Audits were conducted in October 2019 and February 2020.

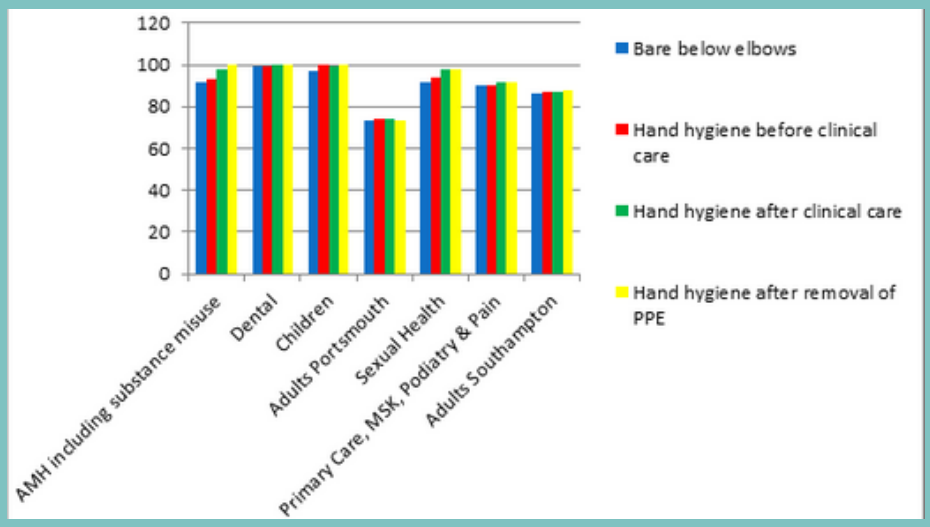
These audits satisfy the guidelines for Infection Prevention in Dental departments.

Audits were conducted in collaboration between the Senior Dental Officer, Dental staff and were peer reviewed by the IP Team Lead.



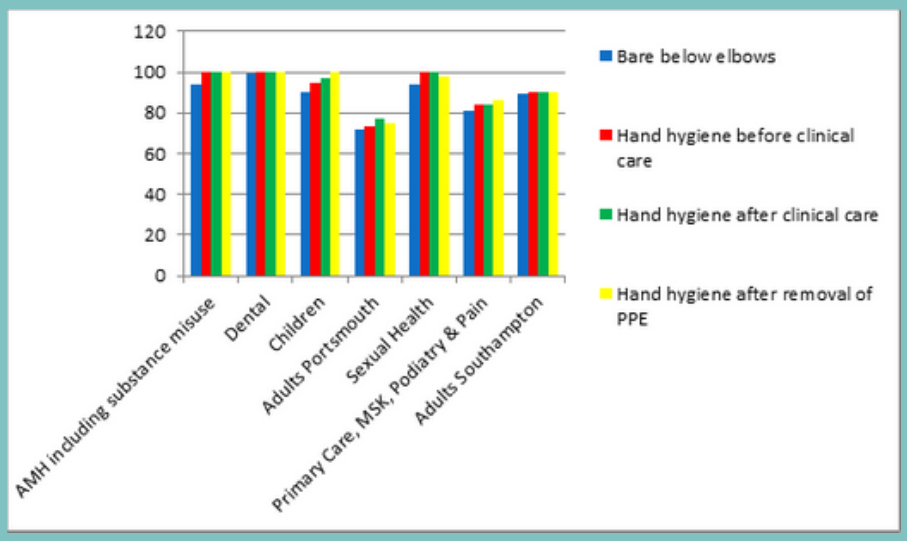
This graph indicates good compliance to standards within Solent NHS Trust's Dental services. HMP Winchester is no longer under the care of Solent NHS Trust and this accounts for an absent figure on the graph.

Hand Hygiene Observational Audit June 2019



The clinical areas of Adults Portsmouth and Adults Southampton scored below the required target compliance figure of 90%. Action Plans are created between the IP Team, Link Advisor and the Ward Managers to address low scores. In Portsmouth, low compliance scores in 1 area, have influenced the overall scores. In Southampton, several teams did not return audits and this has resulted in low compliance. The IP Team relies on Link Advisors to conduct hand hygiene audits in clinical areas. As a result of Covid-19, hand hygiene audit in clinical areas are due to be conducted monthly.

Hand Hygiene Observational Audit December 2019



Compliance scores were lower than the agreed target in Adults Portsmouth because 2 areas did not return their hand hygiene audit. Several areas in MSK equally failed to return their audits.

Scores for all areas who returned their hand hygiene scores were generally high, with averages above 95%.

These results suggest that there is work to be done with teams who are not conducting hand hygiene audits and this is included in the IPT 2020-2021 goals.

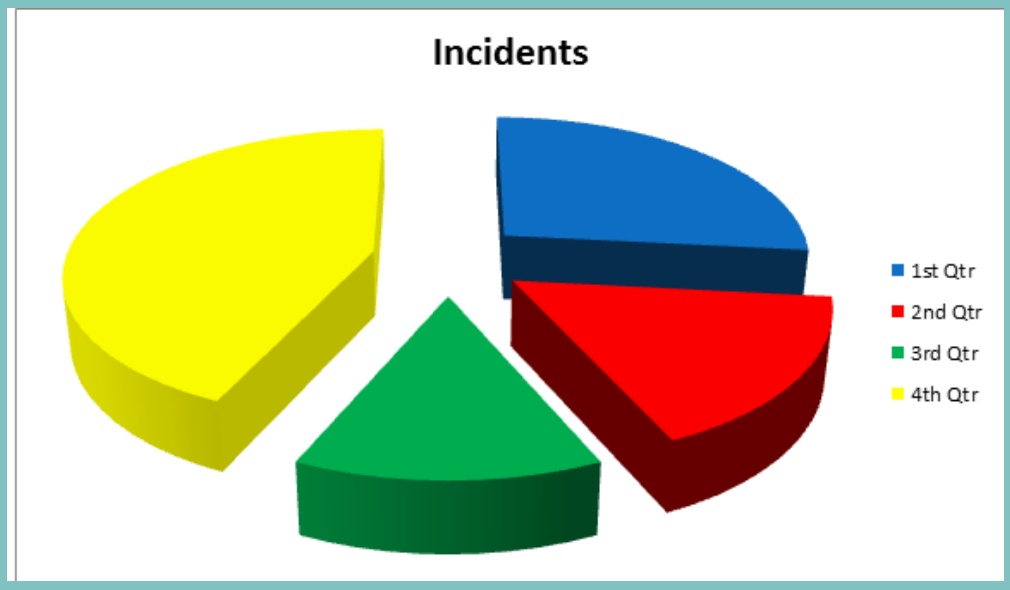
Environmental Audit

All inpatient areas and
some outpatient areas such as Podiatry,
Falcon House and Solent's special
schools were subject to environmental audits
during 2019-2020.

The framework for these audits
is the Quality Improvement Tool (QIT)
from the Infection Prevention Society.
After the initial audit,
a repeat visit at 6 weeks
is offered to review the action plan
made after the primary visit.

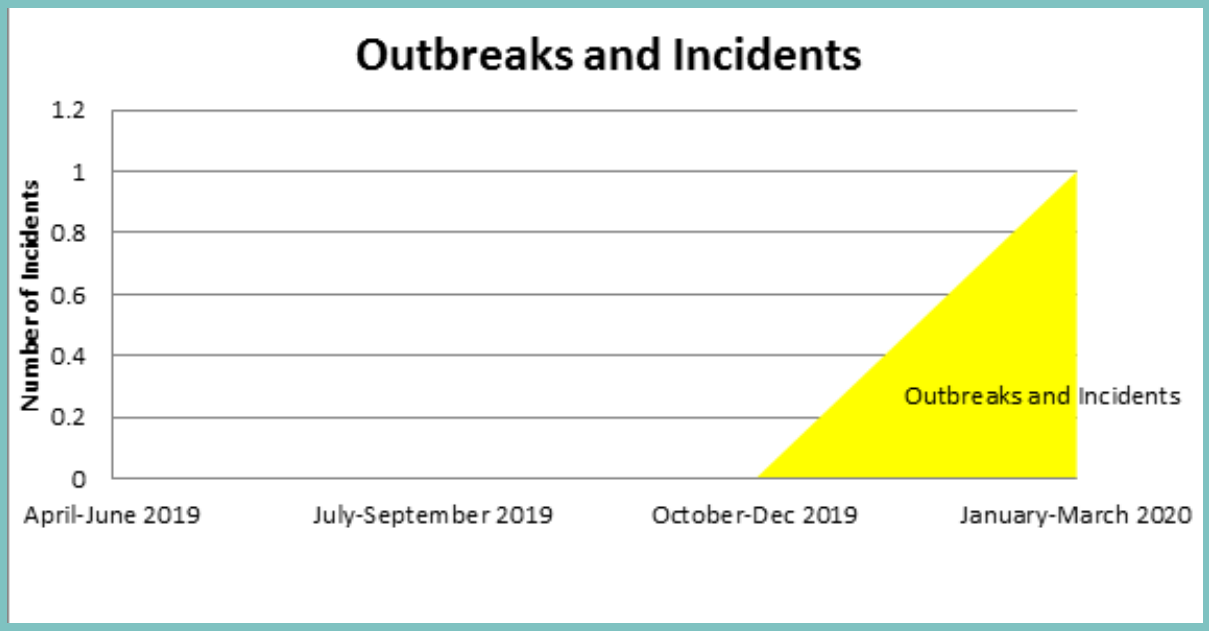
The IP Team has helped inpatient areas identify aspects of their environments in which they need to liaise with the Estates Team in Solent to resolve areas in which damage has occurred and needs repair. In some outpatient areas, the IP Team has identified aspects of the environment that needs refurbishment or equipment to be replaced or items included in a decontamination cycle.

Audit of Sharps Injuries within Solent NHS Trust



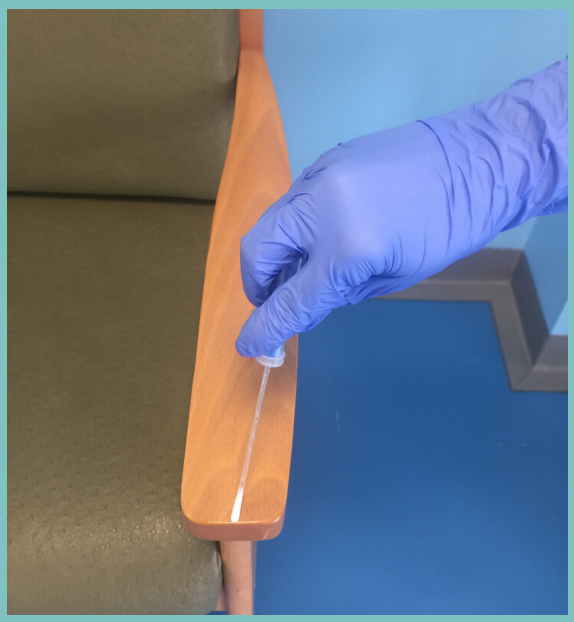
The largest recorded number of incidents occurred in the last quarter of 2019-2020 between January-March 2020. The number of incidents was 13, whereas previous numbers of recorded incidents in the Trust were 8, 5 & 4 for the other quarters. This does perhaps correlate with winter pressures and an increase in levels of preparedness in meeting the challenges of Covid-19. The IP Team respond to each incident with a personal review of learning and plan, to minimise future risk.

Outbreaks of infectious disease in Solent NHS Trust.



There was 1 reported outbreak of infectious disease in Solent NHS Trust during 2019-2020.
This was an outbreak of diarrhoea and vomiting on Brooker Organic Ward (Older Person's Mental Health) in February 2020 . This resulted in 7 patients and 20 staff being affected and as a consequence the ward was closed for 12 days. The IP Team has supported Brooker ward to learn from this with additional teaching, increased ward presence and a review of their cleaning schedule.

Monitoring



Members of the IP Team regularly visit inpatient,outpatient and community sites within Solent to monitor the standards of cleanliness of equipment such as commodes, mattresses, sharps bins, patient touch points and monitoring equipment. They use a sophisticated machine to measure for contamination. Results are fed-back to areas and concerns addressed.

The IP Team continue to work with Water Safety to monitor Legionella levels across Solent sites. water coolers are also monitored regularly. A new contract with a single provider and new water cooler units is due to commence over the course of this next year.

Education

Policies

New policies are written in response to need and existing policies reviewed every 3 years. For Covid-19, Solent has adhered to PHE frameworks, SOP's and guidelines. The IP Team has responded to frequent amendments to guidance and has worked with the Communications Team to disseminate.

Teaching staff

The IP Team provide opportunites to educate staff regularly. This includes teaching staff at induction such as newly qualified nurses and embedding IP principles. It also involves teaching staff outside of Solent who care for Solent patients.

Digital learning

The IP Team update their SolNet pages to provide information to all Solent staff and have recently opened the opportunity for online booking to staff. It is a mandatory requirement that clinical staff complete their annual IP e-learning.

Link Advisors

The IP Team invest regular education opportunities in their Link Advisors who are considered a vital component to the IP Team's influence in Solent.

Opportunities include training of new advisors throughout the year and regular termly workshops. Link Advisors disseminate updates to their clinical areas.

Several Link Advisors have shared their experiences.

Alan Childs writes;

"I love it, the IP Team are fabulously supportive. I have been a Link Advisor for a number of years. There are issues that have needed addressing and we have, such as painted nails.

A move to new premises for my team has improved IP standards because facilities have enhanced opportunity for IP standard precautions.

Covid-19 has also changed mindsets and improved IP in staff and expectations from patients.

My next challenge is identifying my successor when I retire!"

Sam Crossley writes;

"I was nominated to be Link Advisor whilst I was on my honeymoon! I have never truly considered the full depth that infection control goes to, to keep us healthy. I normally allocate a small amount of time to complete the required audits each month and liaise with my managers regarding the outcome. Working in the community with children I often find the standard advice and policy doesn't quite fit the challenges that our service offers, however, the IP Team are excellent at providing advice when I call or email.

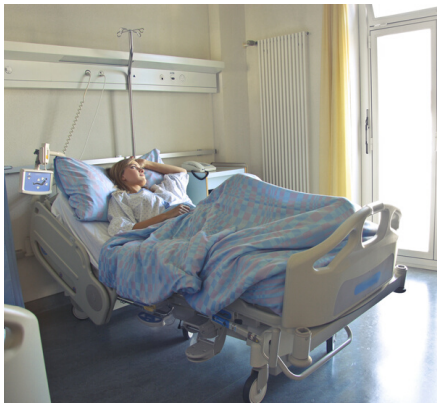
My one area I think could be improved is addressing the specific needs of children's community settings because often there are differences between children's and adults."

Sally Shillaker writes:

"I thoroughly enjoy the role. The IP Team are approachable and available. They send useful prompts for audits, give enough time ahead of training and the quality of teaching is always high."

Ward & community visits

The IP Team conduct regular visits to inpatient, outpatient and community sites across Solent's services.



Visits

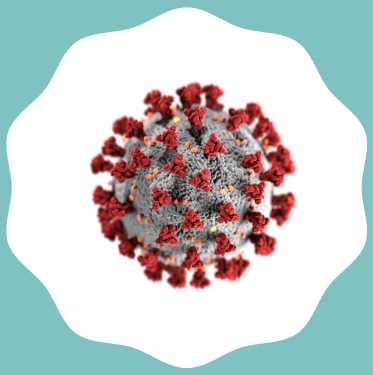
Visits often occur at the invitation of ward managers to trouble shoot or discuss issues affecting IP. Visits also often occur unannounced.

New buildings

IP Team work with clinical teams and construction staff to commission and alter Solent buildings.

Working together

IP Team support staff with audits and identify risks to patients and staff that require prompt attention.

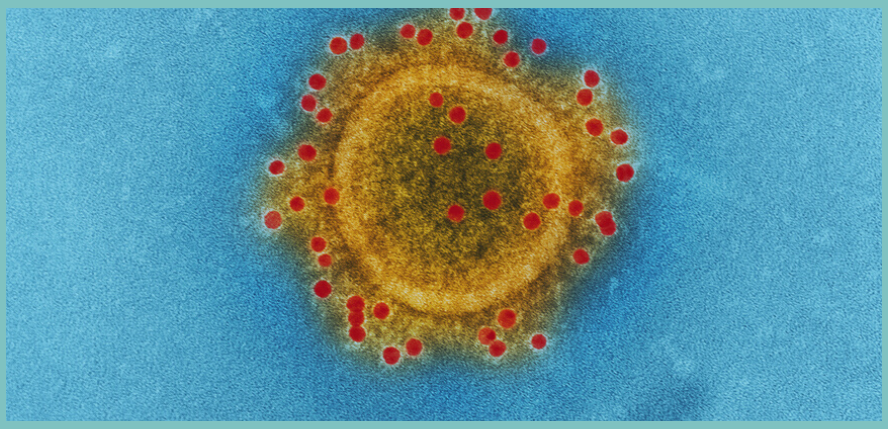


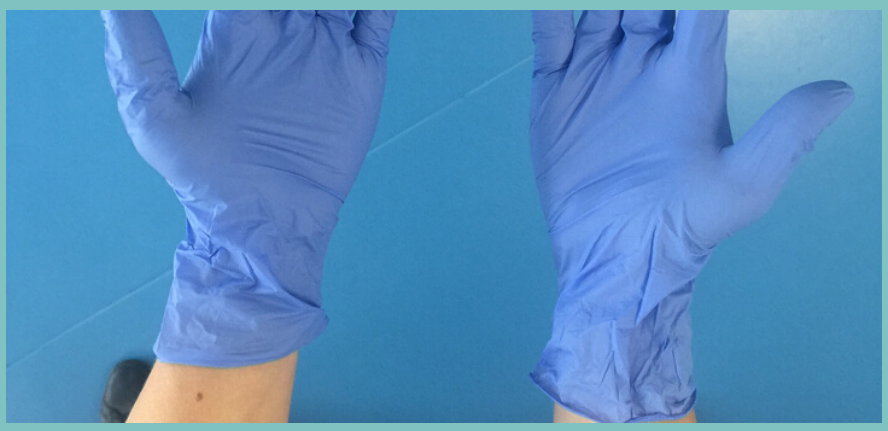
COVID-19

The demands

Covid-19 has and is changing health care delivery. As a team, we have responded to Covid-19 in the following ways;

- Provide expert advice to DIPC and senior leads in Solent NHS trust.
- Upskilling of staff across the Trust to equip them to practice safely in different clinical areas from normal.
- FIT testing of staff to enable them to wear FFP3 masks for specific Aerosol generating procedures,
- Increased presence on wards to monitor correct use of PPE,
- Support to staff to alter clinical environments for Covid-19 patients and implementation of enhanced infection prevention precautions.
- Interpretation of PHE documents and correct implementation Trust wide.
- Support to Portsmouth CCG and GP practices with their response to Covid-19.





Conclusion

This report has highlighted that Infection Prevention can only be effective when the many departments in Solent work together. The IP Team coordinates but relies on collaboration by all teams. We are grateful to all Solent staff who have demonstrated an openness to our support. We intend to continue to explore methods of improving joint working. We would also like to highlight the challenges Covid-19 has placed on all staff in Solent and conclude that there are areas we need to continue to support and these will form our future plans.

IP Team 2020-2021 Goals

- To continue to respond to the challenges of working safely for staff and patients in a global health pandemic.
- Within this phase of recovery, we intend to support services as they resume clinical activity but maintain a high vigilance for any further spikes in transmission rates.
- We will continue to work to prevent other infectious diseases and promote surveillance within Solent by ongoing collaborative working.
- We have identified the need to re-empower staff to ensure high standards of infection prevention by role modelling and reminders. Such practices can be so easily forgotten when staff are working in challenging circumstances.
- We need to work with clinical areas that are not submitting hand hygiene audits to improve their compliance.
- We intend to standardise our areas of monitoring across Solent.
- We intend to re-introduce a newsletter that was started in Autumn 2019 for all staff as a means of communicating across the Trust.

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2019-2024
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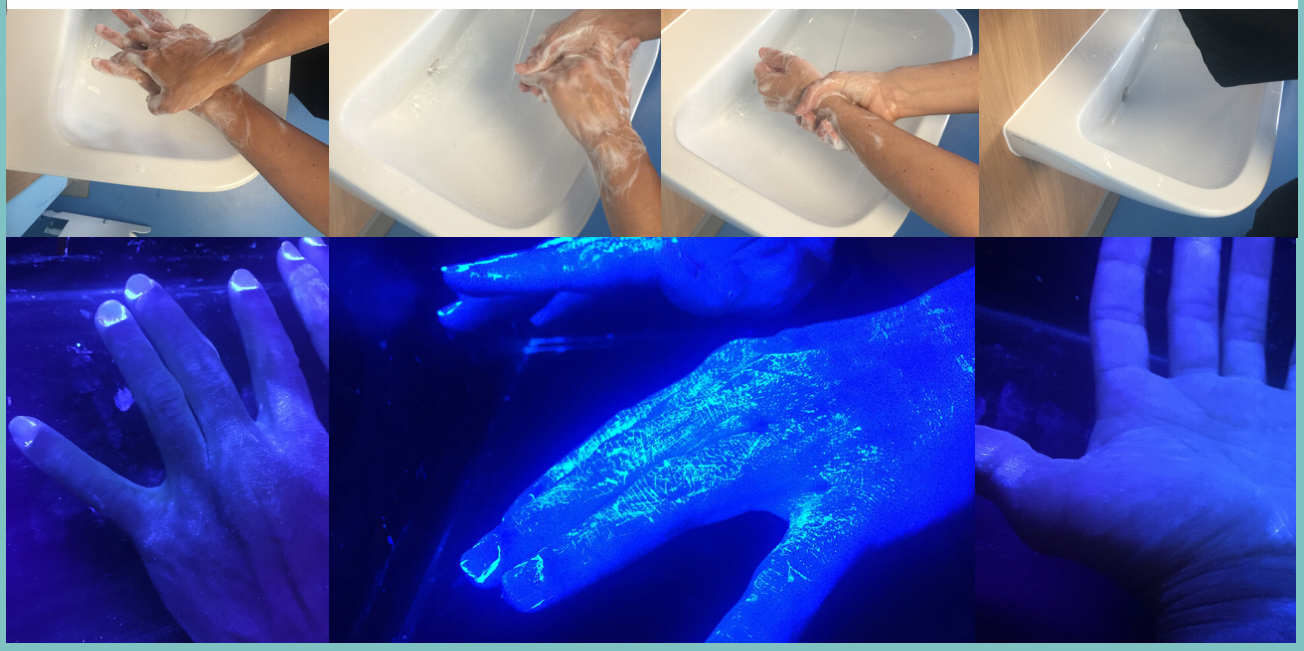
0300 123 6636

snhs.infectionteam@nhs.net

@SolentNHSIPCT

http://intranet.solent.nhs.uk/TeamCentre/InfectionPreventionAndControl/Pages/Home.aspx



Solent Safeguarding Annual Report 1 April 2019 – 31 March 2020

Item 16.5

Foreword by Jackie Ardley, Chief Nurse

I am pleased to share our 2019/20 Annual Safeguarding Report. This document will provide you with an overview of the work we do, to ensure that we protect children and adults at risk who are accessing Solent services from abuse and harm. We continue to work with our partners and key stakeholders across Hampshire, Southampton, Portsmouth and the Isle of Wight to keep the people in our communities, as safe and well as we possibly can.

