Agenda

Solent NHS Trust In Public Board Meeting

Date: Monday 1st February 2021
Timings: 9:30 – 10:50
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	20mins	**Staff Story**	Acting Chief People Officer	To receive
3	09:55	5mins	***Previous minutes, matters arising and action tracker**	Chair	To approve
4	10:00	10mins	**Patient Story - verbal story**	Chief Nurse & Acting Deputy CEO	To receive
5	10:00	10mins	**Contemporary updates inc:** • **Item 5.1 Safety and Quality first & feedback from Board to Floor Visits** • **Item 5.2 - Freedom to Speak Up - Any matters to raise to the Board** • **Item 5.3 - Contemporary Covid Vaccination Update**	Chief Nurse & Acting Deputy CEO COO S'ton	To receive
6	10:10	20mins	**Waiting Lists Review**	COOs and CMO	
Due to the level 5 national emergency, the following reports will be taken as 'read' only:					
7	-.-		**Chief Executive's Report**	Acting CEO	To receive
			Performance Management Report	Executive Leads	To receive
			Infection Prevention Control (IPC) BAF	Chief Nurse & Acting Deputy CEO	
	10:30	10mins	**Exceptions from the above reports**	Chair / All	To discuss

Reporting Committee Exception Reports and Governance matters					
8	10:40	5mins	• **Item 8.1- Workforce and OD Committee (21/01/2021)** - inc Terms of Reference (Item 8.1.1) • **Item 8.2- Quality Assurance Committee (21/01/2021)** - Safe Staffing 6month report (item 8.2.1) • **Item 8.3- Governance &Nominations Committee (11/12/2020)** • **Community Engagement Committee (28/01/2020)- Verbal update** • **Non-Confidential update from Finance & Infrastructure Committee (22/01/2021)- Verbal update**		To receive
			Future dates: • **Mental Health Act Scrutiny Committee (18/02/2021)** • **Audit & Risk Committee (25/02/2021)** • **Charitable Funds Committee (04/02/2021)**		
Any other business					
9	10:45	5mins	**Reflections** • *lessons learnt and living our values* • *matters for cascade and/or escalation to other board committees*	Chair	-
			Any other business & future agenda items	Chair	-
10	10:50	---	**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 29th March 2021***

Minutes

Solent NHS Trust In Public Board Meeting

Monday 7th December 2020
Virtual Zoom Meeting

Chair: Catherine Mason, Trust Chair (CM)	
Members: **Andrew Strevens,** Acting CEO (AS) **David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN) **Jackie Ardley**, Chief Nurse and Acting Deputy CEO (JA) **Dan Baylis**, Chief Medical Officer (DB) **Suzannah Rosenberg**, Chief Operating Officer Portsmouth (SR) **Jas Sohal**, Acting Chief People Officer (JS) **Gordon Fowler**, Acting Chief Finance Officer (GF) **Jon Pittam,** Non-Executive Director (JPi) **Mike Watts,** Non-Executive Director (MW) **Stephanie Elsy,** Non-Executive Director (SE) **Thoreya Swage**, Non-Executive Director (TS) **Gaurav Kumar**, Non-Executive Director (GK)	**Attendees:** **Gordon Muvuti**, Director of Partnerships (GM) **Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC) **Sam Stirling**, Corporate Affairs Administrator (SS) **Angela Robbins,** Senior Community Mental Health Nurse *(item 2)* **Jorge Grace,** Mental Health Practitioner (JG) *(item 2)* **Ophelia Matthias,** Community Engagement Communications Officer (OM) *(item 3)* **Nicola Whyte,** Matron- Jubilee House (NW) *(item 5)* **Andrew Caldwell**, Co-Create *(item 8)* **Chris Box**, Associate Director Estates and Facilities (CB) *(item 10)* **Sadie Bell**, Head of Information Governance (SB) *(item 11)*

*****Judgements and decisions have been made in the context of a Level 3 (regional) incident*****

1	**Chairman's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests**
1.1	CM welcomed all to the meeting. The Board were informed that a representative from 'Co-Create' would be joining at 11am. Apologies were received as noted above 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	**Patient Story**
2.1	JG & AR were introduced to the meeting to present on behalf of the patient. JG provided the background of this complex case and explained referral to the Crisis Team. An overview of challenges in relation to diagnosis, engagement, wheelchair access and lengthy processes for high cost housing placements was shared. AR explained processes implemented to manage behaviours and build a therapeutic relationship, with effective care pathways identified. Positive patient feedback was provided and planning for the future shared.
2.2	JA reflected on AR's Excellence Award nomination and commented on the high level of care and compassion demonstrated. AR highlighted out of hours work and frustrations regarding Covid-19 testing delays impacting housing placement.
2.3	SR asked about experiences working as part of an integrated service between Solent and Portsmouth City Council. JG emphasised strong team working and faster response times as a result.

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2.4	GF queried lengthy process for high cost placements and how this could be improved. JG explained funding challenges and associated processes in place. It was agreed that GF and JA consider further outside of the meeting. **Action- GF & JA.**
2.5	AS asked about support in place for staff within the team, who regularly work in a high stress environment. Strong management/leadership was emphasised and the use of regular supervision sessions highlighted.
2.6	JS asked about further support that could be provided to improve everyday roles. The effects of Covid-19 and staff fatigue were shared. AR also highlighted IT challenges and CM provided assurance of aims to improve, including Board review of an outline IT business case.
2.7	DB commended the work of the team and suggested the need for further consideration of processes to ensure that patients were not missed when moving from one locality to another.
2.8	SE reflected on potential peer/voluntary sector support within the system. The Board discussed the usefulness of access to alternative sectors, however acknowledged potential challenges.
2.9	GM further reiterated the team's strong commitment to care and emphasised regularity of such complex cases. It was suggested that any further challenges in relation to the Wheelchair service were shared directly with JA to ensure appropriate resolution.
2.10	The Board thanked AR & JG for sharing the story. *AR & JG left the meeting.*
3	**Staff Story**
3.1	JS introduced OM to the Board and provided an overview of her working background and specialism in Community Engagement communications. OM shared her personal story and detailed activity undertaken throughout Black History Month, including regular 'Blog'. OM emphasised the importance of using stories and changing narrative to celebrate and advocate for those with protected characteristics. The Board were informed of work undertaken by the Black, Asian & Minority Ethnic (BAME) Resource Group and highlighted the need for ally inclusion and targeted communications. OM reflected on the importance of educating against systemic racism and ensuring mindfulness across organisations.
3.2	CM asked how Solent's approach compared with other organisations. OM commented on high profile nationally, due to the Black Lives Matter Movement and effective catalyst to forward plans. OM shared positive feedback since joining the Trust, including encouragement to share ideas and stories.
3.3	MW queried potential dissipating energy and support required to empower staff to speak out. OM highlighted ongoing momentum and strong support of staff and the Board to emphasise awareness. The importance of ensuring ongoing discussions and willingness to learn was discussed.
3.4	GF asked about further support required and OM reflected on the need for dedicated resource to continue work and drive the culture change required. GM agreed and highlighted the importance of Board understanding of everyday experiences.

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3.5	SE reiterated emphasis on learning required and taking responsibility for equality across the organisation. The Board thanked OM for attending and providing candid, thought provoking discussions. *OM left the meeting.*
4	***Minutes of the meeting held 05th October 2020, matters arising and action tracker**
4.1	The minutes of the last meeting were agreed as an accurate record subject to minor amendments.
4.2	The following actions were confirmed as complete: AC002166, AC002167, AC002168
5	**Safety and Quality First and Feedback from Board to Floor Visits**
5.1	Hawthorns CM provided feedback from the visit and commented on reassurance following recent relocation. The staff were commended for their efforts and confirmed that a small number of actions had been identified. JPi briefed the Board on personal deep dive undertaken regarding the escalations of the low number of inpatient beds and associated concern on the impact within the community regarding suicide. JPi noted assurances identified. *NW joined the meeting.*
5.2	Jubilee House A video was presented to the Board. NW shared experiences of staff on the ward and commented on strong sense of teamwork, despite immense challenges this year. *NW left the meeting.* The Board discussed planning to use Board to Floors to support staff going forward.
6	**Freedom to Speak Up (FTSU) - Any matters to raise to the Board – including:** - **FTSU Steering Group Objectives**
6.1	There were no urgent Freedom to Speak Up matters to raise.
6.2	FTSU Steering Group Objectives JPi updated the Board on current work programmes, including cultural outreach and work with partners in the community. The Board agreed significant assurance of processes in place and wide-ranging objectives. It was confirmed that deliverables were being considered and objectives would be reviewed regularly and presented to the Board. **The FTSU Steering Group Objectives were noted.**
7	**Chief Executive's Report** - **Including: Covid-19 Wave 2 Update**

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7.1	• CM noted that Hampshire and Isle of Wight (HIOW) had been approved as an Integrated Care System. It was agreed that full discussions would be held in Confidential Board. • AS highlighted activity during Black History Month. • The Board were informed that the prestigious Queen's Nurse Award (from the Queen's Nursing Institute) had been awarded to two members of staff for demonstrating a high level of commitment to patient care and nursing practice. • It was confirmed that the Trust had launched the High Intensity Service in HIOW, working in collaboration with partners to deliver a pathfinder service for veterans and their families with dedicated access to mental health and crisis support. • AS reported significant improvement in Flu Vaccination rates, with 84% achieved to date. • AS explained that HIOW STP had been selected as one of the two systems in the region to be part of an NHS England pilot programme, offering an enhanced Occupational Health and Well Being Hub (OH&HWH) and confirmed associated funding. • Increase in community Covid-19 cases was reported and JA briefed the Board on outbreak situations. The Board discussed challenges, learning and work across the system. **The Board noted the CEO update.** *AC joined the meeting.*
8	**Performance Report**
8.1	<u>Operations</u> • AS emphasised Covid-19 impact demonstrated within the dashboards. • DN reported IT challenges and ongoing discussions with service lines to improve. It was confirmed that self-help guidance had also been published and immediate action was in hand. • The Board were updated on waiting list challenges effecting a number of services. High waiting lists for dental were reported and DN briefed the Board on options being considered, including review of governance and safety requirements to receive additional out of area support. MW asked which patients were being impacted by the high Dental service waits. DN confirmed that the Special Care Dental service served vulnerable areas of the population and informed of constant triaging taking place. It was confirmed that the Board would continue to receive regular updates on the status and mitigations in place and a further report was requested at the next meeting. • SR highlighted challenges in relation to the single-handed practitioner model and concerns regarding turnover and recruitment. • Increased referrals and triaging was confirmed. SR informed of recruitment and extra shifts being offered. • The Board noted positive communications performance report.