2019/20 has been a successful, but challenging year for the Trust, with key achievements including praise from NHS England's Head of Safeguarding for the Safeguarding Champions. The Covid-19 pandemic has dramatically changed the way we work across all of our services. Working in healthcare has become increasingly challenging and complex, with information and guidance changing at a rapid pace. I want to take this opportunity to thank our inspirational teams, who continue to work tirelessly to ensure we can keep caring for our communities in the best possible way, whether that be through safeguarding, clinical practice, HR or support staff.

Although it has been a difficult time, the shift in our working practice has given us the opportunity to take our experiences and learning and use them to shape and improve our services for now and in the future. Throughout this report you will see safeguarding activity, collaborative working, improvements and priorities for the year so that we can ensure that we remain responsive to the needs of our colleagues, children, young people, adults at risk and the communities we serve.

Looking forward to the next twelve months and beyond, we enter a new chapter with optimism. We will remain focused on our Solent Safeguarding vision - to empower staff to keep people safe, promoting professional curiosity, challenge and collaboration in the process, and we will continue to work with and include our diverse communities, stakeholders and safeguarding partners to ensure we are all working together towards one main goal.

Executive Summary

This annual report covers the period from 1st April 2019 until 31st March 2020 inclusive. Although the Covid pandemic dramatically affected service provision across the Trust, all safeguarding roles have been fulfilled by the safeguarding team being responsive to demands, by developing flexible and alternative methods to ensure the safeguarding team continued to enable staff to fulfil their safeguarding responsibilities.

The report provides assurance that Solent NHS Trust is compliant in accomplishing its safeguarding responsibilities in line with the safeguarding legislative framework and as required by Commissioners, the 4 Local Safeguarding Children Partnerships, (4SCP), the 4 Local Safeguarding Adults Boards, (4LSAB). Safeguarding children, young people and adult concerns are identified and responded to appropriately.

The Solent NHS Trust Board should be assured that during 2019/20 arrangements were in place to safeguard and protect all those accessing and using Solent NHS services, including children, young people and adults in line with the Care Quality Commission (CQC) Regulation 13 that Service User should be safeguarded from Abuse and Improper Treatment

During the year the team has continued to provide key services and has delivered; advice calls, safeguarding supervision, mandatory training, health navigation within the Portsmouth and Southampton Multi-Agency Safeguarding Hubs, safeguarding case reviews and scoping and joint agency response to unexpected child deaths. The report provides an overview of safeguarding activity undertaken by the Solent NHS Trust Safeguarding Team from 1st April 2019 – 31st March 2020.

Executive Summary Continued

Solent NHS demonstrated safeguarding assurance in 2019/20 by having in place:

- A Named Nurse for Safeguarding children which ensures the Trust meets all statutory requirements
- Solent NHS Board Executive Lead for Safeguarding
- Robust Safeguarding governance and assurance arrangements are in place
- Solent can provide assurance with participation in multiagency partnership working arrangements with the 4 Safeguarding Children Partnerships and the 4 Local Safeguarding Adults Boards
- Safeguarding Children and Safeguarding Adults Training Programmes are in place to ensure compliance with intercollegiate requirements (2018 & 2019).
- Robust recruitment processes are in place including Disclosure and Barring Service Checks (DBS) for all staff requiring that level of clearance. Volunteers within Solent are subject to the appropriate checks prior to working with any clients.

Executive Summary Continued

The priorities for 2020/21 will be delivered by the implementation of the business objectives for the 1st year of the Safeguarding Strategy:

Objective 1: Safeguarding is Everyone's Responsibility

Objective 2: Training will be provided in line with National requirements

Objective 3: Whole family approach to safeguarding

Objective 4: The voice of the child and/or adult at risk will be heard

Objective 5: Feedback will be sought

Contents

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Introduction

Solent's NHS Trust endorses everyone's Human right to live their life free from abuse and harm. Solent's Safeguarding vision is to empower their staff to keep people safe. This will be done with expertise and will promote professional curiosity, challenge and collaboration.

The Trust is committed to working in partnership with key stakeholders across Southampton, Portsmouth, Hampshire and the Isle of Wight to ensure that colleagues and the communities we serve are protected from abuse and harm.

The Trust's safeguarding activity and strategy is rooted in the assertion that:

"It is the human right of every individual to live a life free from abuse and harm".

Safeguarding is everyone's responsibility and it is important that all staff, have the appropriate skills, knowledge and confidence to enable them to recognise and respond appropriately to safeguarding concerns relating to children, young people, adults and families. The report will provide an overview of safeguarding activity and improvements, undertaken by Solent NHS Trust from 1st April 2019 – 31st March 2020.

The 'Think Family' approach to safeguarding exemplifies a combined approach to responding to concerns, whilst taking into consideration that people live in families and communities. Solent NHS Trust advocates the Think Family approach to safeguarding which underpins the Trust's priority to provide quality services that are safe and effective.

Safeguarding Legislative Frameworks

- Changes stipulated in Working Together to Safeguard Children (WTTSC 2018) have been implemented by the 4 Safeguarding Children's Partnerships (SCP)
- The Hampshire, Isle of Wight, Portsmouth and Southampton, (HIPS), Executive Group, has been introduced to provide strategic direction and coordination of safeguarding activity across the pan Hampshire and Isle of Wight area, to promote best practice, implement local and national learning and identify issues requiring strategic intervention by the Safeguarding Partners across the HIPS area
- As an active member of the 4LSCB and associated sub groups, the Trust's Safeguarding team has supported the new working arrangements and will continue to work collaboratively with partner agencies in the forthcoming year
- The Chid Death Overview Panel arrangements have also been reviewed as part of the new WTTSC arrangements and is now a combined process for Hampshire, Southampton, Portsmouth and the Isle of Wight. This will enable a greater level of analysis and identification of themes which will inform future practice
- Solent's safeguarding Children and Adults team comply with current legislative frameworks for safeguarding children and adults, the 4 SCP and 4 LSAB policies and guidelines

Summary of Activity 2019/20

Solent NHS Trust

8145 MASH contacts Navigated. (6150 in 2018/19)

50 supervision sessions provided. (24 in 2018/19).

44 Child practice Reviews, Safeguarding Adults reviews & DHR including scoping. (37 in 2018/19).

624 advice calls Provided. (730 in 2018/19)

43 Training sessions Provided. (31 in 2018/19)

15 Joint Agency Reviews. (5 in 2018/19)

974 Information shared for MARAC (No comparable data is available for 2018/19)

772 Information shared for HRDA (1039 in 2018/19)

Performance Against 2019/20 Priorities

Objective/Improvement for 2019/20	Outcome	Impact
Audit of the effectiveness of the safeguarding advice line	96% of respondents in the audit expressed satisfaction with the advice call	Staff are effective at taking appropriate action to reduce harm and abuse to their patients
The safeguarding team will revise and develop the mandatory safeguarding training program provided to staff in order to deliver a comprehensive training offer.	The training offer was reviewed. New training now provided includes Domestic abuse and integrated safeguarding children and adults training (level 2&3).	Staff are competent at identifying and responding to disclosures of abuse meaning patients and colleagues receive the support they need

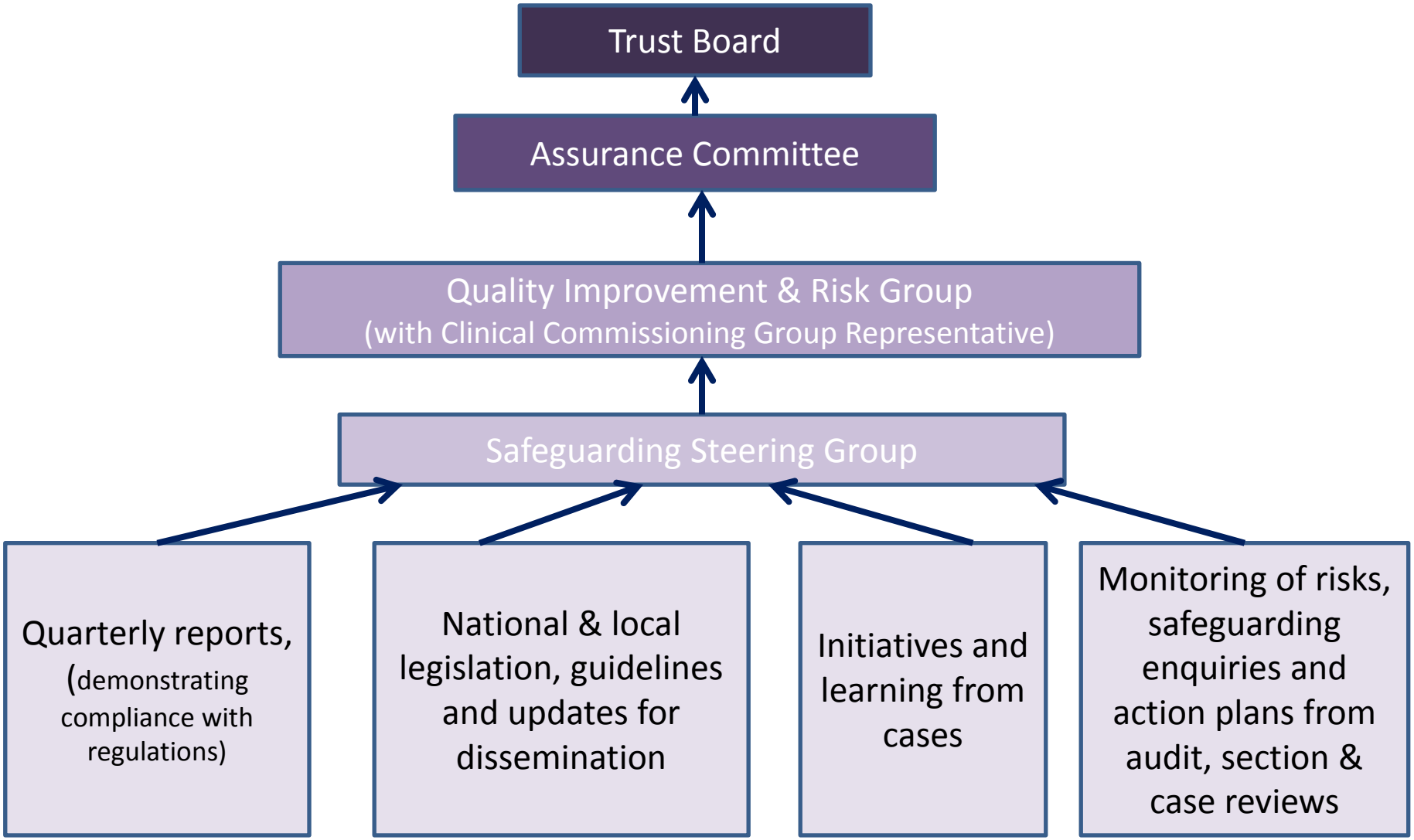
Performance Against 2019/20 Priorities

Objective/Improvement for 2019/20	Outcome	Impact
Embed Making Safeguarding Personal within adult services to allow adults' voices to be heard and listened to within safeguarding activity	Various activities to promote MSP have been completed throughout the year	In 2020/21 anecdotal evidence and data from an audit will be collected to demonstrate the impact the activates have had ensuring the voice of the child and adult is heard
To further strengthen the Think Family Approach to Safeguarding so that silo working is reduced and collaborative working is achieved	Integrated training and polices have been developed, that adopt the Think Family approach to safeguarding, The Think Family Protocol is endorsed by Solent, and has been incorporated into the Safeguarding Strategy 2020/23	Anecdotal evidence gathered from advice calls and referrals into MASH demonstrate that clinicians assess the needs of the family, so that all members receive appropriate support rather than just the individual they are providing care to

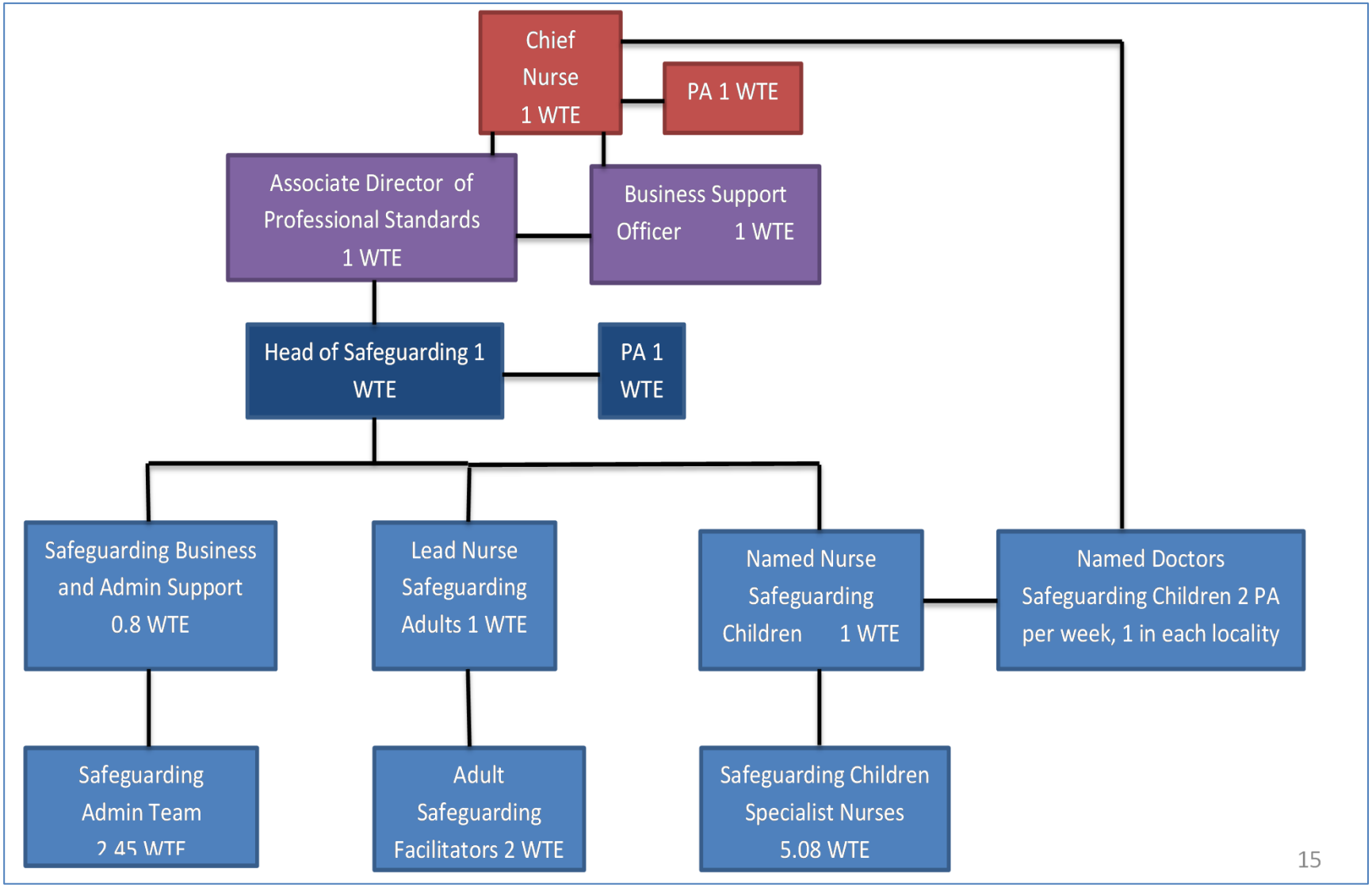
Safeguarding Structure and Governance

- The Chief Nurse provides executive leadership for the safeguarding agenda supported by the Associate Director for Professional Standards and Regulation and the Head of Safeguarding
- The Head of Safeguarding provides the strategic direction and leadership for the Safeguarding Children and Adults Teams, supported by the Named Nurse for Safeguarding Children and the Safeguarding Adults Lead
- The Named Nurses and Named Doctors for Looked After Children, (LAC), remain within the Children's and Families Service Line and provide leadership for the LAC agenda, (Appendix 1)
- Medical leadership for safeguarding children is provided by two Named Doctors for Safeguarding.
- The named doctors work closely with the 3 designated doctors in the Hampshire/Southampton/Portsmouth area raising concerns at the multiagency level around child protection. They are also responsible for liaising with the named doctors in the acute settings in their area.

Governance & Assurance Arrangements



Safeguarding Team Structure



The Safeguarding Team

The safeguarding team support everyone in the Trust to continue to deliver high quality safeguarding to the communities we serve and to our colleagues.

The Named Nurse leads a team of expert Safeguarding Children Specialist Nurses who have enhanced knowledge and skills in relation to safeguarding children. The team provide expertise and promote professional curiosity, challenge and collaboration as well as empowering staff to fulfil their safeguarding responsibilities. The Specialist nurses support the named nurse to discharge her responsibilities.

The Safeguarding Adults Team is led by the Safeguarding Adults Lead, supported by the safeguarding adults facilitators. The team provide expert advice and support on all subjects related to safeguarding and empower staff to apply and embed the six principles of safeguarding into everyday practice. The team support staff to adopt Making Safeguarding Personal so that the voice of adults at risk is heard and their desired outcomes are promoted.

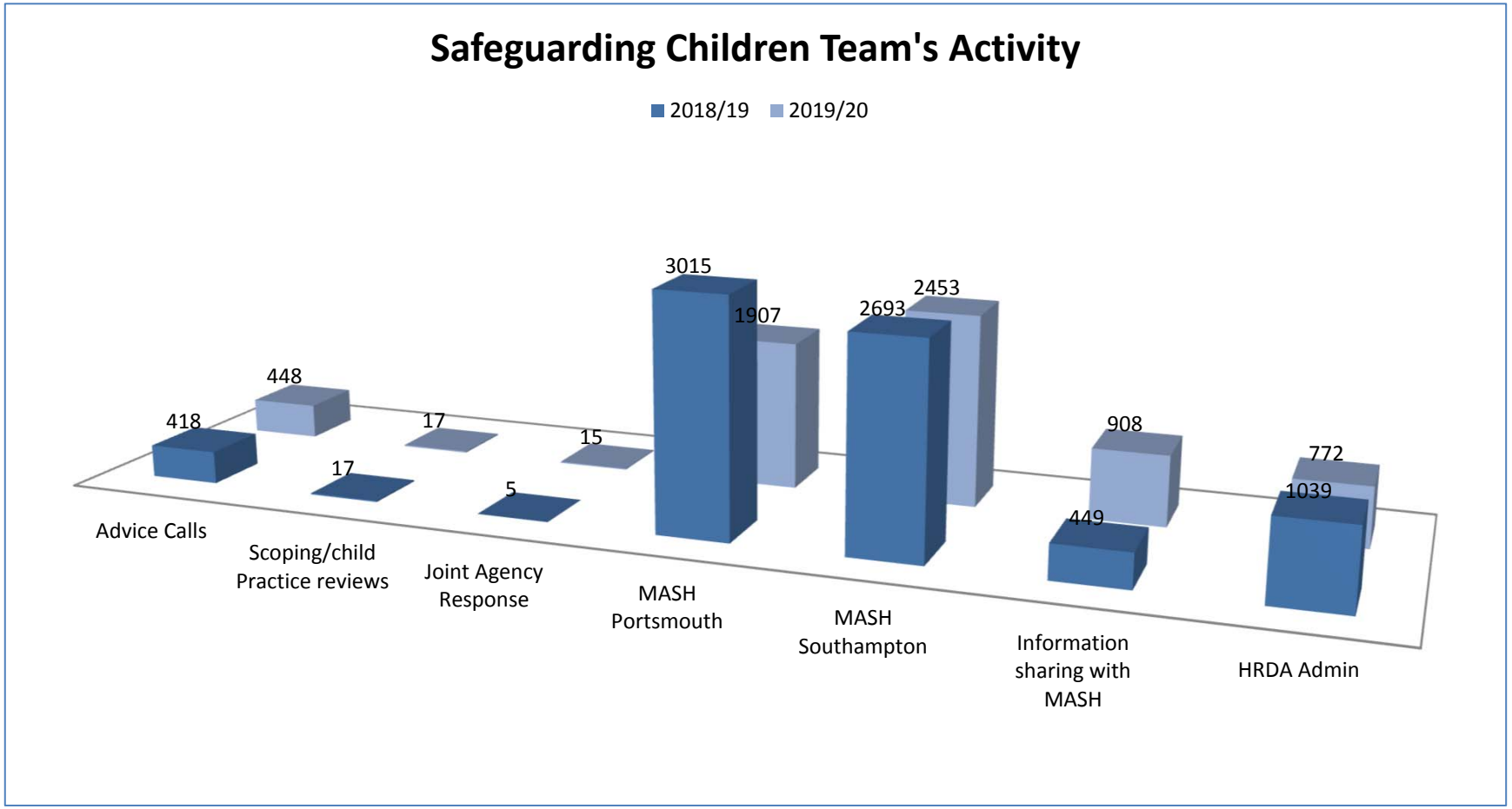
Safeguarding Children Team's Activity

- In 2019/20 the Safeguarding team have led more Joint Agency Responses, (JAR), when compared to the previous year. This means that families have received appropriate support from the team at a very traumatic time in their lives. Learning from each JAR is reviewed and shared to develop and improve multi-agency practice in the future

- The total number of MASH referrals navigated by the team equates to 8145, due to the Covid pandemic the numbers for each geographical area is not available for March and is not included in the graph illustrating the safeguarding children's team's activity. The increase of MASH referrals results accurate information being shared and analysis to inform risk assessment and care planning to improve outcomes for children and their families

- An increase information sharing with Children's Social Care within MASH supports accurate data collection to inform the MASH process

Safeguarding Children's Team Activity



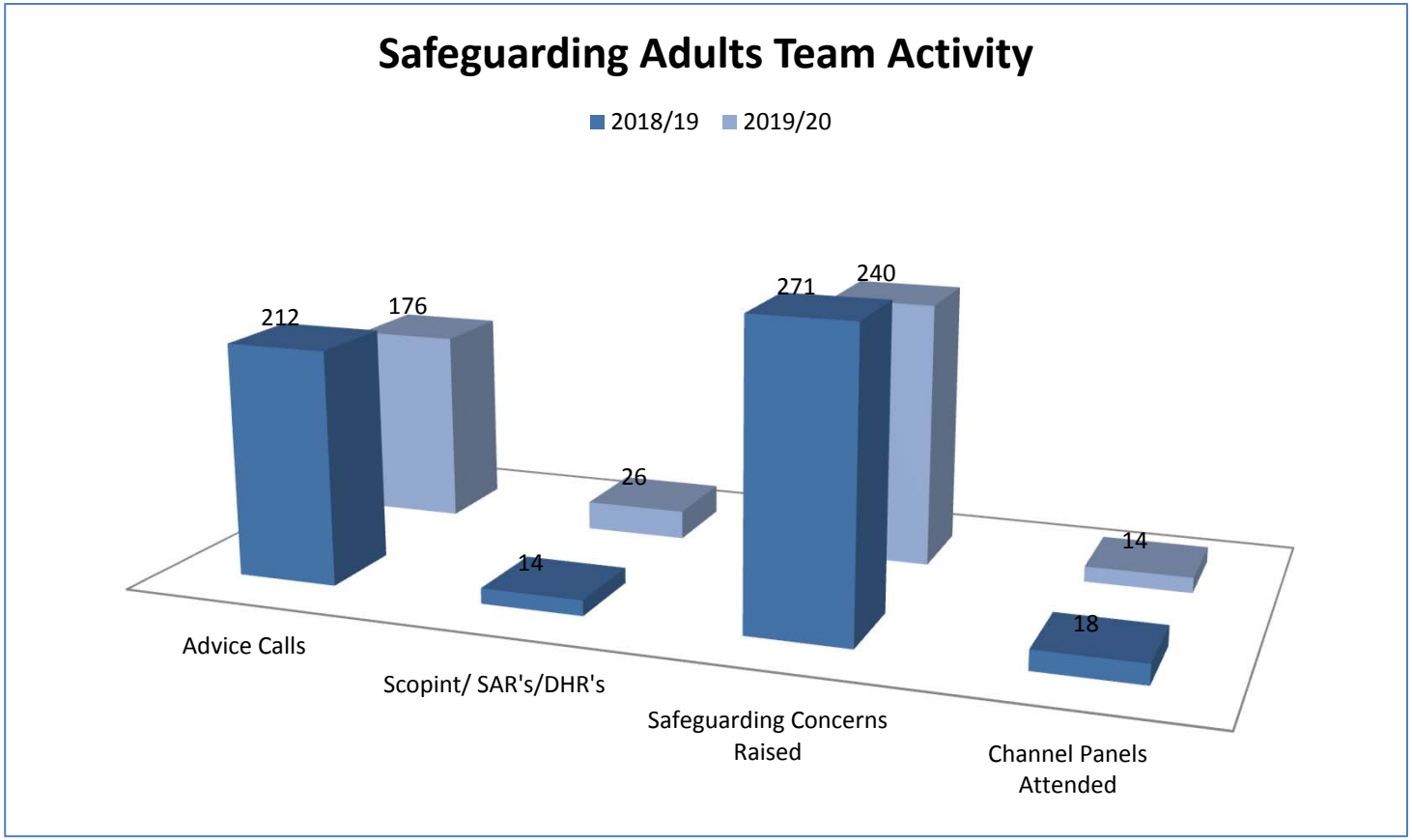
March data for each locality is not available due to Covid pandemic

Safeguarding Adults Team's Activity

- In 2019/20 the Safeguarding Adults team have supported an increased number of Safeguarding Adult Reviews to identify multi-agency learning. This process informs individual and multi-agency service development to improve outcomes for adults. See slides 25 & 26 for the learning and outcomes from SAR.

- During 2019/20 new arrangements were introduced for Hampshire Channel panels. If none of the adults were known to Solent Services, the Trust is represented by Hampshire Clinical Commissioning Group. This has resulted in less panels being attended creating more time for the team to focus on other work streams, such as the Level 3 safeguarding adults training and raising awareness of Making Safeguarding Personal

Safeguarding Adults Team



N.B. Solent represented at Hampshire Channel Panel by CCG Colleagues

Effective Intra-agency Working

To ensure that safeguarding is identified when cases and incidents are reviewed, a representative of the safeguarding team attend, key meetings, such as the learning from death and serious incident panels.

Representation at these meetings enables expert safeguarding advice to be provided and facilitates identification of safeguarding concerns in service provision.

This ensures safeguarding responsibilities and duties are fulfilled, learning identified, to improve service provision and outcomes for children and families.

Effective Multi-Agency Working

- The Chief Nurse, or her designated deputy, the Associate Director for Professional Standards and Regulations, represents Solent at the Southampton and Portsmouth SCP Board meetings and 4LSAB Board meetings. Currently Solent NHS Trust is not required to attend Hampshire Safeguarding Children Board but is represented at the health sub-committee by the named nurse
- A representative from the Safeguarding adults and children teams attend all sub groups to the 4LSAB and Portsmouth & Southampton SCP sub groups, Multi-Agency Conferences and Channel Panels, sharing information to inform risk assessment and decision making
- The Safeguarding Team support work streams from the sub groups including the 4LSAB's response to a document produced by Alcohol Change UK, the HIPS Safe Sleep Campaign to share learning from a thematic review into the subject and the refresh of the 4 LSAB policy & procedures
- Representation and participation in the Boards' work streams ensures that the Trust's perspective is considered, meaning that the needs of the communities we service is incorporated into the strategic decision making and planning of safeguarding activity so that their needs are met

Child Practice Reviews (CPR) & Safeguarding Adults Reviews (SAR)

- Solent NHS Trust's Safeguarding team actively supports and participates in all Safeguarding Child Practice Reviews (CPR) and Safeguarding Adult Reviews (SAR) and continues to be a core member of the children and adult care review sub groups.
- Progress with case reviews is included in the quarterly safeguarding reports. Monitoring of actions from case reviews is included in the safeguarding reporting framework to provide assurance that all actions are completed within agreed timescales

Categories and Themes of Harm from CPR and SAR's

Self Neglect	Substance Misuse	Murder	Co-Sleeping
Non-Accidental Injury	Was not Brought to Appointments	Neglect	Manslaughter
Suicide	Homeless Healthcare	Hoarding	Parental Neglect
	Child Exploitation		

Learning and Outcomes from CPR's & SAR's

Identified Learning	Outcomes	Impact
Safe Sleep advice needs to be promoted and embedded into practice	Health Visitor Sleep Safe Initiative Co-Sleeping guidelines	Parents better informed of risks of Co-sleeping, reducing the risk of co-sleeping occuring
Escalation Policy	SCP escalation policy developed and available to staff Escalation procedures included in training	Clear processes support professional challenge with the aim of achieving good outcomes for families
Children not brought to appointments	Overarching Was Not Brought (WNB) policy developed Named Doctors developing WNB policy for children with complex needs	Professionals take consistent actions when children are not brought to appointments reducing their risk of neglect and improving their health and well being

Learning and Outcomes from CPR's & SAR's Continued

Identified Learning	Outcomes	Impact
Families frequently have unknown adults living in their homes	Systems and processes updated to include unknown adults details in records, when consent is given, to inform care plans	Improved outcomes for children and families
Transitions between services are not co-ordinated	Transition policy developed as part of NHSE/I Quality Improvement Project	Children experience a smooth transition between services and continue to have their needs met
Learning from care reviews needs to be shared to inform service developments	Pathway to cascade learning throughout the Trust was developed Learning from cases incorporated into safeguarding training	Learning is implemented across services to enable high quality, compassionate care to be provided

Section 42 Enquiries

- The Trust's safeguarding adult team co-ordinate all Section 42 enquiries regarding Solent NHS Trust provided care for Southampton, (3 cases) & Portsmouth (6 cases), services. The team quality assure the reports and ensure that appropriate action plans are developed with an associated implementation plan

Section 42 Enquiries

Theme of Section 42 Enquiry	Impact
Pressure Ulcer Care	Trial of new risk assessment
	Information leaflets given to patient and/or relatives
	Pain assessement care plan incorporated into pressure ulcer care
Patients with complex care needs	Introduction of named lead nurse to oversee care
Escorts for patients attending acute hospitals	Standard operating procedure developed to identify requirments for providing escorts, including staffing levels
	Care plans for escorts devised

Managing Allegations & Safe Recruitment

- Concerns about staff members are investigated adhering to the 4 LSAB and 4 SCP frameworks and reported appropriately to the Safeguarding Allegations Management Advisor, (SAMA) and the Local Authority Designated Officer, (LADO)
- In all cases, support was provided to the staff member, keeping them and the patient central to the investigation
- In 2019/20, 7 referrals were made to the SAMA and 6 referrals were made to the LADO
- Referrals to professionals bodies and The Disclosure and Barring Service were considered for all appropriate cases.
- Themes of the concerns included inappropriate relationships, concerns about the behaviour of an acquaintance, physical abuse of a child and inappropriate restraint of an adult

Safeguarding Team Service Improvements in 2019/20

The safeguarding service has been improved in numerous ways to further develop effective safeguarding practice across the Trust. Improvements include:

- A variety of activity during safeguarding month:
  - the launch of the 4LSAB Making Safeguarding Personal tool
  - Education sessions on the learning from Mr D SAR & Child G CPR
  - Raising the profile of safeguarding via Tweets and Trust communications
  - Running a campaign to recruit safeguarding champions
- The Named Nurse for Safeguarding children has launched bi-monthly tutorials to provide an opportunity for practitioners to develop individual safeguarding portfolios, to develop their knowledge and skills to improve outcomes for children and families
- The Named Nurse has provided a Child Exploitation lecture to public health students at Surrey University, some of whom are sponsored by Solent
- A Trust Was Not Brought/Did Not Attend Policy was ratified to provide guidance to staff on appropriate action to take when a child or adult at risk are not brought to appointments

Safeguarding Supervision Service Improvements in 2019/20

- The Named Nurse for Safeguarding Children has commenced safeguarding supervision to the senior nursing leads working at Band 8A, the Family Nurse Practitioners and Family Nurse Supervisors. The new arrangements facilitate local knowledge of policies, safeguarding trends and learning to be incorporated into the supervision that is provided
- Three members of the safeguarding team have commenced restorative supervision training so that the approach can be embedded within safeguarding supervision groups
- Safeguarding supervision provided to the Quality and Safety team supervision groups for Health Visitors delivering the ECHO programme in Portsmouth which supports a safeguarding and restorative model of practice.

Safeguarding Children Team Service Improvements in 2019/20

- Quarterly case reviews meetings for the safeguarding children team, the named doctors for safeguarding children and the Named Nurses for LAC, to discuss and reflect on complex cases
- Implementation of professional safeguarding sessions for the Safeguarding Children's team to promote professional development
- Introduction of a password with colleagues in Southampton MASH to confirm that requests for information are from genuine source
- Work is continuing on agreeing joined up JAR processes across the HIPS areas but will be on hold at present

Safeguarding Adults Team Service Improvements in 2019/20

- The safeguarding adults team are supporting additional opportunities for learning by supporting the programme of “skills slots” at two in-patient units, and facilitating a workshop for the neuro-rehabilitation team
- Stronger working arrangements have been developed with Portsmouth City Council to complete Section 42 enquiries into Solent provided care
- A Safeguarding Adults Facilitator secondment opportunity was introduced in Quarter 1, which provides an opportunity for front line staff to develop their safeguarding knowledge, skills and competencies whilst increasing the range of clinical expertise within their team. The secondee is enabled to share their specialist knowledge within their service area to enhance safeguarding practice

Safeguarding Training Service Improvements 2019/20

- Provision of large scale Safeguarding Adults Level 3 training to increase compliance in line with the Adult Safeguarding – Roles and Competencies for Healthcare Staff, (2018). Staff knowledge and understanding of adult safeguarding has been increased meaning that adults received appropriate support to achieve the outcomes they desire
- A pathway for new training requirements for Level 3 safeguarding children training, (Safeguarding Children and Young People - Roles and Competencies for Healthcare Staff, 2019) has been developed to inform staff what training they are required to complete
- The Safeguarding training programme has been updated to include integrated Safeguarding Children and Adults at Risk Level 2 training, which demonstrates the “Think Family” approach to safeguarding
- Introduction of an Integrated Domestic Abuse Training presentation, (Children & Adults Level 2/3), to reflect the “Think Family” approach to safeguarding and in recognition of the National drive to respond and reduce domestic abuse

Safeguarding Training Compliance (see appendix 2)

- The introduction of the intercollegiate documents for safeguarding training increased the number of staff who required level 3 safeguarding adults and safeguarding children training. Compliance with level 3 adults training has steadily increased throughout the year and is predicted to continue to increase in 2020/21

- Some training sessions were cancelled in March, due to Covid 19, affecting the end of year training compliance, (80.16%). A small portfolio of remote training has been developed to mitigate this and to support staff to maintain and develop their safeguarding knowledge and skills to enable them to fulfil their safeguarding responsibilities

- Access to the Prevent eLearning was impaired through the year due to IT issues. Numerous actions were implemented to support staff to complete the training and understand their responsibilities, these actions have resulted in an increase in compliance to 74.53% year end

Mental Capacity Act (MCA)

- The role of the MHA/MCA lead is embedded with in the Trust. The lead's role, with respect to MCA ,is to offer advice and learning to staff, to enact any new law/polices, to oversee the audit of the use of the Act and to offer assurance to the senior management team of the use of the Act in the Trust to review the relevant policies (The MCA/DOLS policy was reviewed in April 2020 and considered the guidance from the Coronavirus Act 2020

- Training compliance decreased throughout the year, attributable to vacancies within the team which took several months to recruit to. Additionally, the Covid pandemic has impacted on training provision. A dedicated role of MCA trainer has been created who will visit service lines to provide bespoke training

Deprivation of Liberty Safeguards (DoLS) & Liberty Protection Safeguards (LPS)

- The Deprivation of Liberty Safeguards and The Mental Capacity Act 2005 Policy was updated in January 2018 and is compliant with Legislation
- Work has commenced in preparation for the implementation of LPS
- A business plan has been completed and escalated to the senior management team for consideration. The aim of the business plan is to enable the Trust to effectively implement LPS and to strengthen knowledge and training of MCA.

Looked After Children (LAC) Service

- In 2019/20 there have been no organisation changes in the development of the LAC service.

- LAC Annual Reports provide details of LAC activity and service developments and are circulated via the Safeguarding Steering Group

Child Protection Medical Service (CPMS)

- Solent West and East CPMS run a service for referrals from social care and police to assess children for possible abuse; primarily physical and sexual abuse but also includes medical assessment for neglect. The team consists of Paediatric consultants, specialty doctors and specialist nurses

- The specialist nurses take all the advice calls and liaise with the referrer and the Consultant/Speciality doctor on call to either give advice or arrange a medical examination. The nurse will assist in all examinations for physical abuse. They arrange and attend future examinations for neglect and historic sexual abuse. They will co-ordinate all tests and investigations required, for example, skeletal surveys, bloods, medical photography and Ophthalmology

- If capacity and time allows, they will attend strategy meetings following Child Protection Medical examinations if required

Child Protection Medical Service – Advice Calls

In 2019/20 there has been an increase in advice calls in to both CPMS teams, compared to last year.

	East		West	
	2018/19	2019/20	2018/19	2019/20
Total number of calls	296	302	87	133

Child Protection Medical Service (CPMS) – Medicals Completed

- More Child protection medicals were completed by both teams in 2019/20 compared to the previous year. The most common type of concern remained physical abuse.

	East		West	
Nature of case	2018/19	2019/20	2018/19	2019/20
CSA	42	30	25	26
Physical	111	140	106	109
Neglect	3	3	7	20
Total	156	173	138	155

CPMS Improvements in 2019/20

- Joint peer reviews have commenced between the East and West teams but also each team is meeting jointly with their respective acute teams to improve liaison and communication with a view to improving outcomes for families
- A 'Was not Brought' (WNB) leaflet has been produced to send to parents when they have not attended health appointments. This helps explain to parents the importance of attending appointments to maintain the health and welfare of their children
- The named doctors are reviewing the WNB policy to ensure this gives clear guidance for practitioners especially for disabled and vulnerable children who cannot be discharged from our services due to their needs. This will facilitate the early identification of WNB, an indicator of neglect, so appropriate support can be provided to families

Audits & Service Evaluations Completed in 2019/20

Audit/Service Evaluation	Findings	Impact
Advice Line	88% of calls answered in 1 working day. Review of how the advice line is delivered will be completed in 2020/21 to increase response time	Staff receive the support and supervision they require and understand their responsibilities
	96% of respondents were happy with advice that was given	Prompt and appropriate actions can be taken to promote the safety of children and adults
Safeguarding Supervision	A definition of a child with complex needs has been agreed	Staff know which children must be discussed at supervision to ensure robust actions are taken
	4 cases to be discussed in safeguarding supervision each year	Clear parameters are set to allow audit to be conducted to demonstrate supervision is effective and supports professional and service development
	Template for recording safeguarding supervision to be developed	

Audits & Service Evaluations Completed in 2019/20 Continued

Audit/Service Evaluation	Findings	Impact
Service Evaluation Safeguarding Champions	Champions increased knowledge has enabled them to support staff to improve outcomes for families	The effectiveness of champions has been demonstrated and illustrated a positive impact on the outcomes for children and families. An example of this was a child who was experiencing many types of abuse, including sexual abuse, was referred to MASH, received support and is now happier and more stable. Safeguarding is embedded as core business
Quality of SH Referrals	Referrals of a high standard	Clear information is shared, facilitating multi-agency assessment and response to improve outcomes for families
	Importance of reference to thresholds demonstrated & will be included in training	Accurate information will be included in referrals to inform decision making within MASH
Implementation of MCA	Assessment of people's capacity to consent to hospital admission requires improvement	Improved implementation of the MCA will support people to receive person centred care within legislative frameworks

Plaudits & Compliments

- The safeguarding team's "So Safe" newsletter and tutorials has received widespread acclaim. The content has been rated so highly that issues have now been requested by commissioners and Children's Social Care

- NHS England's Head of Safeguarding has praised Solent's Safeguarding Champions, identifying that the number and diversity of the Champions is not replicated anywhere else in the UK

- Commissioners, Safeguarding Children Partnerships including Local Authorities have requested the Named Nurse Tutorial to enable learning to be shared across the safeguarding arena. The Trust's reputation as a valued employer and partner agency has been enhanced by the recognition outside of the Trust, thus encouraging high calibre professionals to seek employment with the Trust, further improving the high quality services we provide

Priorities for 2020/21

The priorities for 2020/21 will be delivered by the implementation of the business objectives for the 1st year of the Safeguarding Strategy. Implementation of the strategy will be affected by the Covid pandemic. However the safeguarding team will remain flexible, creative and adaptable to the challenges faced by the pandemic, to facilitate the implementation of the objectives through out the Trust.