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8.2	Workforce • JS reported that sickness had increased by 1% and would be monitored over the coming months. • It was confirmed that demand for temporary staff and use of agency had also increased. • Preparation for second wave of Covid-19, restoration planning and the vaccination programme was highlighted. • Expected improvements following the implementation of a new learning system were shared. • JS provided an overview of considerations for a permanent programme business case for international recruitment. It was confirmed that 8 international mental health nurses had been recruited and JS explained support being offered to fully establish. • The Board were informed that the Trust had achieved Staff Survey target, with a 66% response rate. Improvements from previous areas with a low response were highlighted. • Considering well led requirements, RC suggested inclusion of WRES and Diversity & Inclusion narrative in future reporting to detail how risks were manifested, as opposed to purely data. JS briefed the Board on full deep dive reports submitted to the Workforce & OD (WOD) Committee, with actions and targets discussed. It was agreed that JS and JA review further outside of the meeting. **Action- JS and JA.**
8.3	Quality • JA provided an overview of work surrounding Covid-19. • It was confirmed that the IPC Board Assurance Framework (BAF) would be presented to a future meeting. • JA reported changes to reporting, including emphasis on positive aspects of work and consideration of stronger audit tools. • Effective Community Engagement work programmes were shared. • JA highlighted successful Learning Disabilities Event held.
8.4	Financial GF briefed the Board on Month 7 results, with an in month and YTD adjusted deficit of £40k, £250k adverse to plan in month and YTD. It was confirmed that a full financial update would be provided in Confidential Board.
8.5	Research AS confirmed national high profile and pride of work achieved within Solent. DB agreed and commented on work led nationally in terms of Covid-19. Positive collaborative working was shared and DB highlighted work beginning in relation to reset and recovery. The Board were informed of discussions being held in the new year regarding how The Academy can define development within services.
8.6	The Self-Declaration was noted.
8.7	**The Board noted the Performance Report.**
9	**Brexit Update and Preparedness – EU Transition Planning**
9.1	DN reported that the Brexit Working Group had been re-established and preparations were underway, despite unclear outcomes.

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9.2	The Board were briefed on preparations from a staffing perspective, including support for staff applying for settle status.
9.3	Constant review of third-party suppliers and refresh of new contracts to ensure robust business continuity arrangements were emphasised.
9.4	DN reported a risk in relation to Portsea traffic congestion and highlighted refreshed and renewed planning. It was confirmed that standard business continuity plans for traffic disruption in Portsmouth were in place.
9.5	RC queried the level of assurance specified. It was noted that there was significant assurance in relation to the Trust's internal processes, however assurance of external factors was sufficient at this stage.
9.6	The Board discussed challenges from a system perspective, particularly within the care sector. **The Brexit Update and Preparedness- EU Transition Planning Report was noted**. *CB joined the meeting.*
10	**Six monthly Health and Safety Update**
10.1	• CB provided an overview of activity taking place to ensure that the Trust was maintaining compliance with statutory requirements. • The Board were briefed on the impact of the pandemic on planned proactive assessments, particularly on inspection, assessment and Audits Programme. CB assured the Board that impacts were low risk. • CB confirmed that H&S workplace inspections were not mandatory, rather a proactive tool used as part of the HSG65 Plan, Do, Act, Check guidance. This was highlighted as low risk and CB informed of ongoing inspections taking place. • Regarding fuel storage, significant asset inspection surveys were highlighted and minimal risk advised. • Focus on the Disability Discrimination Act within estates was emphasised, ensuring disability access within Solent estate design guides and in compliance with building regulations. • CB confirmed that the Trust continues to comply with the Health and Safety at Work Act. • The Board were informed that, following consultation with relevant unions, the Health and Safety Committee was renamed to the Health and Safety Group.
10.2	SR commented on considerations required in relation to space rationalisation and future configuration post Covid-19. CB shared current discussions regarding estate transformations and confirmed that a report regarding surplus property and land would be provided at the next Board meeting. Think this is an action GM highlighted similar challenges across the ICS and the Board discussed potential opportunities to monitor.
10.3	JPi queried Board level assurance of the ligature reduction programme. AS emphasised that risks had been identified and highlighted ongoing programme to significantly mitigate and monitor. It was agreed that the score would remain 'green' due to the robust oversight and planning. **The Board noted the Six-monthly Health and Safety Update**. *CB left the meeting.*

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11	**Information Governance Briefing Report**
11.1	• *SB joined the meeting.* • SB reported a high compliance rate for FOIs, with the Trust achieving 90.9% over the last 3 months. It was confirmed that Subject Access Requests had also achieved compliance of above 95%. • The Board were informed of increase in demand and challenges in relation to capacity within the Information Governance Team. It was confirmed that a business case had been created to consider additional capacity and efficiencies required.
11.2	GF queried increase in requests across other Trusts. SB confirmed increase in requests and business demand across organisations. CM asked about potential triggers/themes and SB commented on further public awareness in obtaining records and activity increase related to Covid-19.
11.3	SE queried the origin of the Subject Access Requests and SB highlighted receipt through the Complaints Team and solicitor/police requests (regarding investigations). SB assured the Board that this was not a reflection on the quality of services provided and emphasised work to ensure co-ordinated responses.
11.4	AS queried work being undertaken to ensure training compliance targets were met. SB emphasised regular monitoring and joint working with the Learning and Development Current 76% compliance rate was confirmed, with the aim to reach 95% by March 2021.
11.5	The Board were informed that NHSE had retracted request for data, as per discussions at the last Board. **The Board noted the Information Governance Briefing Report.** *SB left the meeting.*
Reporting Committees and Governance matters	
12	**Annual Compliance with NHS Constitution**
12.1	**It was agreed to approve the Annual Compliance with NHS Constitution, subject to inclusion of a caveat in relation to GA waiting lists.**
13	**Workforce and OD Committee Exception report from meeting held 10th September 2020**
13.1	• MW informed the Board that the Committee had agreed that areas of the original Workforce Optimisation Programme were descoped due to recent HR changes. • The E-Roster Improvement Programme and associated action plan was agreed and JS confirmed that a business case was being created to address audit findings. **The Workforce and OD Committee Exception Report was noted.**
14	**Community Engagement Committee Exception report**
14.1	*No meeting held since the last report to Board.*
15	**Mental Health Act Scrutiny Committee Exception Report- Verbal update**

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15.1	• The Board were informed of effective Mental Health Act Report presented which highlighted clear exception reporting and prompted discussions relating to care provided. • TS commented on Associate Hospital Manager Report shared and planning to provide a robust process, including service visits. • The Committee Effectiveness Review was discussed and improvements highlighted. **The Board noted the Mental Health Act Scrutiny Committee Exception Report.**
16	**Audit & Risk Committee – Exception Report from meeting held 5th November 2020**
16.1	• JPi highlighted extensive discussions regarding Internal Audit high-risk actions associated with IT asset management and E-rostering. • Full assurance in relation to ICT Procurement deep dive and lessons learned were shared. **The Audit and Risk Committee Exception Report was noted.**
17	**Quality Assurance Committee- Exception Report from meeting held 19th November 2020**
17.1	• The Board were informed of discussions held in relation to management of 'long Covid' and associated funding. • The intention to include deep dives at future meetings was highlighted. **The Board noted the Quality Assurance Committee Exception Report.**
18	**Governance and Nominations Committee- Exception Report**
18.1	*There was no meeting held since the last report to Board.*
19	**Non-Confidential update from Finance & Infrastructure Committee**
19.1	There were no updates to report.
20	**Charitable Funds Committee Exception Report**
20.1	• The Committee received the Quarter 2 2020/21 Finance Report and GK highlighted public donations made via the new 'Go Fund Me' online platform. • GK informed the Board that the Committee had agreed application for NHS Charities Together Stage 3 Grant, which would result in an additional £77k being donated to the charity and agreed consideration of Trust wide Occupational Health and Wellbeing activities that could be supported via this route. • The Independent Examiners report was noted by the Committee. • GK informed of update provided in relation to progress against the NHS Charities Together Covid-19 grants.
20.2	**The Board agreed the updated Terms of Reference and noted the Exception Report.**
Any other business	
21	**Reflections**

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21.1	RC emphasised the importance of remaining conscious of confidential discussions taking place within the In Public Board meeting.
22	**Any other business & future agenda items**
22.1	CM confirmed that chairs action had been taken to include a caveat within the SFI and Standing Orders in relation to Bribery Act compliance. No other business was discussed and the meeting was closed.
23	**Close and move to confidential meeting**

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Action Tracker

Overall Status	Source Of Action	Date Action Generated	Minute Reference/	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
On Target	Board meeting - In Public	07/12/2020	8.2	AC002337	BOD1- Performance Report (Workforce)	Considering well led requirements, RC suggested inclusion of WRES and Diversity & Inclusion narrative in future reporting to detail how risks were manifested, as opposed to purely data. JS briefed the Board on full deep dive reports submitted to the Workforce & OD (WOD) Committee, with actions and targets discussed. It was agreed that JS and JA review further outside of the meeting. **Action- JS and**	Jackie Ardley, Jas Sohal	February 2021 update- Ongoing

Item No.	6					
Presentation to	In Public Board					
Title of Paper	**Service line description of waiting lists**					
Purpose of the Paper	To inform the Board about: 1. Services with breaching waiting lists. 2. Associated risks. 3. Mitigation					
Author(s)	Clinical Directors		Executive Sponsors	Dan Baylis, Suzannah Rosenburg David Noyes		
Date of Paper	January 2021		Committees/Group previously presented	N/A		
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Positive /negative inequalities	N/A					

Summary of Key messages and findings

Background:

Referrals into Solent clinical services generate waiting lists, which are managed via service line and care group governance structures.

Within each waiting list there are clearly defined targets to see, treat and discharge patients. When demand outstrips supply waiting lists are breached, which brings added risk of harm. This is managed and mitigated via an initially agreed RAG system.

Increased demand, historical cuts in community budgets and workforce pressures have negatively impacted on waiting list times.

More recently, the impact of the coronavirus pandemic has put unprecedented demand on services, which has resulted in a surge in waiting lists as a consequence of: stopping clinical services for mutual aid; higher levels of DNA's; reductions in workforce due to shielding, illness or childcare; reduced throughput and therefore, capacity within clinics due to new infection control protocols.

These issues were escalated to the Trust Board via the Clinical Executive Group in December, and a specific action was created to consider more granular detail at a service line level.

Other considerations:

- Waiting list governance

Numbers of patients waiting for care at Solent NHS Trust for more than 52 weeks appears to be an outlier in regional performance statistics. The "true" picture, as believed to be the case by Clinical Directors, is thought to be a very small fraction of this.

The differential between the reported picture and the clinical picture is multifactorial including:

- Definitional issues.
- EPR configurability issues.
- Logical processing issues.
- Human error issues.
- Data analytical issues.
- Reporting constraints.

This differential is enough to render the published reports of limited usability for the management of service waits.

Therefore, alternative methods are used by services for managing waits, reducing the impetus to bring together waiting list management and waiting list assurance. An action is in play for the performance team to find ways of flagging clinically significant waiters (for whatever period).

- Consistent approach to waiting list targets

Although national guidance is lacking, it was recently agreed that Solent's waiting lists should follow the same targets as acute Trusts (18 weeks), unless a clinical reason necessitates exception.

These require review to ensure a consistent approach across the Trust.

- Wave 3 coronavirus

The latter half of 2020 saw significant effort in recovering waiting list positions following the first wave of coronavirus. This paper is currently being written as we attempt to vaccinate the population at the outset of wave 3, with an unprecedented level of demand within our healthcare services.

It is inevitable that waiting list positions will deteriorate until this current pressure has passed.

Within this paper is a summary of major waiting list concerns within each service line. Additional information has also been provided to the Trust Board containing more detailed reports from each service line, and a report on waiting list governance from the CCIO.

Summary of escalated waiting list pressures within each service line

Specialist Dentistry

Description of concerns:

- Children and adults with specialist needs for dentistry are unable to have their care due to a lack of access to General Anaesthesia (eg for tooth extraction).
- Routine (eg filling) dental treatments cancelled in lockdown, urgent treatments have continued (eg pain).

Impact:

- 459 children and 41 adults waiting for a GA procedure.
- 1,652 routine treatments cancelled, leading to potential deterioration of oral health and associated discomfort.

Mitigating factors:

- GA impact on children much smaller than numbers suggest, due to access to different sedation and treatment techniques, plus low levels of reported symptoms.
- GA impact on adults more significant but being mitigated by clinical need prioritisation list, with regular remote clinical reviews and collaborative working with acute sector.
- Urgent appointments have continued, routine appointments being prioritised. New air units and remote consultations have increased capacity.
- These issues are likely to deteriorate over wave 3. New patient referrals (eg check-ups) are not being seen and mitigation is in place. All this is consistent with national dentistry picture and SOP's.