- **Objective 1: Safeguarding is Everyone's Responsibility.** Safeguarding will be embedded throughout the Trust so that it truly becomes everyone's responsibility. It will be the golden thread that runs throughout governance structures, training and care delivery

- **Objective 2: Training.** Safeguarding training will be provided in line with National requirements. It will be responsive to local learning and meet the needs of staff, by being offered in a variety of formats across a range of topics

Priorities for 2020/21 Continued

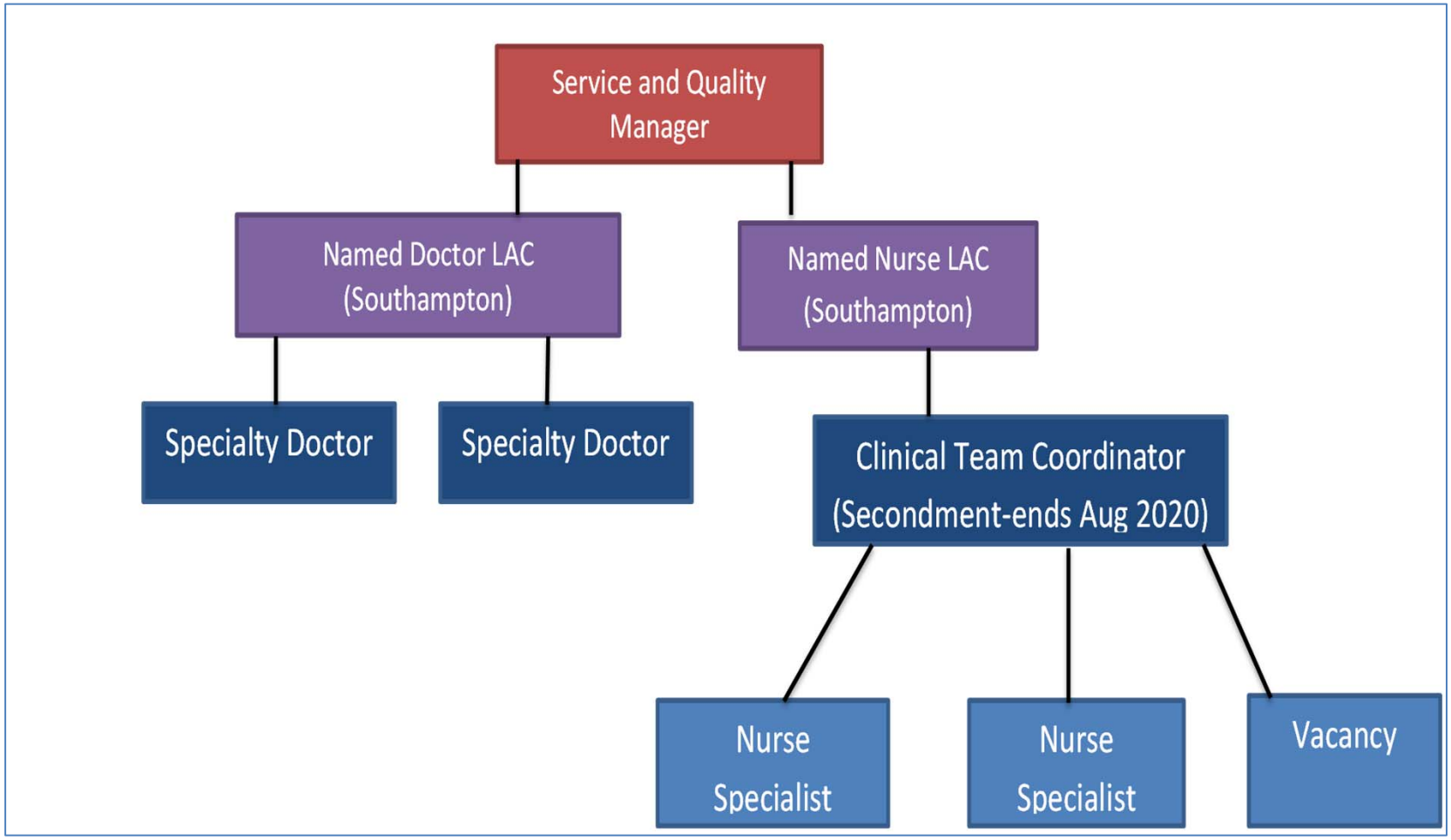
- **Objective 3: Whole family approach** to safeguarding will be a central theme in all safeguarding activity, throughout the Trust

- **Objective 4: The voice of the child and adult** at risk will be heard and used to inform decision making

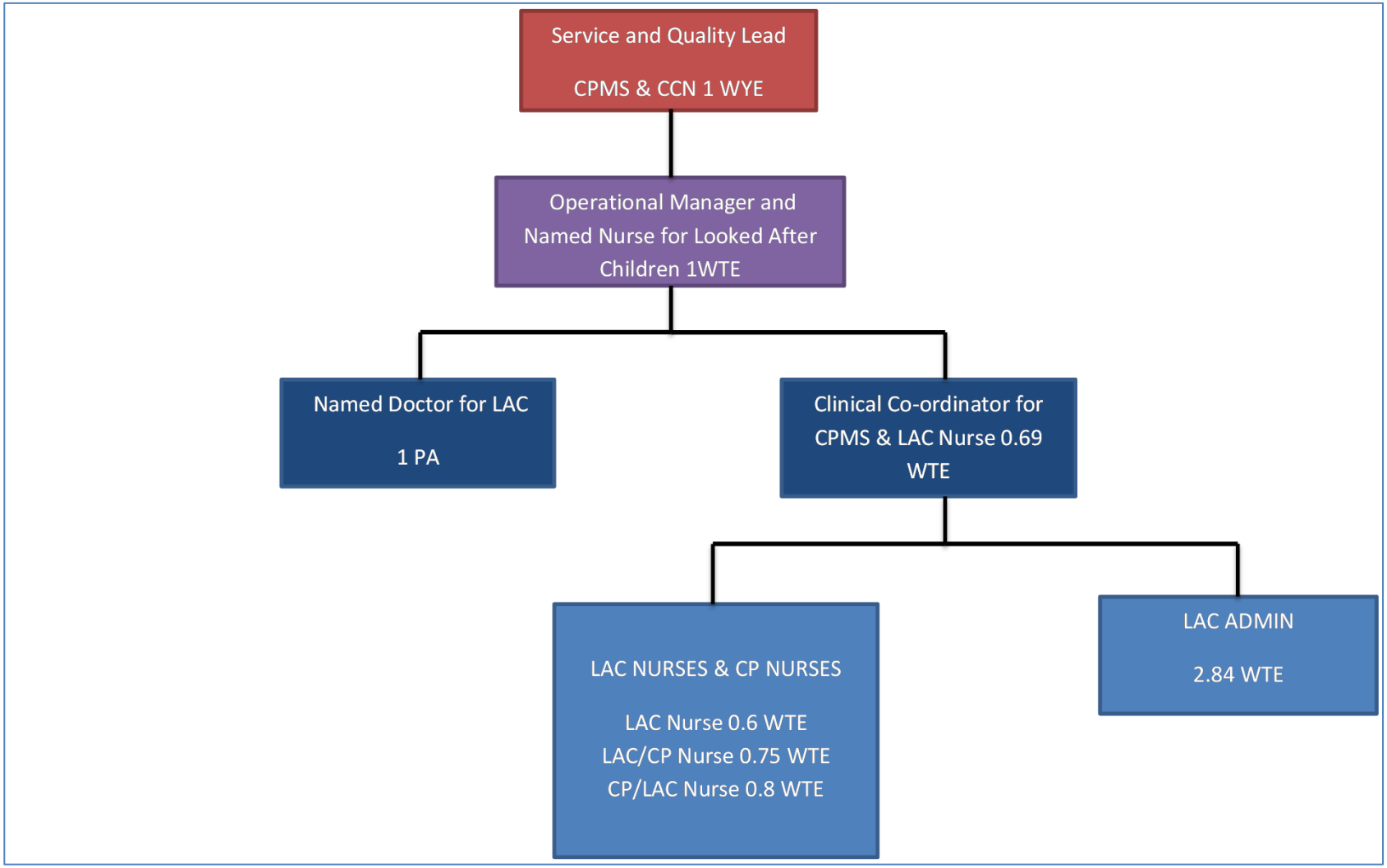
- **Objective 5: Feedback** will be sought to enable our safeguarding team to remain responsive to the needs of our colleagues, children, young people, adults at risk and the communities we serve

Fiona Holder
Head of Safeguarding
10 June 2020

Appendix 1 – LAC Team (West) Structure



Appendix 1 – LAC Team (East) Structure



Appendix 2 - Safeguarding Training Compliance

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	4109	4109	3491	84.96%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	2545	2545	2105	82.71%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	4109	4109	3496	85.08%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	2530	2530	2086	82.45%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	766	766	510	66.58%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	652	652	387	59.36%
NHS|MAND|Safeguarding Children Level 4 - 3 Years|	8	8	8	100.00%
Safeguarding Total (All)	14719	14719	12083	80.16%
Prevent	4073	4073	3042	74.53%
NHS|MAND|Mental Capacity Act - 3 Years|	2524	2524	2008	79.56%

N.B. Compliance was affected by Covid 19 Pandemic as some training was cancelled in March 2020.

Board and Committee Cover Sheet

Item No.	17

Presentation to	In-Public 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 5 June 2020			
Author(s)	Jayne Jenney, Corporate Support Manager and Assistant Company Secretary	Executive Sponsor	Sue Harriman, CEO Catherine Mason, Chair	
Date of Paper	5 June 2020	Committees/Groups previously presented	-----	
Action Required	For decision?	N	For assurance?	Y
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	Sue Harriman							

Summary of business transacted:

Key matters discussed were as follows:

- The **Committee Annual Report** (Appendix 1) was received and the meeting was content that business conducted during the period 2019-20 complied with the Terms of Reference, however delays in some elements of work were acknowledged, due to the Covid pandemic. Objectives for the forthcoming year were discussed and it was agreed to undertake a review of the meeting governance infrastructure to ensure appropriate governance of all meetings.

- The **Governance Overview report** was shared. The Committee noted the current committee structure and acknowledged the NED lead roles, the current NED tenure and NED committee composition.

- The committee received an update on **Well Led preparation** work to provide assurance of a review being undertaken in light of changes to timescales and elements of working practices as a consequence of the current pandemic. Review stages were discussed and it was agreed to consider the commencement of the commissioning process for stage 2 evaluation during quarter 4 2020/21 at the next meeting, subject to possible changes to the current crisis.

- The **Fit and Proper Person Arrangements Assurance Report** was presented and the Committee considered and agreed to continue with the existing 3 year DBS review arrangements for Trust Board members, rather than conducting checks only upon entry into the organisation (as per current Trust policy).

- The **Associate Hospital Manager Diversity and Inclusion** report was shared. It was agreed that the recruitment and consideration of BAME representation and diversity should be progressed. The Committee were informed that Professor Roger Klein is to be invited to a future Board workshop to present on matters associated with BAME.

- Delays with **Board Development Programme** were noted and the Committee were updated on work undertaken so far. It was agreed to review the initial framework and draft procurement brief written pre-Covid to ensure fit for purpose.

Appendix 1

Governance & Nominations Committee Annual Report 2019-20

Introduction

The Governance & Nominations Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2020.

Meetings

During 2019-20 the following meetings were held:

- 12 July 2019
- September 2019 (virtual)
- 13 December 2019
- 6 February 2020

Membership & Attendance

Attendance by members is outlined as follows:

	Meeting				
NAME	12 July 2019	September 2019 (virtual)	13 December 2019	6 February 2020	% attendance
Catherine Mason – Chair Chairman	P	P	P	P	100%
Mick Tutt Non-Executive Director	P	P	P	P	100%
Sue Harriman Chief Executive	P	P	A	*P	75%
Jon Pittam Non-Executive Director	A	P	P	P	75%

P= Present A= Apologies *virtual comments were taken into consideration

Terms of Reference

The Terms of Reference (TOR) for the Committee were considered and it was agreed to simplify the content based on discussions held at the July 2019 meeting.

Status against the achievement of the Committee's Objectives

Objectives	End of Year status
To review non-executive membership of Board Committees upon appointment recommending changes to the Board as appropriate	*Board Committee membership / chair responsibilities and lead roles were considered and agreed at the July 2019 meeting, in December 2019 and again in Feb 2020 following changes in NED appointments.*
To review executive portfolios upon new appointments /resignations to ensure appropriate coverage, succession planning and management of director remits	*An oversight of succession planning arrangements was shared and discussed at the February 2020 meeting.*
To consider governance arrangements in light of future organisational changes and the emerging Health and Social Care environment	*Governance arrangements of Solent with the wider system are regularly considered to ensure appropriate representation and alignment with Solent governance.*
Undertake a comprehensive review of board effectiveness taking into account the requirements of the Well Led Framework.	*The July 2019 meeting considered the timing of an external Well Led Developmental review and it was agreed to undertake prior to the timeline indicated by NHSI/E of June 2021.*

Summary of business conducted in year

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

July 2019

- The composition of the Board and committees were reviewed as well as interim committee chair arrangements following a NED resignation. The committee was assured of arrangements in place to ensure committee quoracy.
- NED lead roles were approved as well as extensions to the SID and Deputy Chair roles.
- The Committee approved proposed changes to the policy ratification process.
- A proposal was considered of the self-evaluation of Board committees and timescales for doing so were shared and agreed.
- It was agreed to conduct a Well Led Development review before the indicated deadline of June 2021.
- The recruitment of new Associate Hospital Managers was noted. The role of AHMs, length of tenure and skills were discussed.

September 2019

- A virtual meeting was held to approve the Terms of Reference for the newly formed Workforce and OD Committee, previously known as the People and OD Committee.

December 2019

- The Committee received a governance summary of a review of membership and composition of committees, NED lead roles and NED tenure.
- Revised Terms of Reference to include a committee annual appraisal and effectiveness exercise were agreed and the committee agenda cycle noted.
- The Associate Hospital Manager governance report was noted.
- The Committee considered Board development activities going forward and a session on team building and behaviours was agreed following changes to the executive and non-executive team. It was also agreed to consider a wider leadership team sessions with access to Board members due to the apparent lack of direct access to NED colleagues previously highlighted by Clinical Directors.

February 2020

- Lead NED roles were agreed.
- The role of the Complaints Panel, frequency of the Mental Health Act Scrutiny Committee and the establishing of the Strategic Partnership Committee were agreed.
- NED membership was summarised and approved.
- The Associate Hospital Manager appraisal recommendation paper was presented and a strengthened governance process with AHM appointments was noted.
- An oversight was provided of succession planning arrangements for the executive team.

Proposed draft objectives for 2020-21 – to be agreed at the forthcoming meeting:

- To see assurance that **succession plans** are in place for Executive and NED colleagues
- To oversee the commissioning of the external review in accordance with the NHSI requirements against the **'Development reviews of Leadership and governance using the Well-Led Framework'** (planned for commissioning during Q4 2020/21 and implementation during Q1 2021/22) and input into the scope of review.
- To review the **internal governance infrastructure** – including Committees and Groups, to ensure structures and meetings are value adding, and allow the most effective and efficient reporting through to Board
- To continue to input into, and be appraised of the planned **Board Development Programme**; and importantly, seek assurance that actions and recommendation following the implementation of the programme are enacted

Conclusion

The Committee has complied with its Terms of Reference during the period under review.	
Report Author(s)	Governance & Nominations NED members Jayne Jenney, Corporate Support Manager and Assistant Company Secretary

Solent NHS Trust

Solent NHS Trust
Finance & Infrastructure Committee– Terms of Reference

1 Constitution

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

2 Purpose

2.1 The Terms of Reference reflect the Board delegated role of the Committee in ensuring appropriate financial frameworks are in place to drive the financial strategy, and provide assurance to the Board on financial and infrastructure matters as directed.

3 Duties

The Committee will make recommendations to the Board in relation to its duties as described below;

3.1 Strategic Financial Planning

- To scrutinise the development of the Trust's commercial and financial strategy (including both revenue and capital), including the underlying assumptions and methodology used, ahead of review and approval by the Trust Board.
- To review the Trust's 2 and 5 year financial plan prior to presentation at the Board and ensure it is aligned to the strategy of the wider health economy, particularly the Hampshire and Isle of Wight STP (ICS) Strategic Delivery Plan and the local ICPs
- To recommend to the board the disposal/acquisition of estates in relation to strategic financial planning and to recommend the strategic use of estates to the Board
- To consider major transformation and productivity in relationship to forward strategy including workforce, ICT and Estates, and that of the STP/ICS and local ICPs.
- The consideration of strategic estates plan (and understanding of funds flows, programme management of estates plans) and plans associated with the STP/ICS and local ICPs
- To set a framework and relevant criteria for evaluating capital investment proposals within the Trust.
- To review any post-implementation investment audits undertaken by or on behalf of the Trust.
- If and when appropriate, the Committee will recommend the incorporation of start-up companies to the Trust Board, for agreement, in relation to any due diligence, warranties, assignments, investment agreements, etc. related to start-up companies.

3.2 Business Planning process In the context of considering wider system plans;

- To ensure alignment of plan, budget and workforce plan, seeking assurance that the plan is produced and owned by the service lines / corporate divisions.
- To understand the impact of plan delivery on clinical quality and be assured that there are QIA processes in place
- To ensure that the resource to deliver the plan is understood and allocated
- To seek assurance that estates and IT strategies are aligned to service plans
- To seek assurance that all associated costs are validated (e.g. estates, IT)
- To review all risks and opportunities to future business and their link into business planning
- To seek assurance on the achievement of business plans and major change programmes

3.3 Annual Budget Setting & Monitoring

- To review the impact of Cost Improvement Plans (CIPs) on forward financial planning
- To scrutinise the financial plan underpinning the Annual Operating Plan
- To consider the Trusts' Control Total and consider the implications of an ICS joint Control Total, ahead of approval by the Board
- To scrutinise the draft budget prior to approval at the Board
- To review and scrutinise the capital programme in relation to estates

3.4 Treasury Management

- To agree the Treasury Management Policy and the subsequent review and implementation of the policy.

3.5 Financial Recovery Programme and financial control

- To review funding sources and budgets
- To review levels of recurrent / non-recurrent CIPs and overall level of savings
- To review the risks and opportunities schedule as a tool to manage the in year forecast outturn
- To review the progress against key milestones of major benefit realisation plans

3.6 Business Management

- To have oversight of activity and capacity data in relation to individual service lines
- To evaluate, scrutinise and review individual investment/divestment decisions, as defined by the SFIs and to monitor on behalf of the Trust Board
- To review relevant Financial Policies and Procedures
- To seek financial governance assurance regarding major work programmes; such as CGI contract reset and CRS project implementation
- To seek assurance on the achievement of the key performance targets in the Trust's strategic plan
- To review the Standing Financial Instructions and Scheme Of Delegation ahead of presentation to the Board

3.7 Trust Risk Management Framework

- Assure application of the Trust risk appetite and tolerance.
- Agree proposals to tolerate risks scoring 15 or above.
- Assure the management and action plans of risks scoring 15 or above.

3.8 Infrastructure (Estates and IT)

- To receive exception reports from the ICT Group and the Estates, Facilities and Sustainability Group
- To approve for recommendation to the Board the Estate and IT strategic plans
- To review key commercial partnerships as appropriate
- To seek assurance regarding operational delivery of estates and IT plans

3.9 Finance and Commercial Group

To receive an 'Exceptions and recommendation' report from the Finance and Commercial group, detailing business transacted and to receive and review recommendations from the Group on investment decisions in accordance with the Scheme of Delegation.

3.10 Other duties

- At the request of the Trust Board, the Committee may review in depth aspects of financial performance where the Board requires additional scrutiny and assurance (for example the delivery of the CIP programme) while recognising that the primary responsibility for the monthly monitoring and review of the Trust's financial performance rests with the full Trust Board.
- The Committee may examine any matter referred to it by the Trust Board or the Audit & Risk

Committee.

- The Committee will conduct an annual appraisal of its effectiveness.

4 Membership

4.1 The Committee will consist of the

- Three Non-executive directors as appointed by the Board,
- Chief Executive and
- Deputy CEO and Chief Financial Officer
- Director of Finance

4.2 A designated alternate person acting in the capacity of a member must be identified where a member is unable to attend a meeting. Such alternates will be authorised to vote if the need arises.

4.3 One of the Non-Executive Director members will be appointed Chair of the Committee by the Board.

4.4 In the event of the Chair being unable to attend all or part of a meeting, the Chair will nominate a replacement from within the membership to deputise for that meeting.

5 Attendees

5.1 Other persons may be invited to attend by the Chair.

6 Meeting administration

6.1 The Company Secretary shall nominate an administrator to act as the Secretary of the Committee**.** Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated promptly to all members

7 Quorum

7.1 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 Deputy CEO and Chief Financial Officer and/or the Director of Finance

8 Frequency

8.1 Meetings will normally be held bi-monthly. Additional ad-hoc meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.

9 Authority

9.1 The Committee is authorised by the Board to investigate any activity within its terms of reference or any matter delegated by the Trust Board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

9.2 The Committee may refer issues to the Audit & Risk Committee as appropriate and vice versa.

10 Reporting

10.1 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	12.1 (May 2020)
Date of next review	May 2021
Approved at Finance & Infrastructure Committee	May 2020

Item 18.2

NHS Solent NHS Trust

Scheme of Reservation and Delegation

Version	Approved by	Date	Date of next review
7	Chairs action (March 3RD 2016) – and noted at March 2016 Board Amendment pg29+30 re: financial sign off thresholds concerning business cases prior to presentation to the Finance & Infrastructure Committee		March 2017
8	Board	November 2016	November 2018
9	Board	September 2017 – amendments made to section 7, financial thresholds as recommended by the Finance & Infrastructure Committee	November 2018
10	Board	Nov 2017 – amendments made as recommended by the Commercial Team	November 2019
11	Board	September 2018 – amendments made as recommended by the Commercial Team and approved via Finance & Commercial Team and Finance & Infrastructure Committee, July 2018 and update to pg 8 to include People and OD Committee and Community Engagement Committee	November 2019
12	Board	Jan 2019 – amendments made to pg 29 and 30 concerning leases and licenses	Chairs Action Jan 2019
13	Board	Document updated to reference new titles throughout and to align with updated SFIs (as agreed by Jan 2020 Finance& Infrastructure Committee)	

Section One - Decisions reserved to the Board of Directors

Reference to the 'Board of Directors' should also be read as the 'Trust Board'.

Decisions reserved to the Board
General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, it wishes, in full session within its statutory powers
Regulations and Control 1.1 Approve Standing Orders (SOs) (the Constitution), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 1.2 Suspend Standing Orders. 1.3 Vary or amend the Standing Orders. 1.4 Ratify any urgent decisions taken by the Chairman and Chief Executive in the next formal public session in accordance with the Standing Orders (section 5.2). 1.5 Approve a scheme of delegation of powers from the Board of Directors to committees of the Board of Directors. 1.6 Require and receive the declaration of members of the Board of Director's interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 1.7 Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust. 1.8 Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 1.9 The Board shall also approve policies with significant public interest or where enactment requires a significant change in the way the Trust operates. Policies presented to the Board for approval should first have been considered and agreed at the Trust Management Team meeting. 1.10 Confirm or if necessary amend the recommendations of Committees of the Board of Directors where the Committees do not have executive powers. 1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held in trust. 1.12 Establish terms of reference and reporting arrangements of all committees that are established by the Board. 1.13 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 1.14 Authorise use of the Trust seal. 1.15 Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with the Standing Orders. 1.16 Discipline members of the Board of Directors or employees who are in breach of statutory requirements or

Standing Orders.

1.17 Undertake a formal review of its own performance and of its committees on an annual basis.

Appointments/ Dismissal

2.1 Appoint and remove the Deputy Chairman of the Board as required.

2.2 Appoint and dismiss committees (and individual members) that are directly accountable to the Board of Directors.

2.3 Confirm appointment of members of any committee of the Board of Directors as representatives on outside bodies.

2.4 Approve proposals of the Remuneration Committee;

2.5 Appointment and removal, (subject to law and their contract) of the Chief Executive and executive directors;

2.6 Ensure that appropriate succession planning is carried out for the Board and senior management team.

2.7 Appointment and removal of the Trust Secretary or equivalent

Strategy, Plans and Budgets

3.1 Define the Trust's mission, vision and strategic objectives. To set the strategic direction to be pursued by the Trust.

3.2 Ensure that ~~a~~ Board development and organisational development plans are in place to support the Trust's delivery of the strategic direction.

3.3 Approve annual operating plans and budgets.

3.4 Deliver the control total agreed with NHS Improvement following consideration and recommendation by the Finance & Infrastructure Committee.

3.5 Approve plans for material service changes and efficiencies.

3.6 Define the Trust's values and standards of conduct.

3.7 Approve proposals for ensuring the safety and quality of services and safety and quality governance for services provided by the Trust, having regard to any guidance issued by the Secretary of State.

3.8 Approve the Trust's policies and procedures for the management of risk.

3.9 Approve the Outline and Final Business Cases for Capital Investment above and beyond the Finance & Infrastructure Committee's delegated limits.

3.10 Approve proposals for acquisition, disposal or change of use of land and/or buildings.

3.11 Approve the opening of bank accounts.

3.12 Approve proposals on individual contracts (other than NHS clinical contracts) of a capital or revenue nature amounting to, or likely to amount to over £3,000,000 regardless of the length of the contract.

3.13 Approve proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board.

3.14 Approve individual compensation payments considering national guidance where relevant.

3.15 Approve proposals for action on litigation against or on behalf of the Trust.

3.16 Approve use of NHS Resolution (formally known as NHSLA) risk pooling schemes (including CNST), which is executed via the Chief Finance Officer.

3.17 Responsible for overseeing the development and implementation of a workforce strategy, ensuring the workforce meets the needs of the organisation and is fit for purpose.

Audit (via the Chief Finance Officer and Chair of the Audit & Risk Committee)

4.1 Approve the appointment (and where necessary the dismissal) of external auditors.

4.2 Notify the external auditor of any problems relating to the service.

4.3 Approve the appointment (and where necessary the dismissal) of internal auditors.

4.4 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit and Risk Committee.

4.5 Approve the remuneration of the external and internal auditors.

Annual Reports and Accounts

5.1 Approve the Annual Accounts, Annual Report and Quality Account and receive a statement of assurance from the Audit and Risk Committee that the Committee has made appropriate enquiries before recommending the documents for approval by the Board.

5.2 Hold an Annual General Meeting at which the report and accounts will be laid and approve any resolutions to be presented to the AGM.

Monitoring

6.1 Receive such reports as the Board of Directors sees fit from Committees in respect of their exercise of powers delegated.

6.2 Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care, NHS Improvements and the Charity Commission shall be reported, at least in summary, to the Board.

6.3 Ensure maintenance of a sound system of internal control and risk management which holds the organisation to account for the delivery of the strategy and seeks assurance that systems of internal control are robust and reliable.

6.4 Ensure that the necessary financial, human and physical resources are in place to enable the Trust to meet its priorities and objectives and periodically review management performance, including through reports from the Chief Finance Officer on financial performance against budget and contracts agreed with commissioners.

Clinical standards and Patient Safety

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

7.2 Oversee the risk management framework implementation of Solent NHS Trust, and ensure appropriate action in relation to adverse events that occur.

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

Section Two - Matters delegated to Board Committees

Committee	Matters delegated by the Board of Directors to Committees
Audit and Risk Committee	In accordance with Standing Orders, the Board shall formally establish an Audit and Risk Committee. The Committee is a non-executive Committee of the Board and has no Committee executive powers, other than those specifically delegated by the Board in the Terms of Reference. The overall purpose of which is to: 1. seek assurance that the Trust's activities are efficient, effective and represent value for money; 2. review the establishment and maintenance of an effective system of corporate governance, internal control and risk management across the whole of the Trust's activities that supports the achievement of the Trust's objectives; 3. monitor the integrity of the financial statements of the Trust; 4. monitor the independent auditor's qualifications, independence and performance; 5. monitor the performance of the Trust's internal audit function ; 6. monitor compliance by the Trust with legal and regulatory requirements; and 7. review the findings of other significant assurance functions, including counter fraud, to the organisation, and consider the implications to the governance of the organisation.
Remuneration Committee	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 makes decisions on behalf of Solent NHS Trust Board 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 settlement agreements/severance pay or other occasional payments to individuals and out of court settlements, taking account of national guidance; • Receive and note decisions of the Clinical Excellence Awards (CEA) panel; • Within the constraints of national frameworks the Committee will agree the remuneration package, allowances and terms of service of the Trust's executive directors. No executive director shall be involved in any decisions as to his/her own remuneration; • Monitor and oversee the evaluation of the performance of the Chief Executive and other individual executive directors; • Approve participation in any performance related pay schemes, where operated by the Trust, and approve the total annual payments made under such schemes; • Ensure that contractual terms on termination, and any payments made, are fair to the individual and the NHS, aligned with the interests of the patients, that

	failure is not rewarded and that the duty to mitigate loss is fully recognised, in line with national guidance where appropriate; and • Be responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who advise the committee, and to obtain reliable, up-to-date information about remuneration in other trusts.
Quality Assurance Committee	The Board shall establish a~~n~~ Quality 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.
Mental Health Act Scrutiny & Deprivation of Liberty Safeguards (DoLS) Scrutiny Committee	The Mental Health Act Scrutiny & Deprivation of Liberty Safeguards (DoLs) Committee [hereby referred to as the MHA&DoLSC] has been 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.
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 Charitable Funds Committee has delegated powers to approve the Charity Accounts on behalf of the Board.
Governance and 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.
Finance & Infrastructure	A 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

Committee	• annual budget setting and monitoring • treasury management~~,~~ • infrastructure (estates and IT) • business management and may on request from the Board review specific aspects of financial performance where the Board requires additional scrutiny and assurance. The Finance and Commercial Group is a subgroup of the Finance & Infrastructure Committee and is responsible for overseeing the Trust's Capital Programme.
Workforce and Organisational Development 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.
Community Engagement Committee	The Committee is responsible for assuring the Board on delivery and development of the community 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.

The Trust's Operational Management is lead by the Chief Executive, as the Accountable Officer and executed via the Executive Management Team.

Section Three - Scheme of delegation derived from Accountable Officer Memorandum

Ref	Delegated to	Duties delegated
3	**CEO**	Responsible for the propriety and regularity of public finances in the NHS; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; and for the efficient and effective use of all the resources in ~~my~~ their charge.
7	**CEO**	Accountable to the board as NHS Accountable Officer to Parliament for stewardship of Trust resources
9	**CEO and CFO**	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	**CEO**	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Through the Annual Governance Statement acknowledge responsibilities for maintaining a sound system of internal control and describe the risk management framework
12, 13	**CEO**	Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
12	**Chairman of the Board of Directors**	Implement requirements of corporate governance.
13	**CEO**	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
14	**CEO**	Provide such information as is requested by the NAO and co-operate with external auditors in any enquiries into the use ~~your~~ the trust has made of public funds. Provide information on any points raised by external auditors which generate public or Parliamentary interest. Ensure internal audit arrangements comply with those described in the NHS Internal Audit Manual and ensure prompt action is taken in response to concerns raised by both external and internal audit.
15	**CFO**	Operational responsibility for effective and sound financial management and information.
15	**CEO**	Primary duty to see that the Chief Finance Officer discharges this function. Ensure the continuing financial viability of the Trust, in particular to ensure that expenditure is contained within available levels of income, and to achieve any other financial objectives set by the Secretary of State for Health with the consent of the

		Treasury, as appropriate. Ensure that the assets of the Trust are properly safeguarded.
16	**CEO**	Ensuring that expenditure by the Trust complies with Parliamentary requirements. Including: • Drawing to the attention of Parliament to losses or special payments by appropriate notation of the statutory accounts; • Obtaining sanction from the NHS Executive for any expenditure which exceeds the limit delegated to the Trust; this includes any novel, contentious or repercussive expenditure, which is by definition outside ~~your~~ theirdelegation; • Ensuring that all items of expenditure, including payments to staff, fall within the legal powers of the Trust, exercised responsibly and with due regard to probity and value for money; • Complying with guidance issued by the NHS Executive on classes of payments which ~~you~~ they should authorise personally, such as termination payments to general and senior managers.
17	**CEO**	Promote the~~ir~~ observance by all staff of the Trusts Code of Conduct and Accountability
18	**CEO and CFO**	Chief Executive, supported by the Chief Finance Officer, to ensure appropriate advice is given to the Board of Directors on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	**CEO**	If Chief Executive considers the Board of Directors or Chairman of Board of Directors is doing something that might infringe probity or regularity, (s)he should set this out in writing to the Chairman of the Board of Directors and the Board of Directors. If the matter is unresolved, (s)he should ask the Audit and Risk Committee to inquire and, if necessary, and the relevant Regulatory Body.
20	**CEO**	Inform the NHS Executive, if possible before the Board takes its decision or in any event before the decision is implemented so that the Executive can if necessary intervene with the Board and inform the Treasury.
21	**CEO**	If the Board of Directors is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board of Directors. If the outcome is that the Chief Executive is overruled it is normally sufficient to ensure that the Chief Executive's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the Department of Health and Social Care. In such cases, and in those described in paragraph 21, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

Section Four - Scheme of delegation derived from the Codes of Conduct and Accountability

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
BOARD	Approve procedure for declaration of hospitality and sponsorship.
BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe to the Code of Conduct.
BOARD	Board members share corporate responsibility for all decisions of the Board.
CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health for the discharge of those responsibilities.
BOARD	The role of an NHS board is to: - be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs - provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed - set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance - set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.
CHAIRMAN	It is the Chairman's role to: - Provide leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda; - ensure the provision of accurate, timely and clear information to directors; - ensure effective communication with staff, patients and the public; - arrange the regular evaluation of the performance of the board, its committees and individual directors; and - facilitate the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.
CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHS Improvement to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health and Social Care to Ministers and to the local community. The duties of the non-Executive Directors are to: constructively challenge and contribute to the development of strategy;

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance; - satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible; - determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and - ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.
CHAIR AND ALL DIRECTORS	Declaration of conflict of interests.
BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health and Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

Section Five - Scheme of Delegation from Standing Orders

SO Ref	Delegated to	Duties delegated
Section 1-definitions	**Chairman of the Board of Directors**	Final authority in interpretation of Standing Orders (SOs).
1.3	**Board of Directors**	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.
2.4	**Board of Directors**	Appointment (and removal) of Deputy Chairman following consideration/ recommendation via the Governance and Nominations Committee.
2.5.2	**Board of Directors**	Joint responsibility for every decision of the Board regardless of their individual skills or status.
2.5.4	**Chief Executive**	Responsible for the overall performance of the executive functions of the Trust
2.5.5	**Chief Finance Officer**	Responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems
3.1.2	**Chairman of the Board of Directors**	The Chairman of the Trust may call a meeting of the Board of Directors at any time.
3.9	**Chairman of the Board of Directors**	At any meeting of the Trust Board the Chairman, if present, shall preside
3.10	**Chairman of the Board of Directors**	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.
3.12.1	**Chairman of the Board of Directors**	In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote).
3.13.1	**Board of Directors**	Suspend Standing Orders, 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.
3.13.4	**Audit and Risk Committee**	The Audit and Risk Committee shall be advised of and review every decision to suspend Standing Orders.
3.14	**Board of Directors**	Vary or amend the Standing Orders if two thirds of the Board members are present at the meeting (i.e 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;.
4.1	**Board of Directors**	The Board of Directors may appoint committees of the Board of Directors. 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	**Board of Directors**	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.
4.6	**Board of Directors**	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).
4.7	**Board of Directors**	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.
5.2	**Chairman of the Board of Directors and CEO**	The powers which the Board of Directors has reserved to itself within these Standing Orders (see paragraph 2.8 of the 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.
5.4.2	**CEO**	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board of Directors subject to any amendment agreed during the discussion.
5.6	**All Staff**	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1.1	**Board of Directors**	Declare relevant and material interests.
7.2.1	**Chief Executive**	Ensure a register of interests is maintained
7.4.1	**Board of Directors and All Staff**	Comply with national guidance contained in HSG 1993/5 *Standards of Business Conduct for NHS Staff* and the Trust's Managing Conflicts of Interest Policy. The Board of Directors and all employees must comply with the Trust's Code of Conduct.
7.4.2 **7.4.4**	**Board of Directors and All Staff**	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 .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. 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.
8.1/8.3	**CEO**	Keep seal in safe place and maintain a register of sealing.
8.4	**CEO and Executive Directors**	Approve and sign all documents which will be necessary in legal proceedings.

Section Six - Scheme of Delegation from Standing Financial Instructions

SFI Ref	Delegated to	Duties delegated
1.2.1	**Board**	(i)Formulating the financial strategy (ii)Requiring the submission and approval of budgets within approved allocations/overall income; (iii)Defining and approving essential features in respect of important procedures and financial systems, including the need to obtain value for money; (iv)Defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Scheme of Delegation document.
1.2.3	**CEO & CFO**	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.
1.2.3	**CEO**	Ultimately accountable to the Board of Directors, and as Accountable Officer, to the Secretary of State, for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources
1.2.3	**CEO**	Overall executive responsibility for the Trust's activities and is responsible to the Chairman and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control
1.2.4	**CFO**	Responsible for: i) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies; ii) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and iii) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time. iv) The provision of financial advice to other members of the Board of Directors and employees; v) The design, implementation and supervision of systems of internal financial control; and vi) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board of Directors may require for the purpose of carrying out its statutory duties.
1.2.5	**All members of the Board of Directors and employees**	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures. Have a duty to disclose any non-compliance with Standing Financial Instructions to the Chief Finance Officer as soon as possible.

1.2.6	**CEO**	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
2.1	**Audit & Risk Committee**	(i)Oversee Internal and External Audit services; (ii)review financial and information systems and monitor the integrity of the financial statements and review significant financial reporting judgments; (iii)review the establishment and maintenance of an effective system of corporate governance, internal control and risk management across the whole of the Trust's activities that supports the achievement of the Trust's objectives; (iv)monitor the integrity of the financial statements of the Trust; (v)monitor the independent auditors' qualifications, independence and performance; (vi)monitor the performance of the Trust's Internal Audit function; and (vii)monitor compliance by the Trust with legal and regulatory requirements (viii)review the findings of other significant assurance functions, including counter fraud, both internal and external to the organisation, and consider the implications to the governance of the organisation
2.1.2	**Chairman of the Audit & Risk Committee**	Raise the matter at the Board of Directors meeting where Audit & Risk Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3 & 2.2.1	**CFO**	Ensure that an adequate internal audit service, for which (s)he is accountable, is provided and involve the Audit & Risk Committee in the selection process when/if an internal audit service provider is changed. Internal audit should report to the Audit & Risk Committee; role of CFO is to assist the committee in the selection process.
2.2.1	**CFO**	(i) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function; (ii) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards; (iii) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; (iv) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee
2.3	**Head of Internal Audit**	Internal Audit will review, appraise and report upon: (i) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures; (ii) the adequacy and application of financial and other related management controls; (iii) the suitability of financial and other related management data; (iv) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from: (a) fraud and other offences; (b) waste, extravagance, inefficient administration; (c) poor value for money or other causes. (v) the economic acquisition and the efficient use of resources (vi) efficient operation of systems and departments (vii) the adequacy of follow up action to audit reports

		(viii) other matters as requested by directors and senior managers and agreed by the Head of Internal Audit, or considered appropriate by the Head of Internal (ix) Internal Audit shall also independently verify the assurance statements in accordance with guidance from the Department of Health and Social Care The Head of Internal Audit will attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chairman of the Board of Directors and Chief Executive. The Head of Internal Audit shall be accountable to the Chief Finance Officer
2.4	**Audit and Risk Committee**	Ensure a cost-effective external and internal audit service.
2.5.1	**Board and all Trust Officers**	All Members of the Board and Trust Officers, severally and collectively, are responsible for ensuring the Trusts resources are appropriately protected from fraud, bribery and corruption.
2.5.2	**CEO & CFO**	Monitor and ensure compliance the NHS Standards for Providers for Countering Fraud, Bribery and Corruption.
2.5.3	**Board of Directors**	Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health and Social Care Fraud and Corruption Manual and guidance.
2.6	**CEO and CFO**	Monitor and ensure compliance with Service Condition 24 of the Standard NHS Contract which covers NHS security management. including appointment of the Local Security Management Specialist.
2.6.2	**Board of Directors**	Nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS).
3.1.1	**CEO**	Compile and submit to the Board an annual operating plan which takes into account financial targets and forecast limits of available resources. The plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.
3.1.2 & 3.1.3	**CFO**	Prepare and submit budgets to the Board of Directors for approval, following presentation at the Finance & Infrastructure Committee. Monitor performance against budget; submit to the Board of Directors financial estimates and forecasts.
3.1.4	**CFO**	Ensure adequate training is delivered on an ongoing basis to budget holders.
3.2	**All budget holders**	Must provide information as required by the Chief Finance Officer to enable budgets to be compiled. All budget holders will sign up to their allocated budgets at the commencement of each financial year. Must make themselves aware of relevant Trust guidance, procedures and instructions on financial management Required to work within the financial limits Responsible for all expenditure against their budget and the use of Trust Resources to deliver work outlined in their local business plans and in

		commissioners contracts
3.3.1	**CEO**	Delegate budget to budget holders.
3.3.2	**CEO & Budget Holders**	Must not exceed the budgetary total or virement limits set by the Board of Directors.
3.4.1	**CFO**	Devise and maintain systems of budgetary control.
3.4.2	**Budget Holders**	Ensure that • any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors; • the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board of Directors.
3.4.3	**CEO**	Identify and implement cost improvements and income generation activities in line with the annual operating plan.
3.6	**CEO**	Submit monitoring returns.
4.1	**CFO**	Preparation and submission of annual accounts and reports.
5.1	**CFO**	Managing banking arrangements approved by the Board of Directors, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
5.1.2	**Board of Directors**	Approve banking arrangements
5.2	**CFO**	Responsible for: • bank accounts; • establishing separate bank accounts for the Trust's non-exchequer funds; • ensuring payments made from bank do not exceed the amount credited to the account except where arrangements have been made; • reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn. • monitoring compliance with Department of Health and Social Care guidance on the level of cleared funds.
5.3	**CFO**	• prepare detailed instructions on the operation of bank account • must advise the Trust's bankers in writing of the conditions under which each account will be operated • authorized to make payments using BACs and CHAPS to establish appropriate procedures in accordance with locally agreed arrangements. • Approve payment by direct debit mandates
5.4	**CFO**	review the commercial banking arrangements of the Trust at regular intervals
5.5.1	**Board of Directors**	• Approves overall treasury policy • Approves external funding arrangements subject to the Treasury policy • Delegates to the Finance & Infrastructure Committee approval the Trust's treasury management detailed policies, processes and controls
5.5.2	**Finance &**	• Recommends to the Board the Trust's detailed treasury management

	Infrastructure Committee	policies, processes and controls • Approves relevant benchmarks for measuring performance • Reviews and monitors investment and borrowing policy and performance against the relevant benchmarks • Ensures proper safeguards are in place for security of the Trust's funds by: approving a list of permitted institutions; approving investment limits for each permitted institution; approving permitted investment types; and ensuring approved bank mandates are in place for all accounts which are updated regularly for changes in signatories and authority levels • Monitors compliance with treasury policies and procedures in particular as regards limits, approved counterparties and types of investments • Delegates responsibility for treasury operations to the Chief Finance Officer Oversees and reviews detailed treasury reporting requirements
6.1 **6.2**	**CFO**	• responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due. • responsible for the prompt banking of all monies received. • approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by statute.
6.2.3	**All employees**	Duty to inform the Chief Finance Officer of money due from transactions which they initiate/deal with.
6.3	**CFO**	responsible for • the appropriate recovery action on all outstanding debts. • establishing and maintaining procedures for issuing credit notes and for debt write off, within delegated limits, after all reasonable steps have been taken • agreeing all write-offs of debts. A list of amounts written off shall be submitted by the Chief Finance Officer to the Audit and Risk Committee twice yearly
6.4	**CFO**	responsible for: (i) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; (ii) ordering and securely controlling any such stationery; (iii) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; (iv) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. ensure that there is a system for recording the transfer of custody of cash, cheques and other negotiable instruments from one person to another, and in what circumstances such records should be made.
6.5	**CFO**	Chief Finance Officer shall ensure that there are systems in place to identify all costs and revenues attributed to each income generation scheme.
7.5.3	**CEO**	Waive formal tendering procedures.
7.5.3	**CEO**	Report waivers of tendering procedures to the Audit & Risk Committee.
7.5.5	**CFO**	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.