Sexual Health

Description of concerns:

- Vasectomy services suspended during lockdown.
- Psychosexual counselling clients declined remote consultation leading to backlog.

Impact:

- 701 men on vasectomy list by June 2020 (vs. 350 normally).
- 50 people waiting psychosexual assessment and/or therapy.

Mitigating factors:

- Delays to booking patients due to reduced capacity (vasectomy) and patient choice around change in delivery methods (psychosexual) have now been recovered and all waiters booked within recommended timescales. Psychosexual delays were solely due to patient choice (patients choosing to wait for a face to face consultation rather than video/telephone call) – there was no reduction in capacity within the service.

Adults Services, Southampton

- Patients within specialist services being seen within acceptable time limits and usually less than 18 weeks; sometimes these become longer because of reduced workforce, spikes in demand, impact of wave 1 coronavirus. However, this is monitored and responded to in terms of risk management. No waits are over 52 weeks.
- Same day community nursing services and urgent response are managed close to capacity and waiting lists are not held.

Adults Services, Portsmouth:

Description of concerns:

- Significant waits for specialist services: speech and language, pulmonary rehab, bladder and bowel, physiotherapy. This has been compounded by patient choice, not wanting face-to-face appointments, and redeployment of staff to support more urgent services.
- Patients with Diabetes being managed via MyDiabetes app.
- Same day community nursing services and urgent response are managed close to capacity and waiting lists are not held.

Impact:

- Average wait at the end of December 7.7 weeks with 243 patients on the SLT waiting list. Impact - risk of complications from poor swallow (nutrition, infection), quality of life - communication.
- 515 people on pulmonary rehab list - no face-to-face rehab (positive impact for respiratory patients), minimal impact for most as classed as being delivered virtually.
- 102 people on bladder and bowel waiting list - impacts quality of life.
- 181 people on physio list - risk of functional decline, falls, social isolation.

Mitigating factors:

- SLT: telephone appointments, triage and urgent patients still seen.
- Pulmonary rehab: face-to-face diverted to virtual classes, maybe better for patients.
- Bladder and bowel: recovery over Autumn, list now down to 19.
- Physio: overlap with PRRT for physio at home when urgent/admission avoidance, recovery plan needed after pandemic, discussion with CCG re: team expansion.

Mental Health

Description of concerns:

- Assessment to intervention (A2i) acute mental health service was missing its 6 week target for assessment, due to staff sickness and vacancies. However, this position was mitigated and waiting time is down to 8 weeks. Recruited permanent staff, due to start between January and March 2021.
- OPMH memory monitoring service is breaching its waiting list targets because of increased demand for dementia treatments.
- Psychology service is experiencing long waits due to impact of covid redeployment and increased demand.

Impact:

- A2i: risks of further deterioration and harm to self and/or others while patients are waiting to be assessed on first referral to service.
- OPMH: 95 of 639 patients having a delayed review of dementia treatments. However, this delay is less than 6 weeks. No significant harm.
- Psychology: 221 patients are breaching (range: 13 - 66 weeks) risk of psychological harm.

Mitigating factors:

- A2i: triage tool in use to identify those who require urgent assessment. Overtime offered to staff and agency/bank staff. Staff recruitment successful and new starters expected in January - March 2021.
- OPMH: additional staffing in place.
- Psychology: use of virtual and group appointments; appointment of new therapists. However, likely that further mitigating measures will be needed.

Children's Services

Description of concerns:

- Significant pressure in ADHD and Autism services, contributing to long delays in assessment and treatment.

Pressure also in psychological services: CBT, DBT and therapy caused by workforce issues and significant demand.
- Delays for integrated therapy service.

Impact:
- Delayed diagnosis and instigation of treatment plans and parental support.
- Deterioration in mental health with increased presentation to unscheduled services - primary care and acute trusts.

Mitigating factors:
- Working with partners to share referrals, suspension of new referrals in some areas, waiting list management and prioritisation, identification of new capacity via workforce.

Primary Care and MPP Services

Description of concerns:

Podiatry:
- Unavailability of New Milton clinic has resulted in 102 patients who are moderate to high risk but have opted to wait until the clinic reopens to receive treatment despite longest wait being up to a year.
- Long waits across the wider service continue.

Pain Service:
- Virtual groups established and consistent good uptake. However, there remains long historic waits specifically FGSEH (Fareham & Gosport and South East Hants CCG area).
- Patient choice and the digital divide, long waits for face-to-face appointments and no plan for when we will be able to resume these at present.

Hydrotherapy:
- Service delivery remains at amber level, with urgent outpatient and ward referrals only. The team have a current capacity of approx. 15% of pre Covid level, due to staffing challenges and IPC requirements for patient care to move from 1:3 to 1:1.
- The team are supporting PHU with a cohort of patients as part of the Covid Mutual Aid.

Diagnostics:
- There are 1,102 patients across the specialist teams who are waiting for a diagnostic primarily from InHealth.

GP surgery:
- The acute prescription requests were as high as 400 waiting to be processed.

Impact:
- In MSK there are significant concerns with diagnostics, with some patients waiting since August 2020 - there remains a risk that significant pathology is hidden.
- Hydrotherapy is currently the only possible route of therapy for a significant cohort, meaning that they fail to rehabilitate putting pressure on other services.
- In Podiatry, patients who are at moderate to high risk of ulceration but are not being seen as regularly as pre Covid have an increased risk of increased hospital admissions.
- In pain services, the impact of no treatment or failing to make progress will be significant upon ED, given that 20% attend prior to a pain service intervention.
- A wait of greater than 6 months has been found to lead to a step wise deterioration in care with some becoming untreatable. Those with digital poverty remain untreated, widening the inequality gulf.
- For the GP surgery, late prescriptions mean increased telephone calls to the surgery.

Mitigating factors:
- In podiatry it may be necessary to discharge those who are not willing to be seen elsewhere.
- With MSK risks are reduced by triage. The service requests priority MRI scans from InHealth based on clinical need. Additional resource for MRI and X ray is also being explored with Practice Plus Group, although this has been ongoing for several months.
- In pain services all patients are prioritised according to national and international guidance. Greater use has been made of virtual sessions, although some fail to make progress.
- For the GP surgery, changing the way the clinicians work through the transformation agenda in the service has brought down the outstanding requests from an average of 200 to between 50 - 150.

• This continues to be a focus for the practice and further improvements are expected.				
Action Required	For decision?	No	For assurance?	Yes
Summary of Recommendations	• The Board is asked to note the report and to receive assurance that mitigating factors are in place to manage waiting lists; and that, where appropriate, partner commissioner and partner organisations are informed of risk. • Also, to note likely impact of current coronavirus wave, work by BI team and CCIO plus a standard approach to breach thresholds.			

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 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	DB/SR/DN							

Item 7.1

NHS Solent NHS Trust

CEO Report – In Public Board

Date: 20 January 2021

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 5 National Emergency, contemporary updates will be provided where appropriate in relation to our continued response****

Section 1 – Things to celebrate

Response to COVID-19 and vaccine rollout programme

With the response to the COVID-19 pandemic continuing, our employees remain focussed on delivering the very best care for service users. Our colleagues worked quickly and innovatively to prepare the COVID-19 vaccination centre in Southampton, which went live on 4 January. We issued a press release to highlight this achievement to stakeholders. Another release then confirmed that more will open across Hampshire and the Isle of Wight in the coming weeks. Both releases saw widespread media interest and coverage. As of 18 January, all of our staff have been offered a slot for a first vaccination.

Lighting Up for Christmas

We designed the Lighting Up for Christmas campaign to recognise and celebrate our people who have made a positive difference to our communities during this difficult year. Our staff had the opportunity to 'nominate' a colleague/patient or member of the public that have played an important role in their lives in 2020. The rainbow has been a prominent symbol throughout 2020 for the NHS family and beyond. Individual light-up rainbows were used to send out as a thank you to those who have been nominated, with the video clips showing people taking/passing the light to those who they want to celebrate.

Portsmouth News campaign

Our colleagues worked together to produce a range of clinician-led articles alongside service user case studies as part of the Portsmouth News's *There for Each Other* campaign.

Over the ten-week period articles were published in print and online, and included two front pages.

Mental health topics covered included: COVID-19 anxiety, bereavement, stress and domestic abuse, and signposted readers to access our resources online and key phone numbers to use.

Partnership with Southampton Football Club

We have formed a promising partnership with Southampton Football Club and Saints Foundation to launch a range of health-focused initiatives. Our colleagues will work closely with the club to raise awareness amongst fans and wider community of some of the region's key health priorities, with the aim of encouraging people to make sustainable changes that will positively affect their own health. This summer, we will launch a mental health campaign with the Foundation, providing support and resources to help men in the Southampton region, particularly within the Saints fanbase.

Section 2 – Internal matters (not reported elsewhere)

Covid-19 Link to BAF#61 – Major Incident, #65 – Covid recovery, #59- Demand and capacity, #55 -Workforce sustainability

The recent decisions taken by the government follow a rapid rise in infections, hospital admissions and death rates across the country. We are seeing this locally, within Hampshire and the Isle of Wight and we continue to see rising cases. Our hospitals are now under more pressure than they have been at any other point during the pandemic. Given the lag between infections and hospital admissions, we recognise that this pressure will only increase over the coming weeks. In early January I wrote to our staff to highlight the emergency situation and to emphasise the need for us all to collectively take the action for which we have previously prepared.

The increase in cases and the pressure on the NHS locally means that are having to take some tough decisions about the services we provide. At the beginning of December, we asked our Clinical Directors in each service line to carefully consider and plan, taking into consideration all the risks, for a time when we may need to stop, reduce or change the way we deliver services. To fully support our hospitals and the people in our populations, working with our partners, we are now enacting those plans in a considered way.

Our priorities, in support of the wider system, are: vaccination centres, in-patient facilities (including increasing the number of beds available within Southampton and Portsmouth), our rapid response services (urgent response services/ rehab and reablement), our mental health services (including CAMHS) and mutual aid to our partner organisations where team members have specialised skills that may be needed (e.g. intensive care trained nurses). We also continue to protect services which are provided to those that are particularly vulnerable (e.g. the Sexual Assault Referral Service). Although these are our priorities, this will not mean that we are stopping all other services. Our approach, which is clinically-led, has been to modify our service offering so that we can free up people to support these priorities to the best effect.

For our staff (both clinical and non-clinical) this means that we have had to ask that some colleagues be partially or fully redeployed, working in a different area for the benefit of patients and individuals. We have taken the learning from Wave 1 of the pandemic to make any redeployment as smooth as possible for the people affected. Redeployment decisions are being made with employees, taking into consideration people's skills and professions, as well as home and work circumstances, and we continue to ensure that the right communication and support is put in place.

We are a workforce dedicated to providing care and supporting patient and families in our communities. However, we appreciate that many of our team have home challenges. We are endeavouring to be as supportive and as flexible as possible to support our colleagues during this difficult time and continue to provide a range of wellbeing options. Given the increasing seriousness of the situation we have re-escalated the frequency of Gold calls to three a week, as part of our Emergency Preparedness, Resilience and Response. A contemporary update regarding vaccinations will be provided separately.

Key Appointments

Sadly Jon Pittam, Deputy Chair and Non-executive Director, will be leaving us at the end of his tenure on 31 March 2021. Jon has been a great advocate of Solent over the years and we would like to formally thank him for his support and contribution, a well as wishing him all the best for the future.

As part of succession planning for Jon's departure, Calum Mercer, will be joining us from 1 February 2021 as an Associate NED before commencing a substantive appointment from 1 April 2021. Calum has several years of experience as an executive and non-executive director in health and social care and a range of other sectors. Calum is the Finance and Operations Director at the Royal College of Psychiatrists and a non-executive director at the Legal Aid Agency (an agency of the Ministry of Justice that manages the legal aid service), Dimensions (the largest not for profit provider of support to people with learning disabilities and autism) and the Housing and Finance Institute (which supports the delivery of more homes and good homes across the country). Calum chairs the Audit and Risk Committees at Dimensions and the Legal Aid Agency.

In addition, the following appointments have been made within the Chief Medical Officer Directorate;

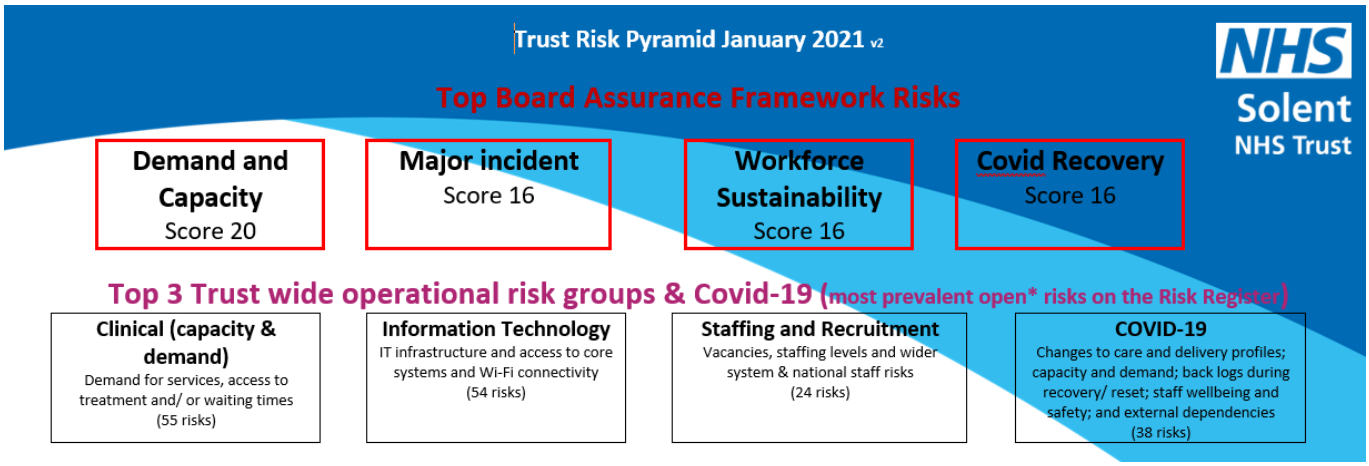
- Mark Kelsey, Associate Medical Officer, Primary Care
- Caroline Hutchings, Associate Medical Officer, Quality and the Professions

Mark is an established practicing GP within Southampton and is currently the chair of Southampton City CCG, a position he has held for a number of years. Mark also has leadership roles within the ICS supporting its digital strategy. He starts with us on 1 March 2021.

Caroline is a consultant in neuro-rehabilitation where she has worked for Solent for a number of years leading our specialist Snowdon and Kite units. Caroline has a real passion for patient safety and quality and has recently also been leading on medical appraisal within the trust.

Operational Risk Register / Board Assurance Framework

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



The risk pyramid summarises our key strategic and trust wide operational risks. The risks on the pyramid continue to move and change at a greater pace than before the Covid-19 pandemic.
There is a change to the Trust's overall risk profile - capacity and demand, staffing and recruitment and IT are now joined by the Covid risks as the most prevalent risk groups on the Risk Register. The Risk Pyramid has been updated to better present the Trust Covid risks, and now includes the top three Vaccination Programme risks.

Currently there are 38 (up from 37 in Dec) Covid specific related risks - these are risks that specifically reference Covid in their description. Eleven of these risks are classified as Very High, 23 High, 3 medium and 1 low. There are other existing risks that Covid may affect indirectly.
The 4 top themes of these risks remain:

- Changes to care and delivery profiles during Covid response e.g. video consultations rather than face to face, seeing urgent cases only and moving to working from home.
- Capacity, demand and back logs during recovery/ reset.
- Staff wellbeing and safety.
- Impact on external dependencies e.g. medical equipment spares.

A summary of the highest risks (scoring ≥ 12) 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 ↔ Target score achieved**	16
59	Business as Usual - Demand and Capacity	David Noyes & Suzannah Rosenberg	16	**20 ↑**	6
65	Covid Recovery	Dan Baylis	16	**16 ↑**	6
55	Workforce Sustainability	Jas Sohal	20	16 External / 12 internal **16 ↔**	12
63	Indirect Commercial Relationships	Gordon Fowler	20	16 External / 6 Internal **12 overall↔ Target score achieved**	12
58	Future organisational function	Andrew Strevens	20	**12↔**	6
53	Financial Sustainability	Gordon Fowler	25	**12 ↔**	6
62	Exec and Leadership capacity	Andrew Strevens	16	**12 ↔**	9
57	Quality Governance, Safety and Professional Standards	Jackie Ardley	20	**12↔**	8

Notably the mitigated risk score for BAF#59 Demand and Capacity has increased to 20 (previously 12) due to diminished capacity to meet demand as staff are redeployed and waiting lists impacted due to service reprioritisation as a consequence of the Wave 2 crisis.

Flu Vaccinations

Having vaccinated just over 90% of staff we continue to offer flu vaccinations to anyone who requests them, and this programme will run until the end of March aligned with the Covid vaccination.

Improving People Practices

A letter was received from the NHS Chief People Officer (CPO) on 1 December 2020 urging NHS organisations to review all disciplinary procedures against the recommendations made in a letter received from the Chair, NHS Improvement in May 2019.

We have made significant and progressive changes to our disciplinary procedures, with the introduction of decision-making tools to ensure consistent decision making and developing sensitive and compassionate approaches aligned to Just Culture principles. Formal action will be the exception, and where this is necessary, there will be continual consideration of health and wellbeing with the emphasis on learning and changing behaviours rather than punishment.
Our disciplinary policy has transformed into the new Improving & Managing Conduct Policy (HR13) and Improving & Managing Conduct Standard Operating Procedure (SOPHR13). In addition, we have made significant improvements to our Suspension Policy (HR41) and Procedure (SOPHR41).

Performance information regarding the operations of our care groups is shown within the Performance Report.

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

HIOW ICS update Link to BAF#58 – Organisational Function

The CEOs and key ICS leads are now meeting 3 times a week to ensure that there is good communication between organisations during this current wave of the COVID-19 pandemic. There is a good joint understanding of the health pressures and responses across the ICS.

An ICS response to the recent NHS England consultation has been submitted. A PSEH response, as well as a Solent response, were also submitted; both emphasised the need to place based care.

Portsmouth and South East Hampshire (PSEH) System Link to BAF#61 – Major Incident, #59- Demand and capacity

System leaders are meeting 7 days a week as occupancy levels at Portsmouth Hospitals University Trust (PHU) remain high and of concern. This is impacting flow through the hospital and ambulance transfers.

In support of the system Solent has opened additional capacity on our inpatient wards; 10 beds at Jubilee House and 7 beds on Spinnaker Ward. Having made the decision to stand down all non-urgent work, the redeployment of staff from other teams has been facilitated.

Plans are in place to increase the Portsmouth Rehabilitation and Reablement Team (PRRT) caseload by 20 but the team has suffered from high levels of covid and non covid sickness for several weeks and is at 55% capacity. Redeployees have augmented the team, but these staff are covering sickness rather than additional capacity at the current time.

Adults Services Portsmouth (ASP) has initiated a Covid Incident Room at Rodney Rd. This has facilitated greater co-ordination and rapid change to services to respond to system pressures. For example, under the leadership of the ASP Clinical Director and in partnership with primary care, the service has quickly developed a Covid Oxygen@Home service as an extension to the Covid Virtual Wards.

Southampton and South West Hampshire System Update Link to BAF#61 – Major Incident, #59- Demand and capacity

Our services have responded strongly to the challenges presented by the unfortunate acceleration and increased intensity of the Covid-19 virus, and we are making a significant contribution to the system

response. As well as working on additional bed capacity options at both the Western Community Hospital and Adelaide Health Centre (which the Board will recall we also converted for emergency use during Wave 1), we have already created an additional 20% of bed capacity by reconfiguring our existing community wards at the Royal South Hants Hospital and Western Hospital. We are applying the learning from Wave 1 and have once again reviewed all our services with a view to what elements we could either defer, scale back or cease. The review was clinically led, has been risk assessed and subjected to Quality Impact Assessments and is focused on meeting the system needs in the midst of this extraordinary crises.

Isle of Wight Update

Link to BAF#58 – Organisational Function and BAF#66- Partnerships

Mental Health Partnership

The partnership with Isle of Wight has now moved into the next phase of the transformation programme. Following the launch of the new 5-year Clinical Strategy, focus is now in the implementation of the new model. We continue to provide key senior leadership support into the divisional leadership team. Gordon Muvuti, Director of Partnerships will continue to work across both organisations and continue developing appropriate links between both organisations to support the partnership and its objectives.

Community Services

There is a desire to maintain pace, however planned engagement and joint events are currently constrained in light of the current pandemic crisis. A Programme Director has been appointed and will commence role in early February but will likely be limited in terms of their induction and physical engagement with front line services and clinicians as a result of the current situation.

National reviews and updates

Although the recent Ockenden Review focuses on those Trusts providing Maternity services we routinely review relevant recommendations following national reviews and from a variety of sources, including those summarised from NHS Providers and circulars from legal partners.

Planning for 2021/22

Link to BAF#53– Financial Sustainability

NHSE/I informed all Trusts in December that further information on FY21/22 Planning would be provided in January 2021. The letter stated key priorities for Trusts to plan for, but also stated that the full financial settlement for the NHS will not be confirmed until much closer to the beginning of the new financial year, reflecting uncertainty over direct Covid-19 costs. The letter further stated that Trusts must commence work early in the New Year to lay the foundation for recovery. Due to the ongoing pandemic there has been no further information provided and expectations are that this will be delayed.

Andrew Strevens
Acting CEO

NHS Solent NHS Trust

Board and Committee Cover Sheet

Item No.	7.2

Presentation to	*In Public Board Meeting*			
Title of Paper	Trust Board Performance Report – December 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 and operational indicators of quality, our workforce, finance and service hotspots.			
Author(s)	Sarah Howarth	Executive Sponsor	Andrew Strevens	
Date of Paper	22/01/2021	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 COVID-19 Response and Operational Performance Commentary

In light of the current pressures all NHS providers are facing due to the worsening position of the COVID-19 pandemic, this iteration of the Trust Board Performance Report follows a different format to usual. The Trust has taken a streamlined but focussed approach to performance governance during the COVID-19 response, emphasising attention on areas of performance that are most pertinent to the current climate.

COVID-19 Integrated Dashboard (section 1.2)

The COVID-19 Integrated Dashboard is updated and utilised daily by Senior Managers across the Trust. This brings together a range of key metrics vital to understanding the current workforce, quality and bed occupancy position across the Trust. The data presented in the COVID-19 Integrated Dashboard is correct as of 20 January 2021.

The COVID-19 Integrated Dashboard replaces the usual operations dashboards in this month's report. All key matters of note from the Integrated Dashboard are referenced within the respective commentary sections.