7.6.2	**Service Line Operational Director or Corporate Associate Director**	The Chief Executive or his nominee should evaluate the quotation and select the quote which gives the best value for money.
7.6.3	**CEO**	Shall maintain a register to show each set of competitive tender invitations dispatched.
7.6.5	**CEO**	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.7	**CEO & CFO**	Where one tender is received will assess for value for money and fair price.
7.6.8	**CEO**	May consider late tenders if exceptional circumstances
7.6.9	**CEO**	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
7.6.11	**CEO**	Will appoint a manager to maintain a list of approved firms.
7.6.12	**CEO & CFO**	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
7.7	**CEO or CFO**	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
7.9	**CEO**	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
7.9	**Board of Directors**	All Private Finance Initiative (PFI)_proposals must be agreed by the Board of Directors.
7.10	**CEO**	The Chief Executive shall nominate an employee who shall oversee and manage each contract on behalf of the Trust.
7.12	**CEO**	The Chief Executive shall nominate employees with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
7.15	**CEO**	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
7.15.5	**CEO**	The Chief Executive shall nominate an employee to oversee and manage the contract on behalf of the Trust.
8.1.1	**CEO**	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
8.3	**CEO**	As the Accountable [Accounting] Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA.
9.1.1	**Board of Directors**	Establish Remuneration Committee and any others required.
9.2.2	**CEO**	Approval of variation to funded establishment of any department.
9.3	**CFO**	Payroll: (i) specifying timetables for submission of properly authorised time records

		and other notifications; (ii) final determination of pay and allowances; (iii) making payments on agreed dates; (iv) agreeing method of payment; (v) issuing instructions (as listed in SFI 9.4.2).
9.3.3	**Nominated managers**	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
9.3.4	**CFO**	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.5	**Chief People Officer**	Ensure that all employees are issued with a Contract of Employment in a form approved by the Trust Management Board and which complies with employment legislation. Deal with variations to, or termination of, contracts of employment.
10.1	**CEO**	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
10.1.3	**CEO**	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
10.2	**CFO**	The Chief Finance Officer is responsible for the requisition, ordering, receipt and payment for goods and services.
10.2.1	**Requisitioner**	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust.
10.2.2	**CFO**	Shall be responsible for the prompt payment of accounts and claims.
10.2.3	**CFO**	(i) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed. (ii) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds. (iii) Be responsible for the prompt payment of all properly authorised accounts and claims. (iv) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. (v) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment. (vi) Instructions to employees regarding the handling and payment of accounts within the Finance Department. (vii) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
10.3	**Appropriate officer**	Make a written case to support the need for a prepayment.
10.3	**CFO**	Approve proposed prepayment arrangements.
10.3	**Budget Holder**	Ensure that all items due under a prepayment contract are received and immediately inform the Chief Finance Officer if problems are encountered.

10.4	**CEO**	Authorise who may use and be issued with official orders.
10.5	**Senior employees**	Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer
10.5.1	**CEO / CFO**	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the Health Building Note 00-08 (Strategic framework for the efficient management of healthcare estates and facilities). The technical audit of these contracts shall be the responsibility of the relevant Director.
10.6	**CFO**	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 256 and 257 of the NHS Act
11.1.1	**CFO**	The Chief Finance Officer will advise the Board of Directors on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
11.1.2	**Board of Directors**	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and Chief Finance Officer
11.1.3	**CFO**	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.1.4	**CEO OR CFO**	Be on an authorising panel comprising one other member for short term borrowing approval.
11.2.2	**CFO**	Advise the Board of Directors on investments and report, periodically, on performance of same.
11.2.3	**CFO**	Prepare detailed procedural instructions on the operation of investments held.
12	**CFO**	Ensure that members of the Board of Directors are aware of the Financial Framework and ensure compliance.
13.1.1 **13.1.2**	**CEO**	Capital investment programme: (i) ensure that there is an adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; (ii) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; (iii) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; and (iv) ensure that a business case is produced for each proposal.
13.1.2	**CFO**	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
13.1.3	**CEO**	Issue procedures for management of contracts involving stage payments.
13.1.4	**CFO**	Assess the requirement for the operation of the construction industry taxation deduction scheme.
13.1.5	**CFO**	Issue procedures for the regular reporting of expenditure and commitment

		against authorised capital expenditure.
13.1.6	**CEO**	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
13.1.7	**CFO**	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
13.2.1	**CFO**	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
13.2.1	**Board of Directors**	Proposal to use PFI must be specifically agreed by the Board.
13.3.1	**CEO**	Maintenance of asset register, on advice from the Chief Finance Officer
13.3.5	**CFO**	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.8	**CFO**	Calculate and pay capital charges in accordance with Department of Health and Social Care requirements.
13.4.1	**CEO**	Overall responsibility for fixed assets.
13.4.2	**CFO**	Approval of fixed asset control procedures.
13.4.4	**Board of Directors, executive directors and all senior staff**	Responsibility for security of Trust assets including notifying discrepancies to the Chief Finance Officer, and reporting losses in accordance with Trust procedure.
14	**CEO**	Delegate overall responsibility for control of stores (subject to Chief Finance Officer responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
14.2.1	**CFO**	Responsible for systems of control over stores and receipt of goods.
14.2.1	**Chief Pharmacist**	Responsible for controls of pharmaceutical stocks
14.2.1	**Designated estates manager**	Responsible for control of stocks of fuel and power supplies
14.2	**Nominated staff**	Security arrangements and custody of keys.
14.2.1	**CFO**	Set out procedures and systems to regulate the stores.
14.2.4	**CFO**	Agree stocktaking arrangements.
14.2.5	**CFO**	Approve alternative arrangements where a complete system of stores control is not justified.
14.2.6	**CFO**	Approve system for review of slow-moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
14.2.6	**Nominated staff**	Operate system for slow-moving and obsolete stock, and report to the DOF evidence of significant overstocking.
14.3.1	**CEO**	Identify persons authorised to requisition and accept goods from NHS Supplies stores.

15.1.1	**CFO**	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	**CFO**	must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
15.2.2	**All Staff**	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Chief Finance Officer.
15.2.2	**CFO**	Where a criminal offence is suspected, the Chief Finance Officer must inform the police if theft or arson is involved. In cases of fraud and corruption the Chief Finance Officer must inform the relevant LCFS and the NHSCFA in accordance with the NHS Standards for Providers in Countering Fraud, Bribery and Corruption.
15.2.2	**CFO**	Notify LCFS, the NHSCFA and External Audit of all frauds.
15.2.3	**CFO**	Notify the Board of Directors and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.4	**Board of Directors**	Approve write off of losses
15.2.5	**CFO**	Authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
15.2.6	**CFO**	Consider whether any insurance claim can be made.
15.2.7	**CFO**	Maintain losses and special payments register.
16.1	**CFO**	Responsible for accuracy and security of computerised financial data.
16.1.2	**CFO**	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurance of adequacy must be obtained from them prior to implementation.
16.1.3	**CFO**	Shall publish and maintain a Freedom of Information Scheme.
16.2	**CFO**	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
16.3	**All employees**	Send details of the outline design of computer systems to the COO Southampton and County Wide services via the Director of IT
16.4	**COO Southampton and County Wide services via the Director of IT**	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
16.5	**CFO**	Where computer systems have an impact on corporate financial systems satisfy themselves that: (i) systems acquisition, development and maintenance are in line with corporate policies; (ii) data assembled for processing by financial systems is adequate, accurate,

		complete and timely, and that a management trail exists; (iii) Chief Finance Officer and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
17.2	**CEO**	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.6	**Senior Managers / Department managers**	Inform staff of their responsibilities and duties for the administration of the property of patients.
18.1	**CFO**	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
19	**CFO**	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
20	**CEO**	Retention of document procedures in accordance with Department of Health and Social Care Guidelines
21.1	**CEO**	Ensure the Trust has a programme of Risk management programme.
21.1	**Board of Directors**	Approve and monitor risk management programme.
21.2	**Board of Directors**	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
21.4	**CFO**	Where the Board decides to use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements. Where the Board of Directors decides not to use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board of Directors is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
21.4	**CFO**	Ensure documented procedures cover management of claims and payments below the limit for settlement of claims (the 'deductible'.)
	CEO and CFO	Responsible for the management and allocation of reserves
	CEO and CFO	Interim Revolving Working Capital Support Facility - The Chief Executive to execute the agreement. The Chief Finance Officer to manage the agreement.

Section seven – Scheme of Delegation for Primary Care Networks

In accordance with the national timetable set (agreements to be submitted by 30th June 2019), our Solent practice signed up to the PCN agreement for the 'South Central Southampton PCN' together with St Mary's Surgery, Alma Medical Centre, Mulberry House Surgery and Walnut Tree Surgery. The agreement requires each member practice to identify a clinical representative to attend PCN meetings.

In accordance with Standing Orders (section 5.4), the CEO has delegated authority to the Clinical Director of Primary Care to fulfil this role, in line with the parameters described within the PCN Agreement and within the financial limits for budget holders delegated to them in their role as Clinical Director.

Section Eight - Scheme of Delegation for capital and revenue expenditure and signatories (*financial values are over the contract lifetime)*

Capital			
Approval of capital plan	Approval by the Board (via the Finance & Commercial Group and Finance & Infrastructure Committee)		
Allocation and virement to individual programmes within the overall agreed budgetary allocation	Finance & Commercial Group agree all allocations, report to Board as appropriate		
Business Case Approval	Approval by Board >£3m	Finance & Infrastructure Committee Between £500k and up to £3m For cases: • ≥ £500k sign off by the CFO required prior to presentation for approval to the Finance & Infrastructure Committee	Finance & Commercial Group Up to £500k For cases: • ≥£250k < £500k sign off by the DOF required prior to presentation for approval at the Finance & Commercial Group
Payment Approval	CEO any £value	Chief Finance Officer any £value	Director of Finance any £value
NHS Improvement Approval	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH		
DH Approval	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury		

Tendering and quotations(*subject to the terms of any contract with the Integrated Supply Chain)					
Formal quotes	Between £5k and £50k				
Formal Tender	Over £50k				
OJEU	Subject to current limits				
Tender Approval					
	Chairman and CEO (and then report to Board)	**CEO**	**CFO (or nominated deputy)**	**Other Executive Directors**	**Others**
Lowest	Over £3m	Up to £3m	Up to £3m	Up to £3m	Up to 50k
Not the Lowest	Over £3m	Up to £3m	Up to £250k		
Single Tender	Over £3m (and notify Audit and Corporate Risk Committee)	Up to £3m (and notify Audit and Corporate Risk Committee)	Up to £250k (and notify Audit and Corporate Risk Committee)		DoF up to £250k(and notify Audit and Corporate Risk Committee)

Revenue Expenditure				
Revenue Plan	Approval by the Board (via Finance & Commercial Group and Finance & Infrastructure Committee)			
Virement between cost centres within overall service line or corporate functional budget	CEO any £value		Over £250k Chief Finance Officer / DOF approval required	Service Line Operational Directors and Corporate Associate Directors up to £50k for any one transaction (and Executive Directors for their respective areas).
Proposed changes that increase overall planned levels	Approval by Board >£3m	CEO any £value	Over £250k Chief Finance Officer / DOF approval required	
Business Case Approval	Approval by Board >£3m	Finance & Infrastructure Committee Between £500k and up to £3m For cases: • ≥ £500k sign off by the CFO required prior to presentation for approval to the Finance & Infrastructure Committee	Finance & Commercial Group Up to £500k (All business cases requiring investment to be presented) For cases: • ≥£250k < £500k sign off by the DOF required prior to presentation for approval at the Finance & Commercial Group	
NHS Improvement Approval	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH			
DH Approval	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury			

New contracts/Contract Renewals/ Novations / Extensions / Terminations/Variations (Annual Value of change) (Over £50k will have been tendered)			
Awarding /terminating contracts and signing contracts (where Solent is the commissioner) *	Approval by Board >£3m Signed by CEO / CFO	Approval >£500k to £3m by Finance & Infrastructure Committee Signed by CFO / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by any of the Executive team (Up to £50k – approved by Operational Director of service or equivalent (i.e. Corporate Associate Director or, where nominated by the relevant executive Director, Head of Service/corporate area) and signed by any of the Executive team or Head of Commercial)
Contract Approval/ termination and signing of documents (where Solent is the provider)	Approval by Board >£3m (Signatures – CEO/ CFO)	Approval >£500k to £3m by Finance & Infrastructure Committee Signed by CFO / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by any of the Executive team (Up to £50k – approved by Operational Director of service or equivalent (i.e. Corporate Associate Director or, where nominated by the relevant Executive Director, Head of Service/corporate area) signed by any of the Executive team or Head of Commercial)
Contract under seal approval	(All seals report to Board via CEO Report)	CEO / CFO approval	(For capital contracts – seals must come via recommendation of Director of Infrastructure)
NHS Improvement Approval on managed service contracts	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH		
DH Approval on managed service contracts	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury		
Letter of intent	Approval by Board >£3m Signed by CEO / CFO	Approval >£500k to £3m by Finance & Infrastructure Committee Signed by CFO / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by Chair/ Deputy Chair of Group (Up to £50k – signed by Operational Director / Corporate Associate Directors)
Issuing contracts of employment and deployment of agency staff	CEO / CFO / Chief People Officer / Recruiting Manager		
Waiver of Tenders and quotations	CEO / CFO (Report to Audit & Risk Committee)	DoF up to £250k (Report to Audit & Risk Committee)	

*Contract variations to specification only with no tenure of value change can be signed by the Director of Strategy or in their absence any Executive Team member (no presentation at Committee required). Lease variations with no tenure or value change can be signed by the Director of Infrastructure or in their absence any Executive Team member (no presentation at Committee required).

No commitments should be made via email.

Delegated financial limits for budget holders

Level	Staff with authority	Requisitions		Invoices - limit (£000)
		Purchase orders – limit (£000)	Non purchase orders – limit (£000)	
1	Chief Executive	No limit	No limit~~1,000~~	No limit~~Zero~~
2	Chief Finance Officer	No limit	No limit	No limit
3	Director of Finance	No limit	No limit	5,000
4	Deputy Director of Finance	5,000	250	5,000
5	Level 1 Management Other Executive Directors, and Financial Controller	250	250	250
6	Head of Procurement	200	200	200
7	Level 2 Management Service Line Operational Directors and Corporate Associate Directors	50	50	50
8	Level 3 Management Senior managers, Heads of Department	20	20	Finance Business Partners and Financial Services Manager up to £5k Finance Managers nil
9	Other budget holders	5	5	5

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Regarding credit notes, the following authorization levels apply

Staff with authority	Limits
Chief Finance Officer	No Limit
Director of Finance	≤£5m
Deputy Director of Finance	≤£5m
Head of financial accounts	≤50,000
Finance business partners	≤£5,000
Financial services & Finance managers	≤£5,000
Finance Managers	≤£1,000

Leases and licenses

The process for signature and/or sealing of leases and licenses is outlined within the 'Estates Department Guide to Finding and Occupying Premises' – reporting and oversight will be via the Estates, Facilities & Sustainability Group.

Item 18.2

Solent NHS Trust

Scheme of Reservation and Delegation

Version	Approved by	Date	Date of next review
7	Chairs action (March 3RD 2016) – and noted at March 2016 Board Amendment pg29+30 re: financial sign off thresholds concerning business cases prior to presentation to the Finance & Infrastructure Committee		March 2017
8	Board	November 2016	November 2018
9	Board	September 2017 – amendments made to section 7, financial thresholds as recommended by the Finance & Infrastructure Committee	November 2018
10	Board	Nov 2017 – amendments made as recommended by the Commercial Team	November 2019
11	Board	September 2018 – amendments made as recommended by the Commercial Team and approved via Finance & Commercial Team and Finance & Infrastructure Committee, July 2018 and update to pg 8 to include People and OD Committee and Community Engagement Committee	November 2019
12	Board	Jan 2019 – amendments made to pg 29 and 30 concerning leases and licenses	Chairs Action Jan 2019
13	Board	Document updated to reference new titles throughout and to align with updated SFIs (as agreed by Jan 2020 Finance& Infrastructure Committee)	

Section One - Decisions reserved to the Board of Directors

Reference to the 'Board of Directors' should also be read as the 'Trust Board'.

Decisions reserved to the Board
General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, it wishes, in full session within its statutory powers
Regulations and Control 1.1 Approve Standing Orders (SOs) (the Constitution), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 1.2 Suspend Standing Orders. 1.3 Vary or amend the Standing Orders. 1.4 Ratify any urgent decisions taken by the Chairman and Chief Executive in the next formal public session in accordance with the Standing Orders (section 5.2). 1.5 Approve a scheme of delegation of powers from the Board of Directors to committees of the Board of Directors. 1.6 Require and receive the declaration of members of the Board of Director's interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 1.7 Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust. 1.8 Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 1.9 The Board shall also approve policies with significant public interest or where enactment requires a significant change in the way the Trust operates. Policies presented to the Board for approval should first have been considered and agreed at the Trust Management Team meeting. 1.10 Confirm or if necessary amend the recommendations of Committees of the Board of Directors where the Committees do not have executive powers. 1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held in trust. 1.12 Establish terms of reference and reporting arrangements of all committees that are established by the Board. 1.13 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 1.14 Authorise use of the Trust seal. 1.15 Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with the Standing Orders. 1.16 Discipline members of the Board of Directors or employees who are in breach of statutory requirements or

Standing Orders.

1.17 Undertake a formal review of its own performance and of its committees on an annual basis.

Appointments/ Dismissal

2.1 Appoint and remove the Deputy Chairman of the Board as required.

2.2 Appoint and dismiss committees (and individual members) that are directly accountable to the Board of Directors.

2.3 Confirm appointment of members of any committee of the Board of Directors as representatives on outside bodies.

2.4 Approve proposals of the Remuneration Committee;

2.5 Appointment and removal, (subject to law and their contract) of the Chief Executive and executive directors;

2.6 Ensure that appropriate succession planning is carried out for the Board and senior management team.

2.7 Appointment and removal of the Trust Secretary or equivalent

Strategy, Plans and Budgets

3.1 Define the Trust's mission, vision and strategic objectives. To set the strategic direction to be pursued by the Trust.

3.2 Ensure that ~~a~~ Board development and organisational development plans are in place to support the Trust's delivery of the strategic direction.

3.3 Approve annual operating plans and budgets.

3.4 Deliver the control total agreed with NHS Improvement following consideration and recommendation by the Finance & Infrastructure Committee.

3.5 Approve plans for material service changes and efficiencies.

3.6 Define the Trust's values and standards of conduct.

3.7 Approve proposals for ensuring the safety and quality of services and safety and quality governance for services provided by the Trust, having regard to any guidance issued by the Secretary of State.

3.8 Approve the Trust's policies and procedures for the management of risk.

3.9 Approve the Outline and Final Business Cases for Capital Investment above and beyond the Finance & Infrastructure Committee's delegated limits.

3.10 Approve proposals for acquisition, disposal or change of use of land and/or buildings.

3.11 Approve the opening of bank accounts.

3.12 Approve proposals on individual contracts (other than NHS clinical contracts) of a capital or revenue nature amounting to, or likely to amount to over £3,000,000 regardless of the length of the contract.

3.13 Approve proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board.

3.14Approve individual compensation payments considering national guidance where relevant.

3.15Approve proposals for action on litigation against or on behalf of the Trust.

3.16Approve use of NHS Resolution (formally known as NHSLA) risk pooling schemes (including CNST), which is executed via the Chief Finance Officer.

3.17 Responsible for overseeing the development and implementation of a workforce strategy, ensuring the workforce meets the needs of the organisation and is fit for purpose.

Audit (via the Chief Finance Officer and Chair of the Audit & Risk Committee)

4.1 Approve the appointment (and where necessary the dismissal) of external auditors.

4.2 Notify the external auditor of any problems relating to the service.

4.3 Approve the appointment (and where necessary the dismissal) of internal auditors.

4.4 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit and Risk Committee.

4.5 Approve the remuneration of the external and internal auditors.

Annual Reports and Accounts

5.1 Approve the Annual Accounts, Annual Report and Quality Account and receive a statement of assurance from the Audit and Risk Committee that the Committee has made appropriate enquiries before recommending the documents for approval by the Board.

5.2 Hold an Annual General Meeting at which the report and accounts will be laid and approve any resolutions to be presented to the AGM.

Monitoring

6.1 Receive such reports as the Board of Directors sees fit from Committees in respect of their exercise of powers delegated.

6.2 Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care, NHS Improvements and the Charity Commission shall be reported, at least in summary, to the Board.

6.3 Ensure maintenance of a sound system of internal control and risk management which holds the organisation to account for the delivery of the strategy and seeks assurance that systems of internal control are robust and reliable.

6.4 Ensure that the necessary financial, human and physical resources are in place to enable the Trust to meet its priorities and objectives and periodically review management performance, including through reports from the Chief Finance Officer on financial performance against budget and contracts agreed with commissioners.

Clinical standards and Patient Safety

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

7.2 Oversee the risk management framework implementation of Solent NHS Trust, and ensure appropriate action in relation to adverse events that occur.

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

Section Two - Matters delegated to Board Committees

Committee	Matters delegated by the Board of Directors to Committees
Audit and Risk Committee	In accordance with Standing Orders, the Board shall formally establish an Audit and Risk Committee. The Committee is a non-executive Committee of the Board and has no Committee executive powers, other than those specifically delegated by the Board in the Terms of Reference. The overall purpose of which is to: 1. seek assurance that the Trust's activities are efficient, effective and represent value for money; 2. review the establishment and maintenance of an effective system of corporate governance, internal control and risk management across the whole of the Trust's activities that supports the achievement of the Trust's objectives; 3. monitor the integrity of the financial statements of the Trust; 4. monitor the independent auditor's qualifications, independence and performance; 5. monitor the performance of the Trust's internal audit function ; 6. monitor compliance by the Trust with legal and regulatory requirements; and 7. review the findings of other significant assurance functions, including counter fraud, to the organisation, and consider the implications to the governance of the organisation.
Remuneration Committee	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 makes decisions on behalf of Solent NHS Trust Board 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 settlement agreements/severance pay or other occasional payments to individuals and out of court settlements, taking account of national guidance; • Receive and note decisions of the Clinical Excellence Awards (CEA) panel; • Within the constraints of national frameworks the Committee will agree the remuneration package, allowances and terms of service of the Trust's executive directors. No executive director shall be involved in any decisions as to his/her own remuneration; • Monitor and oversee the evaluation of the performance of the Chief Executive and other individual executive directors; • Approve participation in any performance related pay schemes, where operated by the Trust, and approve the total annual payments made under such schemes; • Ensure that contractual terms on termination, and any payments made, are fair to the individual and the NHS, aligned with the interests of the patients, that

	failure is not rewarded and that the duty to mitigate loss is fully recognised, in line with national guidance where appropriate; and • Be responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who advise the committee, and to obtain reliable, up-to-date information about remuneration in other trusts.
Quality Assurance Committee	The Board shall establish a~~n~~ Quality 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.
Mental Health Act Scrutiny & Deprivation of Liberty Safeguards (DoLS) Scrutiny Committee	The Mental Health Act Scrutiny & Deprivation of Liberty Safeguards (DoLs) Committee [hereby referred to as the MHA&DoLSC] has been 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.
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 Charitable Funds Committee has delegated powers to approve the Charity Accounts on behalf of the Board.
Governance and 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.
Finance & Infrastructure	A 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

Committee	• annual budget setting and monitoring • treasury management~~,~~ • infrastructure (estates and IT) • business management and may on request from the Board review specific aspects of financial performance where the Board requires additional scrutiny and assurance. The Finance and Commercial Group is a subgroup of the Finance & Infrastructure Committee and is responsible for overseeing the Trust's Capital Programme.
Workforce and Organisational Development 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.
Community Engagement Committee	The Committee is responsible for assuring the Board on delivery and development of the community 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.