We have seen a significant impact on our workforce in this current wave of COVID-19, far greater than that seen during wave one. There have been more than 60 staff absent from work each day over the past month, with diagnosed COVID-19, as well as an additional cohort of staff in self-isolation or on leave due to carer or childcare responsibilities as a direct result of COVID-19. This has mostly affected service delivery and performance during January, so will be discussed in more detail in the next iteration of this report. Further information on workforce performance can be found in section 2.1.

The occupancy levels of our inpatient wards appears to show we have additional capacity, with a reported 79% capacity, however the majority of the remaining capacity is absorbed by areas where beds have had to be temporarily closed due to infection prevention and control measures. Bed occupancy is monitored closely both locally and across the Hampshire and Isle of Wight Integrated Care System (HIOW ICS) on a daily basis.

Since the start of the pandemic there have been six patient deaths on our inpatient wards where the patient has been COVID-19 positive. All deaths have been appropriately investigated and reported.

In recent weeks we have seen a reduction in our Statutory and Mandatory compliance whilst our workforce focusses efforts solely on the delivery of our core services. We currently monitor compliance on a 12-month basis, however there is no national requirement to do this. An internal decision has been agreed to extend renewal dates for core competencies for a further six months in recognition of the challenges we will face over the next few months.

Operational Performance

The seasonal Flu vaccination campaign has now come to a close once again. Solent have achieved well about the recommended threshold of staff receiving the vaccine, with 91% of front-line staff vaccinated, more than any previous year. This is a great achievement for the Trust. With regards to COVID-19 vaccinations, we are strictly prohibited from disclosing the number of staff who have received their vaccine.

Nosocomial COVID-19 Infections

There have been a number of COVID-19 outbreaks across both our community and mental health wards during the past two months. This is predominantly due to the increase in COVID-19 cases across the local area and is a challenge being faced by all NHS organisations at present. All necessary actions have been taken to protect staff and patients and all cases are managed in line with local and national Infection Prevention and Control guidance.

Waiting Times

The impact of COVID-19 on our waiting lists continues to worsen, with the impact in January likely to even more significant as staff absence has increased, and focus is shifted to priority service delivery. As a result of the continued concern around waiting list monitoring, a paper has been shared with the Trust Board this month to outline the challenges faced around waiting list management and monitoring. A brief summary of these issues is outlined below:

Referrals into Solent clinical services generate waiting lists which are managed via service line and care group governance structures. Within each waiting list there are clearly defined targets to see, treat and discharge patients.

There has been increasing demand on our services, historical cuts in community budgets and workforce pressures, all negatively impacting waiting times. More recently, the impact of COVID-19 has put unprecedented demand on services which has resulted in a surge in waiting lists as a consequence of: stopping or stepping back clinical services for mutual aid; higher levels of DNAs; reductions in workforce due to shielding, illness or childcare; reduced throughput and therefore capacity within clinics due to new infection prevention and control protocols.

Other considerations:

1. Waiting list governance - Numbers of patients waiting for care at Solent NHS Trust for more than 52 weeks appear to be an outlier in regional performance statistics. The “true” picture as believed to be the case by clinical directors is thought to be a very small fraction of this.

   The differential between the reported picture and the clinical picture is multifactorial including:

   - definitional issues
   - patient record configuration issues
   - logical processing issues
   - human error issues
   - data analytical issues
   - reporting constraints

   The Performance Team are working with clinical directors to resolve and mitigate the above listed issues to reach a point whereby the reported performance matches the clinical view.

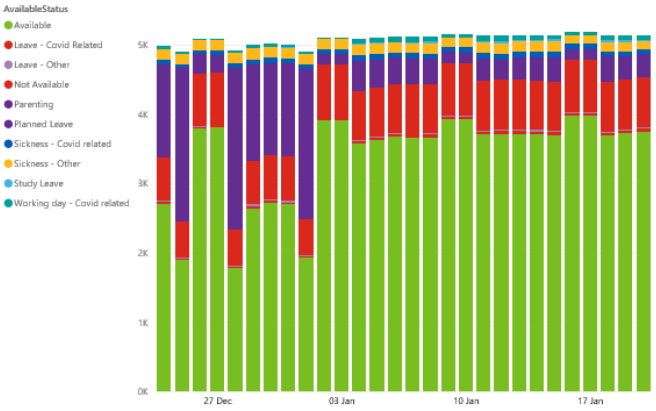
2. Consistent approach to waiting list targets - Although national guidance is lacking it was recently agreed that Solent’s waiting lists should follow the same targets as acute trusts (18 weeks) unless a clinical reason necessitates exception. These require review to ensure a consistent approach across the trust.

3. COVID-19 Impact - The latter half of 2020 saw significant effort in recovering waiting list positions following the first wave of COVID-19. Due to the impact of this second wave, it is inevitable that waiting list positions will deteriorate until this current pressure has passed.

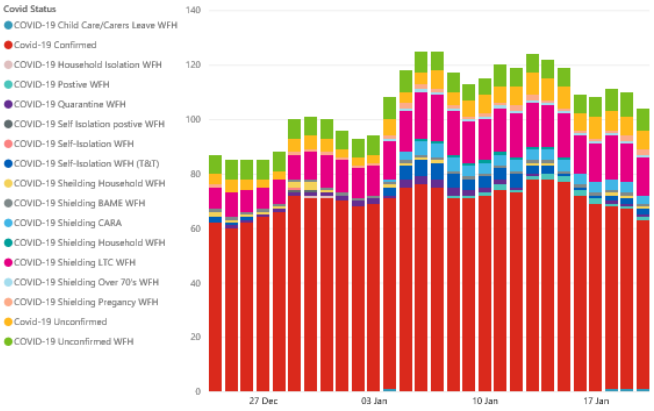
COVID-19 Integrated Dashboard

Solent NHS Trust

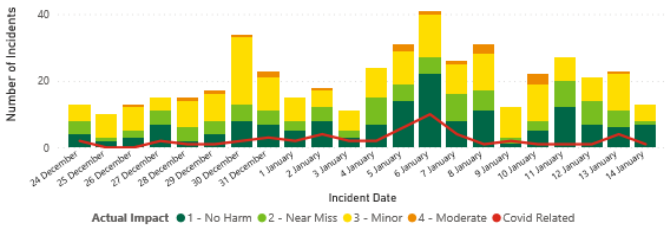
Workforce: Staff Availability (ESR)



Worforce: COVID-19 Related Absence (ESR)



Quality: Number of Incidents (Ulysses)



Operations: Inpatient Occupancy/ Capacity (SystmOne)

MOST RECENT POSITION

Cost Centre	Total Capacity	Total Occupied	Total DToC	Available Beds	Occupancy %
402550 Orchards PICU - Maples	10	7		3	70%
402555 Orchards Acute-Hawthorn	14	6		8	43%
403074 Lower Brambles Ward	19	12		7	63%
403076 Fanshawe Ward	11	11		0	100%
403080 Snowdon Ward	14	14		0	100%
403088 The Kite Unit	10	9	2	1	90%
403130 Spinnaker Ward	24	19		5	79%
403156 Brooker	22	18	1	4	82%
403160 Jubilee Hse Contnu Care	20	18		2	90%
405632 COVID19 Hamble House	0	0		0	NaN
405634 COVID19 Adelaide	0	0		0	NaN
Winter Resilience	0	0		0	NaN
Total	**144**	**114**	**3**		**79%**

Quality: Community Deaths

COVID-19 DEATHS (ULYSSES)

62

Quality: Inpatient Deaths

COVID-19 DEATHS (ULYSSES)

6

Quality: RIDDOR

FROM 01/04/2020

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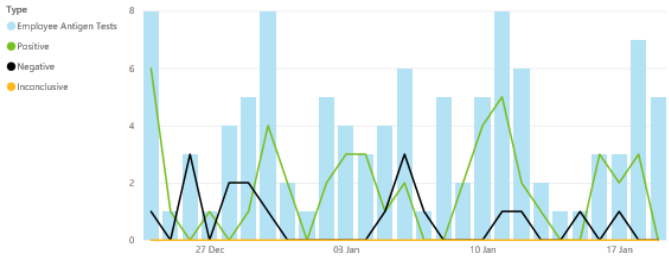
Worforce: COVID-19 Antigen Tests



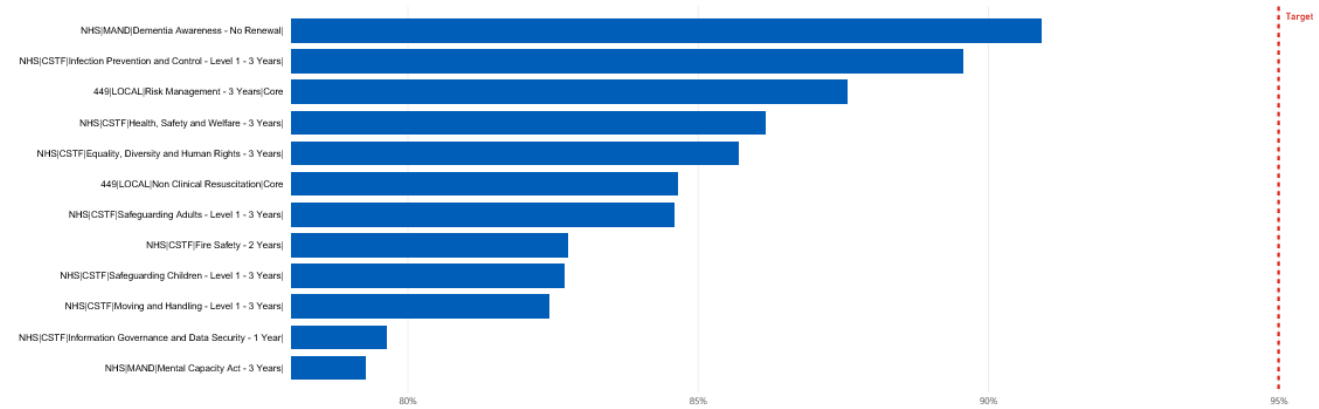
Workforce: Statutory & Mandatory Compliance

85%

Workforce: Clinical Supervision Compliant %

64%

Workforce: Statutory & Mandatory Training Compliance by Competency



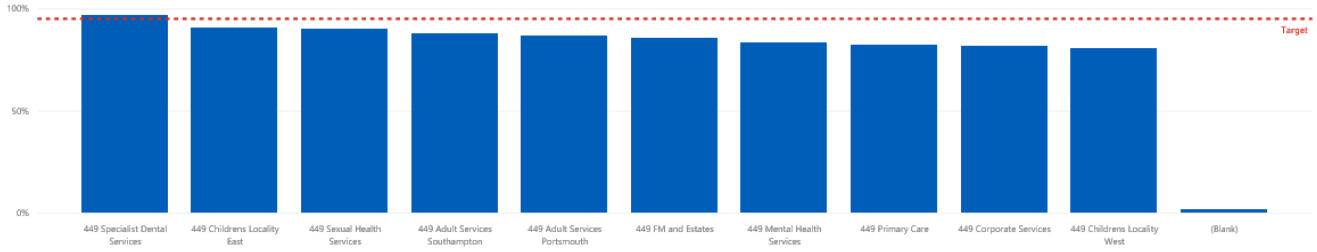
Workforce: Risk Assessment Completion for 'At Risk' Staff

92.6%

Workforce: Risk Assessment Completion for BAME Staff

100.0%

Workforce: Statutory and Mandatory Training Compliance Rate By Service Line



1.3 Chief Operating Officers' Commentary and Performance Subcommittee Exceptions

Performance Subcommittees in December

A decision was taken to stand down the Performance Review Meetings and the associated Performance Subcommittee meeting relating to December performance as a direct result of the pressures being felt across the Trust due to COVID-19. The Chief Operating Officers have provided their commentary on key areas as outlined below and any matters of urgent escalation are dealt with on an exceptional basis. Other items of operational performance have been picked up in section 1.1.

Southampton & County Wide Care Groups Chief Operating Officer's Commentary

Hampshire & Isle of Wight Military MH Alliance

The Alliance has expanded its geography from the Portsmouth area to cover the whole Hampshire & Isle of Wight now with over 35 member organisations. Under this umbrella, we have delivered a number of projects, such as for the Armed Forces Covenant Fund, a Tackling Serious Stress Programme, which in Q2 has supported 101 veterans and 9 family members at PositiveMinds, Solent Recovery College and Talking Change with demand beginning to reach pre-COVID levels again.

Development of the Veterans' Community Response Team (VCRT) with key partners is underway and we are awaiting a decision from Portsmouth Hospitals University Trust (PHUT) regarding plans to establish the Veterans' Alcohol Support Nurse service at QA Hospital.

Gambling and alcohol addiction support from Society of St James for serving Navy personnel has now been stood up and is currently providing support to 9 Royal Navy personnel, remotely at present due to Covid-19 restrictions but a base at HMS Nelson has been established and will provide face to face support when possible.

Mental Health First Aid & Suicide Awareness training sessions from We Are Hummingbird Health in partnership with Solent Mind for Navy personnel, have continued at HMS Nelson, Excellent, Sultan & Collingwood with over 60 personnel attending. Due to COVID-19 restrictions, delivery is currently online.

The PositiveMinds Naval Families Outreach Worker service is being developed and the first focus group of Naval families is planned for February.

Primary Care/MSK, Pain and Podiatry

We have recently been successful in being awarded contracts to deliver our Physiotherapy First Contact Practitioner (FCP) service into two new Primary Care Network (PCN) groups in Hampshire, both of which our outside of our current physiotherapy footprint.

As mentioned in the last Board report, compounded by the current resurgence in COVID-19, waiting lists for services such as MSK and Podiatry are continuing to worsen.

Children and Families West

The forecasted and previously reported rise in demand on our CAMHS provision is now being realised. During quarter 3 of 2020/21, our services received the highest number of referrals in a 3-month period to date, 513, approximately 200 higher than would have normally been expected. Despite recent investments in CAMHS to help mitigate the historic increasing trend of demand and presenting complexities, the nationally recognised issue of filling CAMHS clinical posts is a significant limiting factor. The service continues to explore innovative methods to improve recruitment, however immediate pressures are impacting waiting times on an increasing caseload size. The service continues to prioritise provision based on clinical need during the pandemic.

Special Care Dental Service

The current wave of COVID-19 has had a deleterious impact on the Special Care Dental Service, with very significant curtailment of our ability to conduct General Anaesthetic (GA) work and we have had to reduce our domiciliary service and Intravenous (IV) sedation service to urgent cases only. As previously described, it will likely take this service years to recover from the impact of COVID-19 on their waiting lists.

Solent East Care Group Chief Operating Officer's Commentary

Operational and Clinical Directors have assessed all service delivery to prioritise the continuation of urgent services and business critical functions as a result of the current COVID-19 response.

Adults Portsmouth

For Adults Portsmouth that has meant pausing some aspects of specialist services; Speech and Language Therapy, MSK, Bladder & Bowel, Community Neurological Services and Pulmonary Rehabilitation. All services continue to offer a level of triage to ensure that urgent referrals are not reviewed. A number of staff from these teams have already been redeployed to our inpatient services and Urgent Community Response service (PRRT). There will be an impact on waiting times for these services when we return to business as usual, which is a concern.

Mental Health

The Mental Health Services prioritisation focusses on safe staffing levels for the inpatient wards, Crisis and Home Treatment teams as well as offering more first assessment appointments and intensive case management. This will be achieved through new recruitment which is in train (including the Mental Health international recruitment programme) and moving staff between teams.

The national community transformation programme has been paused for six weeks as now is not the right time to be undertaking the significant co-production and redesign of mental health services with partners

Children and Families East

Lessons learned from the first wave of COVID-19 has led us to prioritise Health Visiting services due to safeguarding concerns. Services which will be partially paused are Neuro-diversity assessments, Paediatric Therapies and School Nursing (subject to commissioner approval Local Authority Public Health).

1.4 NHS Improvement Single Oversight Framework

Month: Dec-20

	Indicator Description	Internal / External Threshold	Threshold	Current Performance	Capability	Variance
Quality of Care Indicators						
Organisational Health	Staff sickness (rolling 12 months)	I	4%	4.6%	F	
	Staff turnover (rolling 12 months)	I	14%	11.1%	P	
	Staff Friends & Family Test - % Recommended Employer	I	80%	*	*	*
	Proportion of Temporary Staff (in month)	I	6%	6.2%	F	
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%	97.0%	P	
	Mental Health Friends & Family Test - % positive	E	95%	90.9%	?	
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%	69.6%	P	
	% clients in employment	E	5%	4.4%	?	
Safe	Occurrence of any Never Event	E	0	0	?	
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	1	?	
	VTE Risk Assessment	E	95%	97%	?	
	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%	99.3%	P	H
Maximum 6-week wait for diagnostic procedures	E	99%	54.0%	F	
Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0	P	
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50%	100.0%	?	
Data Quality Maturity Index (DQMI) - MHSDS dataset score**	E	95%	92.3%	F	
Improving Access to Psychological Therapies (IAPT)					
- Proportion of people completing treatment moving to recovery	E	50%	57.9%	P	
- Waiting time to begin treatment - within 6 weeks	E	75%	99.0%	P	
- Waiting time to begin treatment - within 18 weeks	E	95%	100.0%	P	

Use of Resources Score					
Use of Resources Score	E	2	1	P	

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

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

1.5 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 1.4):

Staff Sickness

The staff sickness indicator continues to indicate that without significant intervention, the target will not be achieved. The sickness rate has remained stable at 4.6% for the past 3 months. This is the lowest rate since July 2019. The current impact of the COVID-19 pandemic, however, has seen initial rates for January increase, due to the number of staff having to self-isolate, or being diagnosed with COVID-19. The full impact of this will be reported during the next Trust Board Performance Report for February. Further narrative on Workforce metrics can be found in the Workforce Dashboard Commentary (section 2.1).

Proportion of Temporary Staff (in month)

The proportion of temporary staffing used continues to be flagged as a 'Fail' against the Capability rating this month following 10 consecutive months above target. This period reflects the time in which COVID-19 has been prevalent and the subsequent impact this has had on staffing demands and availability. Further narrative on Workforce metrics can be found in the Workforce Dashboard Commentary (section 2.1).

Maximum 6 Week Wait for Diagnostics Procedures

Waiting times for Diagnostics procedures (applicable to the national DM01 submission) have flagged a 'Fail' on the capability rating following 8 months of significant under performance. Capacity has been reduced since the beginning of the COVID-19 response, and the action plan and trajectory put in place to restore this activity and associated performance has been significantly impacted by the national lockdown in November and the beginnings of the second wave. Solent continue to work closely with the third-party provider to monitor the waiting list backlog and ensure priority patients are appropriately triaged and seen.

Data Quality Maturity Index (DQMI) – Mental Health Services Dataset (MHSDS) Dataset Score

The DQMI score continues to be identified as a 'Fail' on the capability rating, as a result of non-achievement of the target. The DQMI score has remained at 92% since the tail end of 2019/20, since the focus shifted off of the DQMI. This was as a result of the national CQUIN scheme linked to this metric ending in March 2020. Discussions around the quality of the information within the MHSDS have taken a slight pause whilst all efforts are focussed on priority service delivery due to the second wave of COVID-19.

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

Maximum 18 weeks from referral to treatment (RTT) – incomplete pathways

The 18-week RTT target has flagged both a 'Pass' on the capability rating, and a 'Special Cause Note – High' on the Variance rating this month. This is as a result of six months of consistent improvement above the target. The services applicable to the 18-week RTT target have been operating under fairly normal circumstances for the period July to December 2020 although delivering some appropriate consultations via telephone or video call. It is possible that there may be a slight deterioration to this position in the next report given the current extreme pressures being

faced across all services. It also is worth noting that the numbers of new referrals into these services are around 20-25% lower than the equivalent months in 2019 (pre-COVID-19), meaning fewer patients require access to our services, making consistent achievement of the target more obtainable.

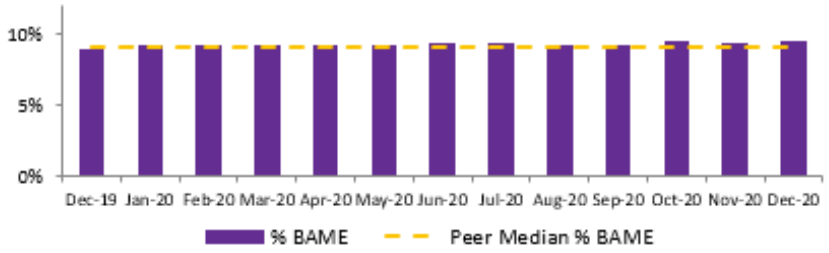
2.1 Workforce Integrated Performance Report