The Trust's Operational Management is lead by the Chief Executive, as the Accountable Officer and executed via the Executive Management Team.

Section Three - Scheme of delegation derived from Accountable Officer Memorandum

Ref	Delegated to	Duties delegated
3	CEO	Responsible for the propriety and regularity of public finances in the NHS; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; and for the efficient and effective use of all the resources in ~~my~~ their charge.
7	CEO	Accountable to the board as NHS Accountable Officer to Parliament for stewardship of Trust resources
9	CEO and CFO	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	CEO	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Through the Annual Governance Statement acknowledge responsibilities for maintaining a sound system of internal control and describe the risk management framework
12, 13	CEO	Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
12	Chairman of the Board of Directors	Implement requirements of corporate governance.
13	CEO	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
14	CEO	Provide such information as is requested by the NAO and co-operate with external auditors in any enquiries into the use ~~your~~ the trust has made of public funds. Provide information on any points raised by external auditors which generate public or Parliamentary interest. Ensure internal audit arrangements comply with those described in the NHS Internal Audit Manual and ensure prompt action is taken in response to concerns raised by both external and internal audit.
15	CFO	Operational responsibility for effective and sound financial management and information.
15	CEO	Primary duty to see that the Chief Finance Officer discharges this function. Ensure the continuing financial viability of the Trust, in particular to ensure that expenditure is contained within available levels of income, and to achieve any other financial objectives set by the Secretary of State for Health with the consent of the

		Treasury, as appropriate. Ensure that the assets of the Trust are properly safeguarded.
16	**CEO**	Ensuring that expenditure by the Trust complies with Parliamentary requirements. Including: • Drawing to the attention of Parliament to losses or special payments by appropriate notation of the statutory accounts; • Obtaining sanction from the NHS Executive for any expenditure which exceeds the limit delegated to the Trust; this includes any novel, contentious or repercussive expenditure, which is by definition outside ~~your~~ theirdelegation; • Ensuring that all items of expenditure, including payments to staff, fall within the legal powers of the Trust, exercised responsibly and with due regard to probity and value for money; • Complying with guidance issued by the NHS Executive on classes of payments which ~~you~~ they should authorise personally, such as termination payments to general and senior managers.
17	**CEO**	Promote the~~ir~~ observance by all staff of the Trusts Code of Conduct and Accountability
18	**CEO and CFO**	Chief Executive, supported by the Chief Finance Officer, to ensure appropriate advice is given to the Board of Directors on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	**CEO**	If Chief Executive considers the Board of Directors or Chairman of Board of Directors is doing something that might infringe probity or regularity, (s)he should set this out in writing to the Chairman of the Board of Directors and the Board of Directors. If the matter is unresolved, (s)he should ask the Audit and Risk Committee to inquire and, if necessary, and the relevant Regulatory Body.
20	**CEO**	Inform the NHS Executive, if possible before the Board takes its decision or in any event before the decision is implemented so that the Executive can if necessary intervene with the Board and inform the Treasury.
21	**CEO**	If the Board of Directors is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board of Directors. If the outcome is that the Chief Executive is overruled it is normally sufficient to ensure that the Chief Executive's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the Department of Health and Social Care. In such cases, and in those described in paragraph 21, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

Section Four - Scheme of delegation derived from the Codes of Conduct and Accountability

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
BOARD	Approve procedure for declaration of hospitality and sponsorship.
BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe to the Code of Conduct.
BOARD	Board members share corporate responsibility for all decisions of the Board.
CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health for the discharge of those responsibilities.
BOARD	The role of an NHS board is to: - be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs - provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed - set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance - set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.
CHAIRMAN	It is the Chairman's role to: - Provide leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda; - ensure the provision of accurate, timely and clear information to directors; - ensure effective communication with staff, patients and the public; - arrange the regular evaluation of the performance of the board, its committees and individual directors; and - facilitate the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.
CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHS Improvement to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health and Social Care to Ministers and to the local community. The duties of the non-Executive Directors are to: constructively challenge and contribute to the development of strategy;

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance; - satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible; - determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and - ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.
CHAIR AND ALL DIRECTORS	Declaration of conflict of interests.
BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health and Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

Section Five - Scheme of Delegation from Standing Orders

SO Ref	Delegated to	Duties delegated
Section 1-definitions	**Chairman of the Board of Directors**	Final authority in interpretation of Standing Orders (SOs).
1.3	**Board of Directors**	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.
2.4	**Board of Directors**	Appointment (and removal) of Deputy Chairman following consideration/ recommendation via the Governance and Nominations Committee.
2.5.2	**Board of Directors**	Joint responsibility for every decision of the Board regardless of their individual skills or status.
2.5.4	**Chief Executive**	Responsible for the overall performance of the executive functions of the Trust
2.5.5	**Chief Finance Officer**	Responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems
3.1.2	**Chairman of the Board of Directors**	The Chairman of the Trust may call a meeting of the Board of Directors at any time.
3.9	**Chairman of the Board of Directors**	At any meeting of the Trust Board the Chairman, if present, shall preside
3.10	**Chairman of the Board of Directors**	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.
3.12.1	**Chairman of the Board of Directors**	In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote).
3.13.1	**Board of Directors**	Suspend Standing Orders, 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.
3.13.4	**Audit and Risk Committee**	The Audit and Risk Committee shall be advised of and review every decision to suspend Standing Orders.
3.14	**Board of Directors**	Vary or amend the Standing Orders if two thirds of the Board members are present at the meeting (i.e 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;.
4.1	**Board of Directors**	The Board of Directors may appoint committees of the Board of Directors. 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	**Board of Directors**	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.
4.6	**Board of Directors**	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).
4.7	**Board of Directors**	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.
5.2	**Chairman of the Board of Directors and CEO**	The powers which the Board of Directors has reserved to itself within these Standing Orders (see paragraph 2.8 of the 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.
5.4.2	**CEO**	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board of Directors subject to any amendment agreed during the discussion.
5.6	**All Staff**	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1.1	**Board of Directors**	Declare relevant and material interests.
7.2.1	**Chief Executive**	Ensure a register of interests is maintained
7.4.1	**Board of Directors and All Staff**	Comply with national guidance contained in HSG 1993/5 *Standards of Business Conduct for NHS Staff* and the Trust's Managing Conflicts of Interest Policy. The Board of Directors and all employees must comply with the Trust's Code of Conduct.
7.4.2 **7.4.4**	**Board of Directors and All Staff**	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 .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. 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.
8.1/8.3	**CEO**	Keep seal in safe place and maintain a register of sealing.
8.4	**CEO and Executive Directors**	Approve and sign all documents which will be necessary in legal proceedings.

Section Six - Scheme of Delegation from Standing Financial Instructions

SFI Ref	Delegated to	Duties delegated
1.2.1	**Board**	(i)Formulating the financial strategy (ii)Requiring the submission and approval of budgets within approved allocations/overall income; (iii)Defining and approving essential features in respect of important procedures and financial systems, including the need to obtain value for money; (iv)Defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Scheme of Delegation document.
1.2.3	**CEO & CFO**	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.
1.2.3	**CEO**	Ultimately accountable to the Board of Directors, and as Accountable Officer, to the Secretary of State, for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources
1.2.3	**CEO**	Overall executive responsibility for the Trust's activities and is responsible to the Chairman and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control
1.2.4	**CFO**	Responsible for: i) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies; ii) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and iii) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time. iv) The provision of financial advice to other members of the Board of Directors and employees; v) The design, implementation and supervision of systems of internal financial control; and vi) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board of Directors may require for the purpose of carrying out its statutory duties.
1.2.5	**All members of the Board of Directors and employees**	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures. Have a duty to disclose any non-compliance with Standing Financial Instructions to the Chief Finance Officer as soon as possible.

1.2.6	**CEO**	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
2.1	**Audit & Risk Committee**	(i)Oversee Internal and External Audit services; (ii)review financial and information systems and monitor the integrity of the financial statements and review significant financial reporting judgments; (iii)review the establishment and maintenance of an effective system of corporate governance, internal control and risk management across the whole of the Trust's activities that supports the achievement of the Trust's objectives; (iv)monitor the integrity of the financial statements of the Trust; (v)monitor the independent auditors' qualifications, independence and performance; (vi)monitor the performance of the Trust's Internal Audit function; and (vii)monitor compliance by the Trust with legal and regulatory requirements (viii)review the findings of other significant assurance functions, including counter fraud, both internal and external to the organisation, and consider the implications to the governance of the organisation
2.1.2	**Chairman of the Audit & Risk Committee**	Raise the matter at the Board of Directors meeting where Audit & Risk Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3 & 2.2.1	**CFO**	Ensure that an adequate internal audit service, for which (s)he is accountable, is provided and involve the Audit & Risk Committee in the selection process when/if an internal audit service provider is changed. Internal audit should report to the Audit & Risk Committee; role of CFO is to assist the committee in the selection process.
2.2.1	**CFO**	(i) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function; (ii) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards; (iii) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; (iv) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee
2.3	**Head of Internal Audit**	Internal Audit will review, appraise and report upon: (i) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures; (ii) the adequacy and application of financial and other related management controls; (iii) the suitability of financial and other related management data; (iv) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from: (a) fraud and other offences; (b) waste, extravagance, inefficient administration; (c) poor value for money or other causes. (v) the economic acquisition and the efficient use of resources (vi) efficient operation of systems and departments (vii) the adequacy of follow up action to audit reports

		(viii) other matters as requested by directors and senior managers and agreed by the Head of Internal Audit, or considered appropriate by the Head of Internal (ix) Internal Audit shall also independently verify the assurance statements in accordance with guidance from the Department of Health and Social Care The Head of Internal Audit will attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chairman of the Board of Directors and Chief Executive. The Head of Internal Audit shall be accountable to the Chief Finance Officer
2.4	**Audit and Risk Committee**	Ensure a cost-effective external and internal audit service.
2.5.1	**Board and all Trust Officers**	All Members of the Board and Trust Officers, severally and collectively, are responsible for ensuring the Trusts resources are appropriately protected from fraud, bribery and corruption.
2.5.2	**CEO & CFO**	Monitor and ensure compliance the NHS Standards for Providers for Countering Fraud, Bribery and Corruption.
2.5.3	**Board of Directors**	Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health and Social Care Fraud and Corruption Manual and guidance.
2.6	**CEO and CFO**	Monitor and ensure compliance with Service Condition 24 of the Standard NHS Contract which covers NHS security management. including appointment of the Local Security Management Specialist.
2.6.2	**Board of Directors**	Nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS).
3.1.1	**CEO**	Compile and submit to the Board an annual operating plan which takes into account financial targets and forecast limits of available resources. The plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.
3.1.2 & 3.1.3	**CFO**	Prepare and submit budgets to the Board of Directors for approval, following presentation at the Finance & Infrastructure Committee. Monitor performance against budget; submit to the Board of Directors financial estimates and forecasts.
3.1.4	**CFO**	Ensure adequate training is delivered on an ongoing basis to budget holders.
3.2	**All budget holders**	Must provide information as required by the Chief Finance Officer to enable budgets to be compiled. All budget holders will sign up to their allocated budgets at the commencement of each financial year. Must make themselves aware of relevant Trust guidance, procedures and instructions on financial management Required to work within the financial limits Responsible for all expenditure against their budget and the use of Trust Resources to deliver work outlined in their local business plans and in

		commissioners contracts
3.3.1	**CEO**	Delegate budget to budget holders.
3.3.2	**CEO & Budget Holders**	Must not exceed the budgetary total or virement limits set by the Board of Directors.
3.4.1	**CFO**	Devise and maintain systems of budgetary control.
3.4.2	**Budget Holders**	Ensure that • any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors; • the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board of Directors.
3.4.3	**CEO**	Identify and implement cost improvements and income generation activities in line with the annual operating plan.
3.6	**CEO**	Submit monitoring returns.
4.1	**CFO**	Preparation and submission of annual accounts and reports.
5.1	**CFO**	Managing banking arrangements approved by the Board of Directors, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
5.1.2	**Board of Directors**	Approve banking arrangements
5.2	**CFO**	Responsible for: • bank accounts; • establishing separate bank accounts for the Trust's non-exchequer funds; • ensuring payments made from bank do not exceed the amount credited to the account except where arrangements have been made; • reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn. • monitoring compliance with Department of Health and Social Care guidance on the level of cleared funds.
5.3	**CFO**	• prepare detailed instructions on the operation of bank account • must advise the Trust's bankers in writing of the conditions under which each account will be operated • authorized to make payments using BACs and CHAPS to establish appropriate procedures in accordance with locally agreed arrangements. • Approve payment by direct debit mandates
5.4	**CFO**	review the commercial banking arrangements of the Trust at regular intervals
5.5.1	**Board of Directors**	• Approves overall treasury policy • Approves external funding arrangements subject to the Treasury policy • Delegates to the Finance & Infrastructure Committee approval the Trust's treasury management detailed policies, processes and controls
5.5.2	**Finance &**	• Recommends to the Board the Trust's detailed treasury management

	Infrastructure Committee	policies, processes and controls • Approves relevant benchmarks for measuring performance • Reviews and monitors investment and borrowing policy and performance against the relevant benchmarks • Ensures proper safeguards are in place for security of the Trust's funds by: approving a list of permitted institutions; approving investment limits for each permitted institution; approving permitted investment types; and ensuring approved bank mandates are in place for all accounts which are updated regularly for changes in signatories and authority levels • Monitors compliance with treasury policies and procedures in particular as regards limits, approved counterparties and types of investments • Delegates responsibility for treasury operations to the Chief Finance Officer Oversees and reviews detailed treasury reporting requirements
6.1 **6.2**	**CFO**	• responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due. • responsible for the prompt banking of all monies received. • approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by statute.
6.2.3	**All employees**	Duty to inform the Chief Finance Officer of money due from transactions which they initiate/deal with.
6.3	**CFO**	responsible for • the appropriate recovery action on all outstanding debts. • establishing and maintaining procedures for issuing credit notes and for debt write off, within delegated limits, after all reasonable steps have been taken • agreeing all write-offs of debts. A list of amounts written off shall be submitted by the Chief Finance Officer to the Audit and Risk Committee twice yearly
6.4	**CFO**	responsible for: (i) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; (ii) ordering and securely controlling any such stationery; (iii) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; (iv) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. ensure that there is a system for recording the transfer of custody of cash, cheques and other negotiable instruments from one person to another, and in what circumstances such records should be made.
6.5	**CFO**	Chief Finance Officer shall ensure that there are systems in place to identify all costs and revenues attributed to each income generation scheme.
7.5.3	**CEO**	Waive formal tendering procedures.
7.5.3	**CEO**	Report waivers of tendering procedures to the Audit & Risk Committee.
7.5.5	**CFO**	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.

7.6.2	**Service Line Operational Director or Corporate Associate Director**	The Chief Executive or his nominee should evaluate the quotation and select the quote which gives the best value for money.
7.6.3	**CEO**	Shall maintain a register to show each set of competitive tender invitations dispatched.
7.6.5	**CEO**	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.7	**CEO & CFO**	Where one tender is received will assess for value for money and fair price.
7.6.8	**CEO**	May consider late tenders if exceptional circumstances
7.6.9	**CEO**	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
7.6.11	**CEO**	Will appoint a manager to maintain a list of approved firms.
7.6.12	**CEO & CFO**	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
7.7	**CEO or CFO**	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
7.9	**CEO**	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
7.9	**Board of Directors**	All Private Finance Initiative (PFI)_proposals must be agreed by the Board of Directors.
7.10	**CEO**	The Chief Executive shall nominate an employee who shall oversee and manage each contract on behalf of the Trust.
7.12	**CEO**	The Chief Executive shall nominate employees with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
7.15	**CEO**	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
7.15.5	**CEO**	The Chief Executive shall nominate an employee to oversee and manage the contract on behalf of the Trust.
8.1.1	**CEO**	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
8.3	**CEO**	As the Accountable [Accounting] Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA.
9.1.1	**Board of Directors**	Establish Remuneration Committee and any others required.
9.2.2	**CEO**	Approval of variation to funded establishment of any department.
9.3	**CFO**	Payroll: (i) specifying timetables for submission of properly authorised time records

		and other notifications; (ii) final determination of pay and allowances; (iii) making payments on agreed dates; (iv) agreeing method of payment; (v) issuing instructions (as listed in SFI 9.4.2).
9.3.3	**Nominated managers**	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
9.3.4	**CFO**	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.5	**Chief People Officer**	Ensure that all employees are issued with a Contract of Employment in a form approved by the Trust Management Board and which complies with employment legislation. Deal with variations to, or termination of, contracts of employment.
10.1	**CEO**	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
10.1.3	**CEO**	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
10.2	**CFO**	The Chief Finance Officer is responsible for the requisition, ordering, receipt and payment for goods and services.
10.2.1	**Requisitioner**	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust.
10.2.2	**CFO**	Shall be responsible for the prompt payment of accounts and claims.
10.2.3	**CFO**	(i) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed. (ii) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds. (iii) Be responsible for the prompt payment of all properly authorised accounts and claims. (iv) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. (v) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment. (vi) Instructions to employees regarding the handling and payment of accounts within the Finance Department. (vii) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
10.3	**Appropriate officer**	Make a written case to support the need for a prepayment.
10.3	**CFO**	Approve proposed prepayment arrangements.
10.3	**Budget Holder**	Ensure that all items due under a prepayment contract are received and immediately inform the Chief Finance Officer if problems are encountered.

10.4	**CEO**	Authorise who may use and be issued with official orders.
10.5	**Senior employees**	Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer
10.5.1	**CEO / CFO**	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the Health Building Note 00-08 (Strategic framework for the efficient management of healthcare estates and facilities). The technical audit of these contracts shall be the responsibility of the relevant Director.
10.6	**CFO**	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 256 and 257 of the NHS Act
11.1.1	**CFO**	The Chief Finance Officer will advise the Board of Directors on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
11.1.2	**Board of Directors**	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and Chief Finance Officer
11.1.3	**CFO**	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.1.4	**CEO OR CFO**	Be on an authorising panel comprising one other member for short term borrowing approval.
11.2.2	**CFO**	Advise the Board of Directors on investments and report, periodically, on performance of same.
11.2.3	**CFO**	Prepare detailed procedural instructions on the operation of investments held.
12	**CFO**	Ensure that members of the Board of Directors are aware of the Financial Framework and ensure compliance.
13.1.1 **13.1.2**	**CEO**	Capital investment programme: (i) ensure that there is an adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; (ii) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; (iii) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; and (iv) ensure that a business case is produced for each proposal.
13.1.2	**CFO**	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
13.1.3	**CEO**	Issue procedures for management of contracts involving stage payments.
13.1.4	**CFO**	Assess the requirement for the operation of the construction industry taxation deduction scheme.
13.1.5	**CFO**	Issue procedures for the regular reporting of expenditure and commitment

		against authorised capital expenditure.
13.1.6	**CEO**	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
13.1.7	**CFO**	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
13.2.1	**CFO**	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
13.2.1	**Board of Directors**	Proposal to use PFI must be specifically agreed by the Board.
13.3.1	**CEO**	Maintenance of asset register, on advice from the Chief Finance Officer
13.3.5	**CFO**	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.8	**CFO**	Calculate and pay capital charges in accordance with Department of Health and Social Care requirements.
13.4.1	**CEO**	Overall responsibility for fixed assets.
13.4.2	**CFO**	Approval of fixed asset control procedures.
13.4.4	**Board of Directors, executive directors and all senior staff**	Responsibility for security of Trust assets including notifying discrepancies to the Chief Finance Officer, and reporting losses in accordance with Trust procedure.
14	**CEO**	Delegate overall responsibility for control of stores (subject to Chief Finance Officer responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
14.2.1	**CFO**	Responsible for systems of control over stores and receipt of goods.
14.2.1	**Chief Pharmacist**	Responsible for controls of pharmaceutical stocks
14.2.1	**Designated estates manager**	Responsible for control of stocks of fuel and power supplies
14.2	**Nominated staff**	Security arrangements and custody of keys.
14.2.1	**CFO**	Set out procedures and systems to regulate the stores.
14.2.4	**CFO**	Agree stocktaking arrangements.
14.2.5	**CFO**	Approve alternative arrangements where a complete system of stores control is not justified.
14.2.6	**CFO**	Approve system for review of slow-moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
14.2.6	**Nominated staff**	Operate system for slow-moving and obsolete stock, and report to the DOF evidence of significant overstocking.
14.3.1	**CEO**	Identify persons authorised to requisition and accept goods from NHS Supplies stores.