Month: Dec-20

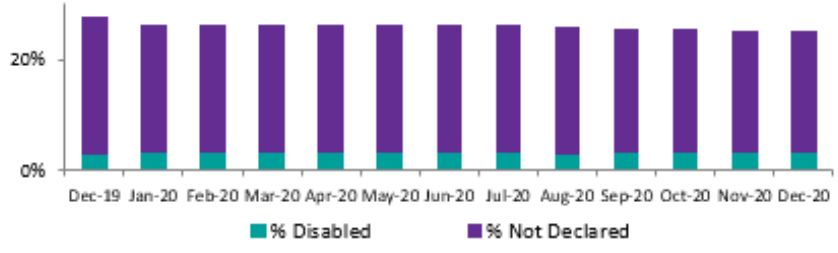
Planning

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

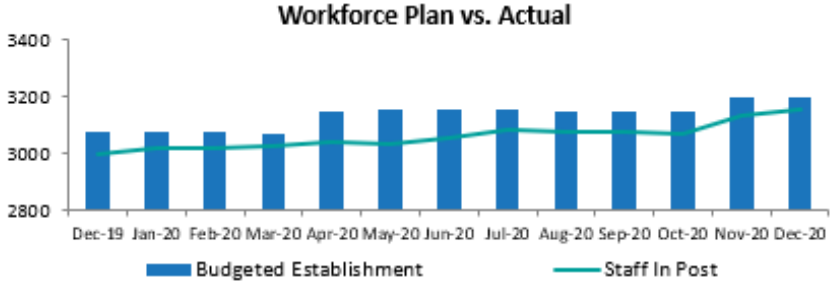
WRES



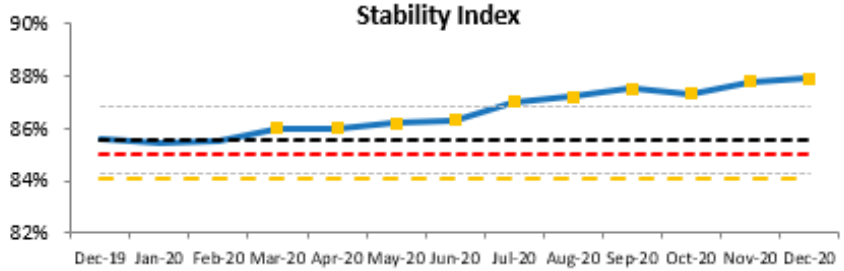
WDES



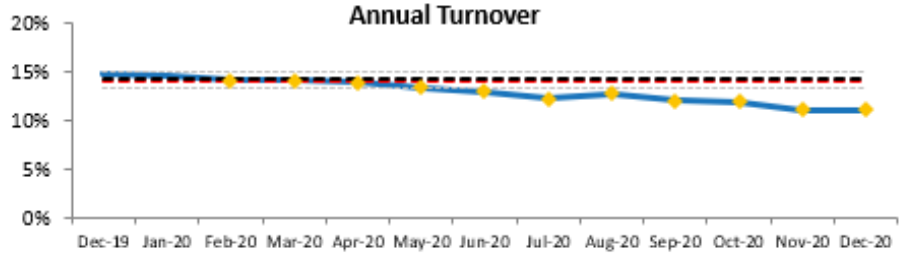
Actual vs. Planned

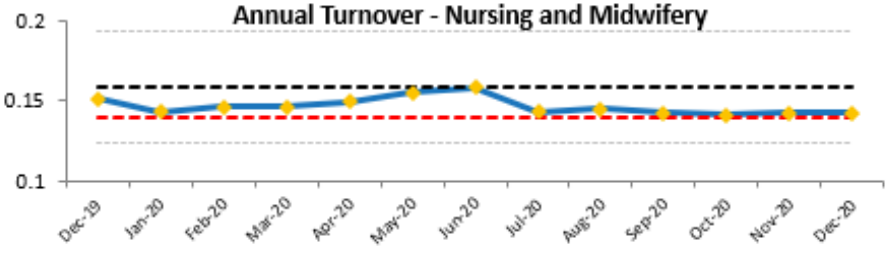


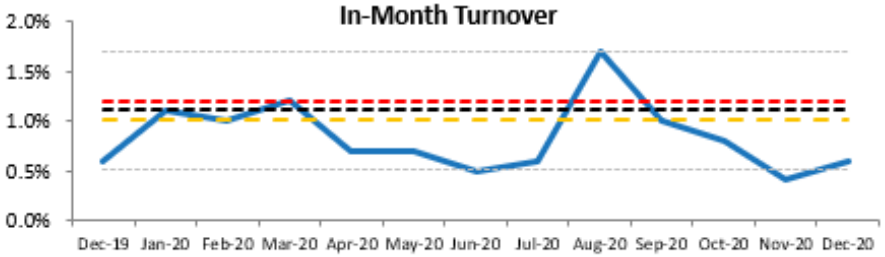
Stability Index



Turnover







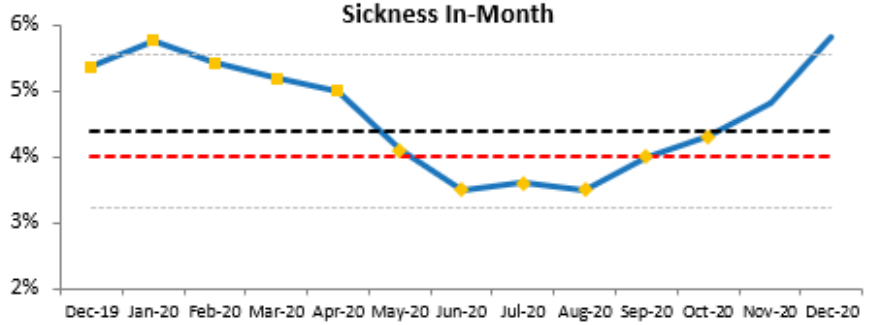
Overall, performance against the workforce plan is positive, however it should be noted that Budgeted Full Time Equivalent (FTE) in post for December is based upon a temporary budget plan. In Month 8, the increase in Budgeted Establishment (BE) relates to a TUPE in Childrens Services. Contingency planning has been undertaken to identify workforce requirements in order to meet surge requirements in response to COVID-19. Revised Solent, regional and system plans were submitted and approved in early October. Recruitment activity is progressing well to fulfil the workforce plans for M7 - M12. Stability continues on an upward trajectory and above the mean since April 2020. Our workforce annual turnover has reported below the mean since April 2020.

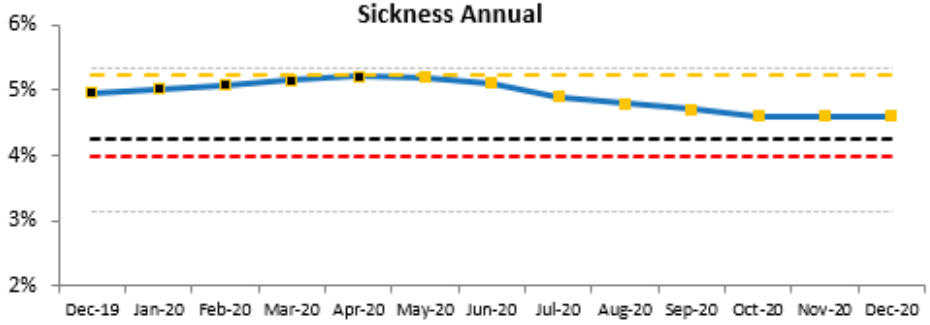
Deployment

Month: Dec-20

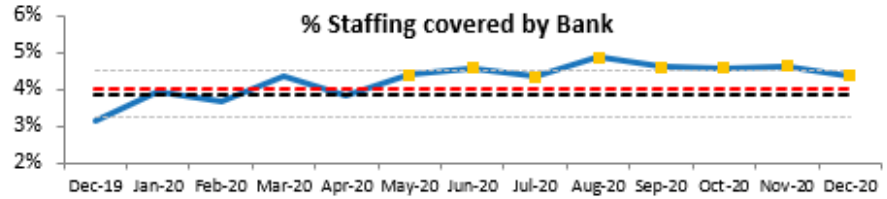
Key: Data | Target | Mean | Upper / Lower Control Limit | 6 Points Above/Below Mean | Rising/ Falling Trend (6 points) | Peer Median

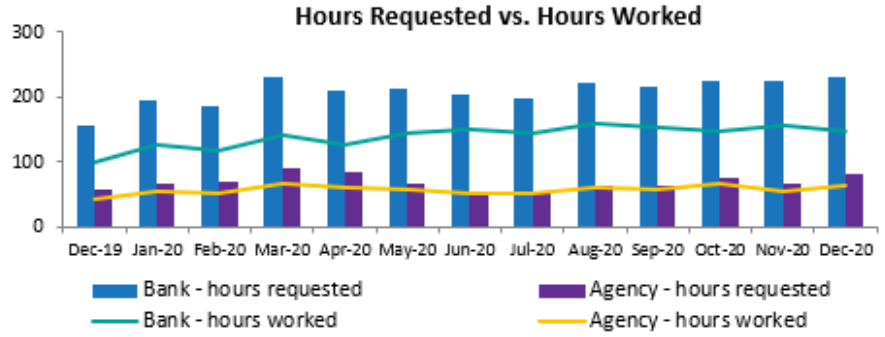
Sickness



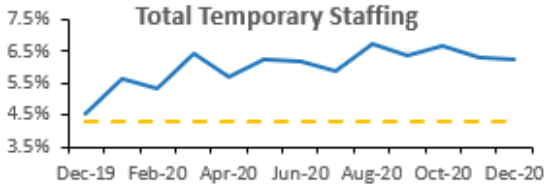


Bank & Agency





In Month Cost: Bank - £326140 Agency - £261653



Rostering

Current Position: 1 / 4

Sickness In Month - This has increased by 1% during December. A 0.8% increase due to COVID-19 related sickness absence from November to December.

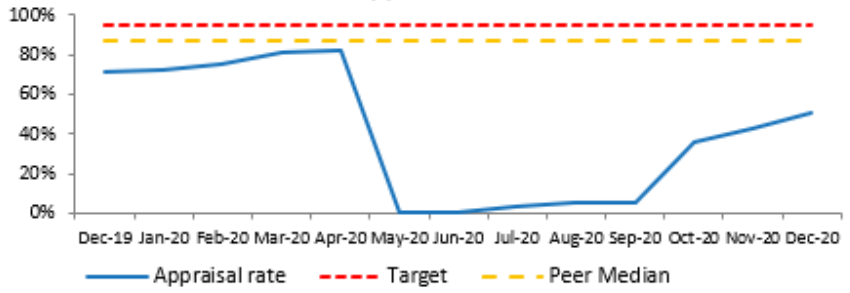
COVID-19 sickness will not be recognised in formal sickness management and additional support is in place for those suffering long term COVID-19 symptoms such as extended sick pay and phased return. Annual Sickness is reporting below the peer median and steadily decreasing since May 2020.

The total additional staffing (Bank & Agency) costs for December 2020 is £855,350.00 . Use of bank/agency has remained static throughout the month, with total demand for bank shifts at 5387 requested. Bank cover decreased in month to 69% of total requests and agency cover levels have increased to 24%. Focus is currently on bank recruitment to assist with both the Vaccination Hubs across Hampshire & Isle of Wight and also COVID-19 additional beds across our inpatient areas and potential opening of new wards. Bank requests remain extremely high across our inpatient areas due to COVID-19 related sickness of staff and high number of staff required to self-isolate. The numbers of agency placements booked has increased to support ward areas and allows them to have dedicated agency staff as part of staffing numbers.

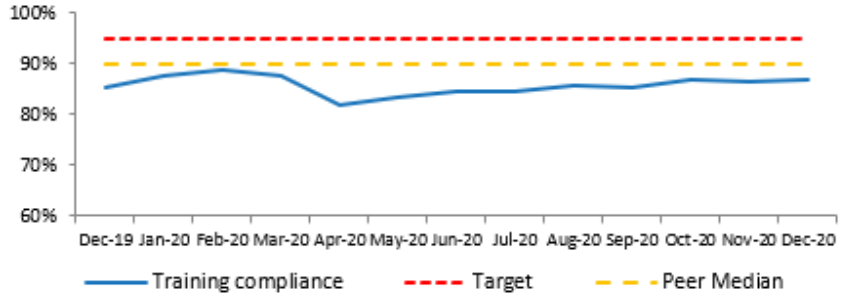
Development

Month: Dec-20

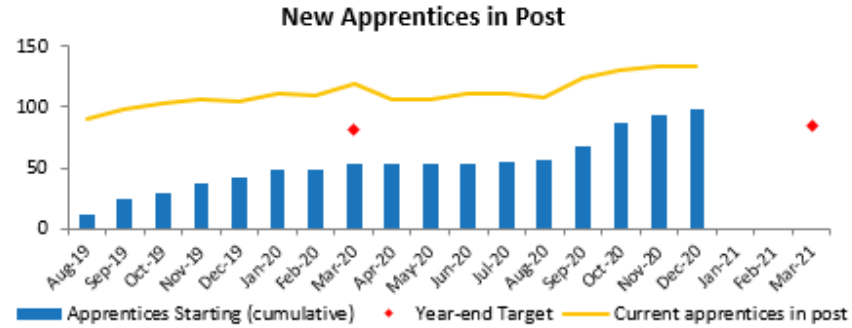
Appraisals



Stat & Mand Training



Apprentices



Engagement

Friends and Family Test (FFT)

Percentage of Staff who would recommend Solent as an Employer

80%

Q2 2019/20

Please note: Collection of Staff FFT has been paused during 2020/21 due to the COVID-19 pandemic.

Staff Survey

Percentage of Staff who would recommend Solent as an Employer

69%

2019/20

The statutory and mandatory training rate in December 2020 was 87% against a target of 90%. Mandatory and Statutory Training compliance is discussed at Performance Review Meetings, with the e-learning system cited as an obstacle to success. Reporting of training has moved onto BI and following service feedback a refreshed report has been designed and published. Appraisals for 2020/21 were due to be completed by the end of November. People partners continue to work with services to log appraisals and career conversations that have taken place. 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.