15.1.1	**CFO**	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	**CFO**	must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
15.2.2	**All Staff**	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Chief Finance Officer.
15.2.2	**CFO**	Where a criminal offence is suspected, the Chief Finance Officer must inform the police if theft or arson is involved. In cases of fraud and corruption the Chief Finance Officer must inform the relevant LCFS and the NHSCFA in accordance with the NHS Standards for Providers in Countering Fraud, Bribery and Corruption.
15.2.2	**CFO**	Notify LCFS, the NHSCFA and External Audit of all frauds.
15.2.3	**CFO**	Notify the Board of Directors and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.4	**Board of Directors**	Approve write off of losses
15.2.5	**CFO**	Authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
15.2.6	**CFO**	Consider whether any insurance claim can be made.
15.2.7	**CFO**	Maintain losses and special payments register.
16.1	**CFO**	Responsible for accuracy and security of computerised financial data.
16.1.2	**CFO**	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurance of adequacy must be obtained from them prior to implementation.
16.1.3	**CFO**	Shall publish and maintain a Freedom of Information Scheme.
16.2	**CFO**	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
16.3	**All employees**	Send details of the outline design of computer systems to the COO Southampton and County Wide services via the Director of IT
16.4	**COO Southampton and County Wide services via the Director of IT**	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
16.5	**CFO**	Where computer systems have an impact on corporate financial systems satisfy themselves that: (i) systems acquisition, development and maintenance are in line with corporate policies; (ii) data assembled for processing by financial systems is adequate, accurate,

		complete and timely, and that a management trail exists; (iii) Chief Finance Officer and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
17.2	**CEO**	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.6	**Senior Managers / Department managers**	Inform staff of their responsibilities and duties for the administration of the property of patients.
18.1	**CFO**	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
19	**CFO**	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
20	**CEO**	Retention of document procedures in accordance with Department of Health and Social Care Guidelines
21.1	**CEO**	Ensure the Trust has a programme of Risk management programme.
21.1	**Board of Directors**	Approve and monitor risk management programme.
21.2	**Board of Directors**	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
21.4	**CFO**	Where the Board decides to use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements. Where the Board of Directors decides not to use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board of Directors is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
21.4	**CFO**	Ensure documented procedures cover management of claims and payments below the limit for settlement of claims (the 'deductible'.)
	CEO and CFO	Responsible for the management and allocation of reserves
	CEO and CFO	Interim Revolving Working Capital Support Facility - The Chief Executive to execute the agreement. The Chief Finance Officer to manage the agreement.

Section seven – Scheme of Delegation for Primary Care Networks

In accordance with the national timetable set (agreements to be submitted by 30th June 2019), our Solent practice signed up to the PCN agreement for the 'South Central Southampton PCN' together with St Mary's Surgery, Alma Medical Centre, Mulberry House Surgery and Walnut Tree Surgery. The agreement requires each member practice to identify a clinical representative to attend PCN meetings.

In accordance with Standing Orders (section 5.4), the CEO has delegated authority to the Clinical Director of Primary Care to fulfil this role, in line with the parameters described within the PCN Agreement and within the financial limits for budget holders delegated to them in their role as Clinical Director.

Section Eight - Scheme of Delegation for capital and revenue expenditure and signatories (*financial values are over the contract lifetime)*

Capital			
Approval of capital plan	Approval by the Board (via the Finance & Commercial Group and Finance & Infrastructure Committee)		
Allocation and virement to individual programmes within the overall agreed budgetary allocation	Finance & Commercial Group agree all allocations, report to Board as appropriate		
Business Case Approval	Approval by Board >£3m	Finance & Infrastructure Committee Between £500k and up to £3m For cases: • ≥ £500k sign off by the CFO required prior to presentation for approval to the Finance & Infrastructure Committee	Finance & Commercial Group Up to £500k For cases: • ≥£250k < £500k sign off by the DOF required prior to presentation for approval at the Finance & Commercial Group
Payment Approval	CEO any £value	Chief Finance Officer any £value	Director of Finance any £value
NHS Improvement Approval	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require-NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH		
DH Approval	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury		

Tendering and quotations(*subject to the terms of any contract with the Integrated Supply Chain)					
Formal quotes	Between £5k and £50k				
Formal Tender	Over £50k				
OJEU	Subject to current limits				
Tender Approval					
	Chairman and CEO (and then report to Board)	**CEO**	**CFO (or nominated deputy)**	**Other Executive Directors**	**Others**
Lowest	Over £3m	Up to £3m	Up to £3m	Up to £3m	Up to 50k
Not the Lowest	Over £3m	Up to £3m	Up to £250k		
Single Tender	Over £3m (and notify Audit and Corporate Risk Committee)	Up to £3m (and notify Audit and Corporate Risk Committee)	Up to £250k (and notify Audit and Corporate Risk Committee)		DoF up to £250k(and notify Audit and Corporate Risk Committee)

Revenue Expenditure				
Revenue Plan	Approval by the Board (via Finance & Commercial Group and Finance & Infrastructure Committee)			
Virement between cost centres within overall service line or corporate functional budget	CEO any £value		Over £250k Chief Finance Officer / DOF approval required	Service Line Operational Directors and Corporate Associate Directors up to £50k for any one transaction (and Executive Directors for their respective areas).
Proposed changes that increase overall planned levels	Approval by Board >£3m	CEO any £value	Over £250k Chief Finance Officer / DOF approval required	
Business Case Approval	Approval by Board >£3m	Finance & Infrastructure Committee Between £500k and up to £3m For cases: • ≥ £500k sign off by the CFO required prior to presentation for approval to the Finance & Infrastructure Committee	Finance & Commercial Group Up to £500k (All business cases requiring investment to be presented) For cases: • ≥£250k < £500k sign off by the DOF required prior to presentation for approval at the Finance & Commercial Group	
NHS Improvement Approval	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require-NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH			
DH Approval	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury			

New contracts/Contract Renewals/ Novations / Extensions / Terminations/Variations (Annual Value of change) (Over £50k will have been tendered)			
Awarding /terminating contracts and signing contracts (where Solent is the commissioner) *	Approval by Board >£3m Signed by CEO / CFO	Approval >£500k to £3m by Finance & Infrastructure Committee Signed by CFO / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by any of the Executive team (Up to £50k – approved by Operational Director of service or equivalent (i.e. Corporate Associate Director or, where nominated by the relevant executive Director, Head of Service/corporate area) and signed by any of the Executive team or Head of Commercial)
Contract Approval/ termination and signing of documents (where Solent is the provider)	Approval by Board >£3m (Signatures – CEO/ CFO)	Approval >£500k to £3m by Finance & Infrastructure Committee Signed by CFO / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by any of the Executive team (Up to £50k – approved by Operational Director of service or equivalent (i.e. Corporate Associate Director or, where nominated by the relevant Executive Director, Head of Service/corporate area) signed by any of the Executive team or Head of Commercial)
Contract under seal approval	(All seals report to Board via CEO Report)	CEO / CFO approval	(For capital contracts – seals must come via recommendation of Director of Infrastructure)
NHS Improvement Approval on managed service contracts	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require-NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH		
DH Approval on managed service contracts	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury		
Letter of intent	Approval by Board >£3m Signed by CEO / CFO	Approval >£500k to £3m by Finance & Infrastructure Committee Signed by CFO / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by Chair/ Deputy Chair of Group (Up to £50k – signed by Operational Director / Corporate Associate Directors)
Issuing contracts of employment and deployment of agency staff	CEO / CFO / Chief People Officer / Recruiting Manager		
Waiver of Tenders and quotations	CEO / CFO (Report to Audit & Risk Committee)	DoF up to £250k (Report to Audit & Risk Committee)	

*Contract variations to specification only with no tenure of value change can be signed by the Director of Strategy or in their absence any Executive Team member (no presentation at Committee required). Lease variations with no tenure or value change can be signed by the Director of Infrastructure or in their absence any Executive Team member (no presentation at Committee required).

No commitments should be made via email.

Delegated financial limits for budget holders

Level	Staff with authority	Requisitions		Invoices - limit (£000)
		Purchase orders – limit (£000)	Non purchase orders – limit (£000)	
1	Chief Executive	No limit	No limit~~1,000~~	No limit~~Zero~~
2	Chief Finance Officer	No limit	No limit	No limit
3	Director of Finance	No limit	No limit	5,000
4	Deputy Director of Finance	5,000	250	5,000
5	Level 1 Management Other Executive Directors, and Financial Controller	250	250	250
6	Head of Procurement	200	200	200
7	Level 2 Management Service Line Operational Directors and Corporate Associate Directors	50	50	50
8	Level 3 Management Senior managers, Heads of Department	20	20	Finance Business Partners and Financial Services Manager up to £5k Finance Managers nil
9	Other budget holders	5	5	5

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Regarding credit notes, the following authorization levels apply

Staff with authority	Limits
Chief Finance Officer	No Limit
Director of Finance	≤£5m
Deputy Director of Finance	≤£5m
Head of financial accounts	≤50,000
Finance business partners	≤£5,000
Financial services & Finance managers	≤£5,000
Finance Managers	≤£1,000

Leases and licenses

The process for signature and/or sealing of leases and licenses is outlined within the 'Estates Department Guide to Finding and Occupying Premises' – reporting and oversight will be via the Estates, Facilities & Sustainability Group.

Finance and Infrastructure Committee Annual Report 2019-20

Item 18.3

NHS Solent NHS Trust

Introduction

The Finance Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by Trust Board. This report summarises the Committee's activity for the year 01 April 2019 to 31 March 2020.

Meetings

During 2019-2020 the following meetings were held;

- 24 May 2019
- 22 July 2019
- 23 September 2019
- 22 November 2019
- 23 January 2020
- 23 March 2020

Membership & Attendance

Attendance by members is outlined as follows:

NAME	April	May	June	July	August	September	October	November	December	January	February	March	% attendance
Stephanie Elsy Non-Executive Director (Chair since May 2019)		P		P		P		P		P		P	100%
Mike Watts Non-Executive Director (Member until Jan 2020)		P		P		P		P		P			100%
Sue Harriman Chief Executive		P		P		P		P		A		A	67%
Andrew Strevens Chief Finance Officer		P		P		P		P		P		P	100%
Gaurav Kumar Non-Executive Director (Member since February 2020)								P		P		P	100%
Thoreya Non-Executive Director (Member since February 2020)												P	100%
Gordon Fowler Director of Finance (Member since November 2019)								P		P		A	67%

P= Present **A= Apologies**

Terms of Reference

The Terms of Reference were reviewed in May 2019; the committee agreed no changes were required.
The Terms of Reference were reviewed again in November 2019, the following changes were made;

- Name of Committee updated to Finance and Infrastructure Committee to reflect the oversight of ICT and Estates.
- Membership updated to reflect Andrew Strevens positions as Chief Finance Officer/Deputy CEO and added Gordon Fowler as Director of Finance.
- Quorum amended to consist of three members including at least two NEDs and the Deputy CEO or Director of Finance.
- Additional line added under annual budget setting 'To consider the Trusts' Control Total and consider the implications of an ICS joint Control Total, ahead of approval by the Board'.

Status against the achievement of the Committee's Objectives

In May 2019 the Finance Committee agreed a number of objectives for financial year 2019/20. The table below summarised the current position against these objectives.

Objectives	Mid-year review status (Nov 19)	Full-year review status (May 20)
•Delivery of 19/20 budget; monthly monitoring of YTD, forecast outturn including financial risks.	Reported at each Finance Committee meeting.	Reported at each Finance and Infrastructure Committee; objective complete.
•Deficit for 19/20 – review and validate after Q1 close.	Reviewed; objective complete.	Objective complete.
•Monitor and review CIPs throughout 19/20.	Reported at each Finance Committee meeting.	Reported at each Finance and Infrastructure Committee; objective complete.
•Budget plan and timetable for 20/21; review milestones and track progress.	Work in progress; on-going.	Due to national COVID emergency all work on the 20/21 budget plan has been suspended. We are following national guidance and will be funded on a break-even basis until at least 31 October.
•Receive regular STP updates including clear visibility of system savings.	Regular updates received at each Finance Committee meeting as part of the monthly finance pack.	Reported at each Finance and Infrastructure Committee; objective complete.
•Continue with the development of a rolling capital plan.	20/23 capital plan has been drafted and presented to CAG. On-going discussions are taking place with the Executive Team before presenting to Finance and Commercial and Finance Committee.	20/21 to 22/23 capital plan presented to February 2020 Finance and Commercial Group, the meeting was not quorate; however, approval was provided outside the meeting between the executive team.
•Develop a budget plan in line with national guidance.	LTP for the local STP has been submitted. Awaiting National guidance for financial year 20/21 for individual Trust plans.	Due to national COVID emergency all work on the 20/21 budget plan has been suspended. We are following national guidance and will be funded on a break-even basis until at least 31 October.
•Continued monitoring of the Procurement strategy.	Objective on-going, latest update received at the September 2019 Finance Committee meeting.	Annual update due September 2020; objective complete.
•Monitoring of the Social Value Act through updates from Finance and Commercial Group.	Objective progressing, update due to be presented at the November Finance Committee meeting.	Objective not met during the year and will be carried forward into 2020/21; impact of COVID-19 will make local sourcing more relevant.
•Receive and review matters escalated from Finance and Commercial Group.	Escalation items reported at each Finance Committee meeting.	Reported at each Finance and Infrastructure Committee; objective complete.
•Receive regular estate updates.	Regular estates updates are reported at each Finance Committee meeting.	Reported at each Finance and Infrastructure Committee; objective complete.
•Review business cases as required.	Business cases reviewed as and when presented to Finance Committee.	Objective complete.

The Committee mid-year review was received and agreed in November 2019.

Summary of business conducted in year

The main business conducted by Finance Committee during 2019/20 is summarised as follows;

- Received regular updates on the monthly financial position.
- Received regular updates on the capital plan/capital position.
- Approved capital requests within the approval limits of the committee.
- Received regular updates on the aged debt position.
- Received budget and planning updates.
- Received updates on the planning timetable/national guidance.
- Received CIP updates including YTD spend v CIPs.
- Received updates on the financial risk of Brexit.
- Received monthly escalation updates from Finance and Commercial Group.
- Approved business cases within the approval limits of the committee.
- Received regular STP updates.
- Received regular ICT updates.
- Received regular Estate updates.
- Received updates regarding VAT liability.
- Received regular updates on the Board Assurance Framework (BAF).
- Received and agreed the 19/20 agenda cycle.
- Received and approved contractual documentation including SAVO's.
- Received updates on the Assurance Framework for Third Party Contractors.
- Received updates in relation to Procurement Strategy including updates on the National Procurement Strategy.
- Reviewed and analysed the Committee Appraisal questionnaire results.
- Received and reviewed Internal Audit Recommendations
- Received updates on 20/21 contract position/negotiations.
- Received updates on the new finance dashboard infographics.
- Considered requirements to support national COVID emergency.

- Received regular commercial updates through the Commercial Escalation report plus the following commercial updates;
  - PCN Agreement
  - 0-19 Section 75 agreement (Portsmouth)
  - 0-19 Hampshire services
  - Mental Health New Care Models bids
  - Contract negotiation close down report

- Received regular Estates updates including:
  - Catering.
  - St James/St Mary's redevelopment.
  - Estate Utilisation/McKinsey report.
  - Solent Owned Surplus Property.
  - CHP and NHSPS properties of interest to Solent.
  - RSH/WCH Bed optimisation.

- Received and updated the following:
  - Finance Committee TOR (Annually) – Reviewed May and November 2019.
  - Scheme of Delegation (Bi-Annually) – Reviewed March 2020, deferred to May 2020 due to COVID.
  - Standing Financial Instructions (Bi-Annually) – Reviewed January 2020.

Finance Committee escalation updates were provided from the Finance Committee Chair to Trust Board.

Objectives for 2020/21

To be agreed at May 2020 Finance Committee;

- Delivery of 20/21 budget; monthly monitoring of YTD, forecast outturn including financial risks.
- Deficit/surplus for 20/21 – review and validate after Q1 close.
- Monitor and review CIPs throughout 20/21.
- Budget plan and timetable for 21/22; review milestones and track progress.
- Receive regular STP updates including clear visibility of system savings.
- Continue with the development of a rolling capital plan.
- Develop a budget plan in line with national guidance.
- Continued monitoring of the Procurement strategy.
- Receive and review matters escalated from Finance and Commercial Group.
- Receive regular Estate updates.
- Receive regular ICT updates.
- Receive regular BAF updates.
- Review Internal Audit Recommendations.
- Review business cases, including capital requests, as required.
- Receive annual benchmarking update.
- Annual review and analysis of the Committee Appraisal questionnaire results.
- Annual review of Assurance Framework for 3rd Party Contractors.
- Consider COVID requirements.
- Monitoring of Social Value Act

Conclusion

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

Report Author(s)	Andrew Strevens, Deputy CEO/Chief Finance Officer 

Item 19

Solent NHS Trust
Trust Board Terms of Reference

Reference to "the Board" shall mean the Trust Board

1 Constitution

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

1.2 The Board has established the following Committees:

- Audit & Risk Committee
- Governance & Nominations Committee
- Remuneration Committee
- Mental Health Act Scrutiny Committee
- Assurance Committee
- Finance Committee
- Charitable Funds Committee
- Workforce and OD Committee
- Strategic Partnership Committee

2. Purpose

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

3. Responsibilities

3.1 The general responsibilities of the board are:

- to maintain and improve quality of care;
- to ensure that the trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to foster positive and productive external relationships with partners and stakeholders in the local health economy, in particular with patient/user groups and forums; Local Authorities, Health and Wellbeing Boards, Sustainability & Transformation Partnership partners, Healthwatch and Primary Care.
- to exercise collective responsibility for adding value to the trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the trust board will work in a way that makes the best use of the skills of

non-executive and executive directors.

3.2 **Leadership**

The board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the trust is a good employer by the development of a workforce strategy/plan and its appropriate implementation and operation;
- promotes the health and wellbeing of staff
- implementing effective board and committee structures and clear lines of reporting and accountability throughout the organisation.

3.3 **Quality**

The board:

- ensures that the trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- has an intolerance of poor standards, and fosters a culture that puts patients first;
- ensures that it engages with all its stakeholders, including patients and staff on quality issues; and
- ensures that issues are escalated appropriately and dealt with.

3.4 **Strategy**

The board:

- sets and maintains the trust's strategic vision, aims and objectives, being cognisant of Sustainability and Transformation Partnership for Hampshire and the Isle of Wight, ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- monitors and reviews management performance to ensure the trust's objectives are met;
- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, and ensures its delivery as a means of taking forward the strategy of the trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the trust.

3.5 Culture, ethics and integrity

The board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of trust business;
- ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- ensures fairness and continuity to improve people practices;
- embeds the Learning Organisation and Quality Improvement ethos into all activities;
- ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time;
- is responsible for maintaining a Freedom to Speak Up Culture

3.6 Governance and Compliance

The board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHs provider organisations;
- ensures that all licence conditions relating to the trust's governance arrangements are complied with;
- ensures that the trust has comprehensive governance arrangements in place that guarantee that the resources vested in the trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the trust fulfils its accountability requirements;
- ensures that the trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the regulators;
- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of trust business;
- agrees the schedule of matters reserved for decision by the board of directors;
- ensures the proper management of and compliance with the Mental Health Act and other statutory requirements of the trust;
- approves the Annual Report, Quality Account and Annual Accounts
- considers directives, comments and recommendations from its committees and takes the appropriate action
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions
- ensures that the statutory duties of the trust are effectively discharged;
- acts as corporate trustee for the trust's charitable funds;
- will conduct an annual appraisal of the Board's effectiveness.

3.7 Risk

The board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the trust's clinical and corporate activities;
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;

3.8 Finance

The board:

- ensures that the trust operates effectively, efficiently, economically;
- oversees the achievement of the Trust's Control Total;
- ensures the continuing financial viability of the organisation;
- ensures the proper management of resources and that financial responsibilities are fulfilled;
- ensures that the trust achieves the targets and requirements of stakeholders within the available resources;
- reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

4 Membership

- The Trust Board will comprise the following:

<u>Voting members:</u>

  - Independent Chair (Chairperson)
  - Five Non-Executive Members
  - Chief Executive

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

Non voting members:

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

- In the case of the number of votes for and against a motion being equal, the Chair of the Board will have a second, casting vote.
- A manager who has been appointed formally to act up for an officer member during a period of incapacity or temporarily to fill an officer member vacancy, shall be entitled to exercise the voting rights of the officer member.
- Members will be expected to attend at least 75% of meetings.
- When an executive director member is unable to attend a meeting, a nominated deputy must be identified. The nominated deputy must be a direct report to the Board member.

5 Attendees

- The following will be attendees at the meeting;
  - Associate Director of Corporate Affairs and Company Secretary
- In addition, lead officers representing other services/departments may attend when required or at the invitation of the Chair.

6 Secretary and Administration

- The Corporate Support Manager and Assistant Company Secretary or their nominee shall act as the secretary of the committee**.**
- The administration of the meeting shall be supported by the Corporate Support Manager and Assistant Company Secretary who will arrange to take minutes of the meeting and provide appropriate support to the Chairman and committee members.
- The agenda and any working papers shall be circulated to members five working days before the date of the meeting.

7 Quorum

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

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

8 Frequency

- Meetings will be held every other month or more frequently if required, under the Chairmanship of the Solent NHS Trust Chair.
- The following meetings will be held:
  - In Public Meeting
  - Confidential Meeting
  - Workshops (in private) to support board development and strategic planning

9 Notice of meetings

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

10 Minutes of meetings

- The secretary shall minute the proceedings of all meetings, including recording the names of

those present and in attendance.

- The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly**.**
- Minutes of meetings shall be circulated promptly to all members once agreed.
- Minutes will be available under the Freedom of Information Act 2000.

11 Authority

The Board may :

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

12 Reporting

- The Board will develop an Annual Cycle of Business where scheduled items throughout the year will be presented.
- The Board will receive updates (including exception reporting) from its reporting Committees via the relevant Committee Chairs. The Chairs of Committees will also be responsible for ensuring relevant information and decisions are reported and cascaded back through the appropriate communication channels.
- The Board will receive project reports on an ad-hoc basis.
- Member's attendance at meetings will be disclosed in the Trust's Annual Report.

Version	10
Agreed at Trust Board	August 2020
Date of Next Review	August 2021