Manager Self Service has successfully launched on 1 October 2020 which enables all managers to have access to additional functionality and controls e.g. approving employee requests and maintaining assignment details and personal information.

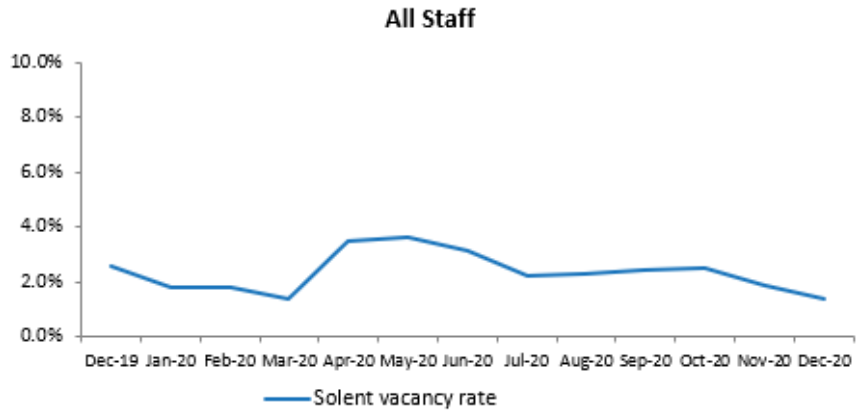
Procurement of the Learning Management System (LMS) is now complete and implementation commencing with a view to going live in April 2021. This will be a significant boost for morale, and will significantly strengthen our learning and development infrastructure.

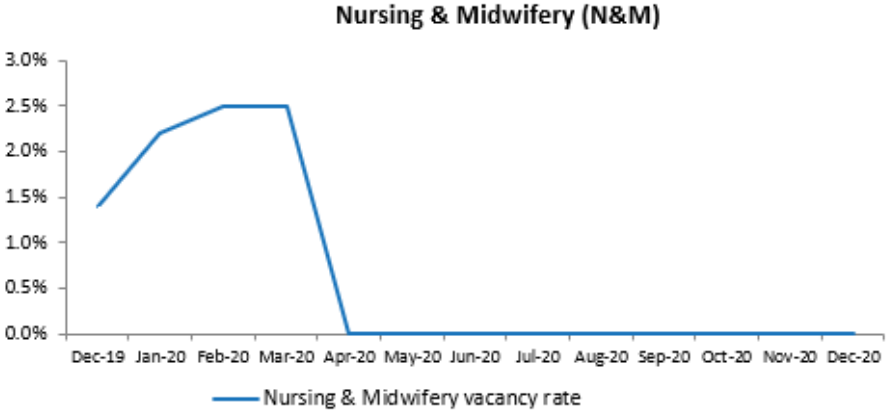
Increasing the intake of apprentices has been a focus for Q3 with apprentices due to join the trust during Q4. The aim is to increase the number of apprentices to 5% above target (35 across disciplines in 2020/21); we will be seeking to utilise apprenticeships as a structured pathway into the Trust, for career development, and this pipeline will also support succession planning and talent management.

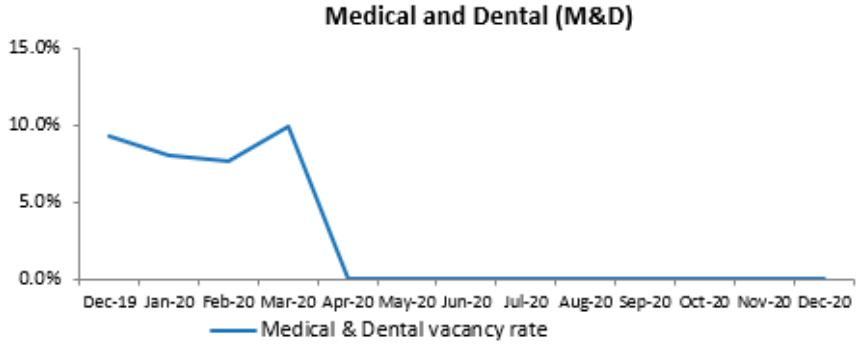
Acquisition

Month: Dec-20

Vacancy Rate







The current vacancy rate of 1.4% equates to 44.1 FTE across the trust, this has decreased from 1.9% in November. Vacancy rates are highest in Facilities Management and Estates (FME) at 16.2%. FME have opted to not fill substantive vacancies whilst redesigning team structure and continue to use bank and agency. Trust vacancy rate has slowly been decreasing since April 2020 when this was 3.5%. However, the R&R budgeted establishment is currently not included in these figures, R&R BE has increased from October 2020 – March 2021 meaning when the additional R&R BE is reflected in the reports we can expect the vacancy rate to rise. N&M and M&D Vacancy rates - Due to the impact of COVID-19, permanent budgets were not allocated to individual service lines or occupational groups and we are therefore unable to report this information at present.

Stability and turnover have improved generally in recent months. Evidence would suggest that people are not changing roles as frequently as they might due to unusual circumstances and the uncertain future of the economy. We are currently exploring a couple of options to create a pipeline of Mental Health Nurses in collaboration with International Global Learners Programme (Chief Nursing Officer led) and have offered to 8 Mental Health Nurses.

Leadership and Culture

Month: Dec-20

Learning

Procurement is now complete for the new Learning Management System. Project meetings have now commenced and IT requirements and site Branding sessions in progress. System training for the L&D team will commence shortly along with data uploads . The target implementation date is on track for the 1 April 2021. Trust Induction is still being offered virtually over zoom and from the start of December has been held weekly to manage the increase in numbers of staff joining the Trust. The session is a welcome to the organisation, covering the goals, values and benefits of working in Solent.

Engagement

December was used as an opportunity for employees to reflect on the year gone by and to recognise the magnitude of people's commitment and dedication. Our internal communications, which is key to building a culture of employee engagement, focussed on people within Solent reflecting on their experiences during 2020. As part of this work, a 'light up for Christmas' film was curated – the aim of the film was to shine a light on colleagues, as well as people in the community, that had supported others within Solent during 2020 – this content was also shared externally.

At Christmas time, the Acting CEO sent a small gift and thank you card to every employee as a clear sign of recognition. This small token of gratitude was really well received, with people taking to Team Solent on Facebook to express their thanks. The Acting CEO also shared an end of year message through the medium of film.

NHS England and Improvement has confirmed that NHS Staff Survey results are due in the first quarter of 2021. Work continues to ensure action planning happens at corporate and team level, with support provided to managers to assist them in having a good quality conversation with people in their team/s and to help with the creation of meaningful action plans.

Leadership

During November and December, 90 minute workshops were held over zoom for senior managers regarding virtual meetings management. These practical sessions were delivered by Hennesy Consulting and covered good practice for managing meetings as well as the technical side of running virtual meetings over zoom and MS teams. L&D took over the running of these sessions in January, although currently on hold due to the COVID-19 crises.

We are now promoting online guides for leaders and managers from the NHS Elect online offer via our Solnet page.

Inclusion

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. Work has started on implementing the Sexual Orientation Monitoring Standard across the Trust. Work continues on the anti-discrimination project. There was an extremely successful International Disabilities Day conference on 3 December and this included interactive forum theatre pieces by SimComm Academy. 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 through a Lived Experience Network which is run by our Occupational Health team which welcomes stories for people with any protected characteristics. The Diversity and Inclusion team and resource groups continue to support the COVID-19 risk assessment and are planning bespoke communications on the COVID-19 vaccine for the BAME community. Solent was also successful in its application to take part in the Reciprocal Mentoring programme run by the Leadership Academy. A pilot programme run by Hennessey Consulting on group coaching sessions for staff with protected characteristics has been put on hold due to the pandemic.

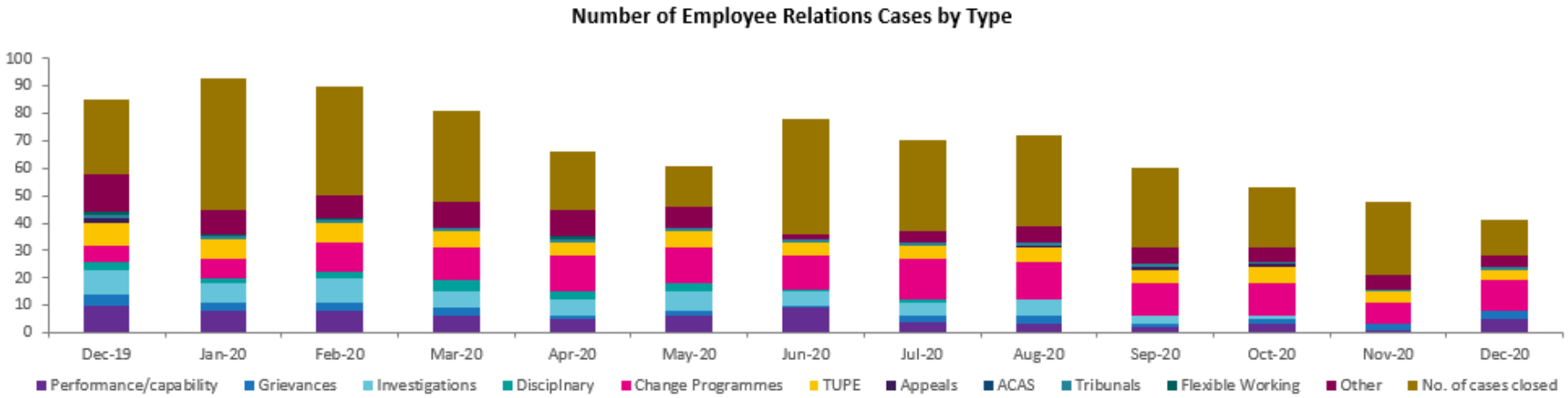
Wellbeing

Employee influenza vaccination programme is progressing well and as of Jan reached 91% of frontline staff.
Health and wellbeing strategy and the People and OD plan has been reviewed in line with the impact of COVID-19 and in light of the NHS People Plan. Health and wellbeing offer has been refreshed in light of additional pandemic challenges and this was launched early January.
Occupational Health and wellbeing services are continuously adjusting support mechanisms to meet the rapidly changing needs of the workforce.
Long COVID cases are increasing and continue to be support via the Occupational Health Long COVID support pathway.
Programme manager appointed for the Wellbeing Hub across HIOW. Project start date will be delayed due to the pandemic.

Change and Employee Relations

Month: Dec-20

Employee Relations



Across 2020 we have continued to see a decrease in the overall Employee Relations (ER) cases. There are 75 cases currently being managed during December by the team, an increase of 11 compared with November. We are managing a number of complex cases and have 15 cases of organisational change 4 of which are TUPE projects.

In the context of policy reviews; we now have in place refreshed policies which ensure people are at the centre of our response and to focus on promoting informal resolution. In line with the People Framework WOD document, the Resolution Policy, Improving and Managing Conduct Policy and Suspension, Exclusion or Transfer Policy were previously approved at Policy Steering Group and uploaded to SolNet on 18 December. The SOPs and toolkits were updated over the Christmas period ready for launch and comms in January. The first workshop held 16 September, with a further held on 9 December, supporting the upskilling of managers, with 98 of our managers attending the workshops. We are currently proceeding to work to establish a Just Culture, through a leadership development and manager skills programme in total; 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.

D&I ESR Data

People services are exploring reasons for non-completion of D&I fields in ESR, the majority of which relate to declaring a disability. A monthly reminder has been introduced in employee self service in December 2020 to encourage individuals to check their information and complete missing fields to enable us to understand our population and prioritise decisions about patient and employee services/support accordingly. An engagement campaign led by resource groups will take place in February 2021.

Diversity & Inclusion Fields completed in ESR

97.5%

Target - 100%

Notes

Month: Dec-20

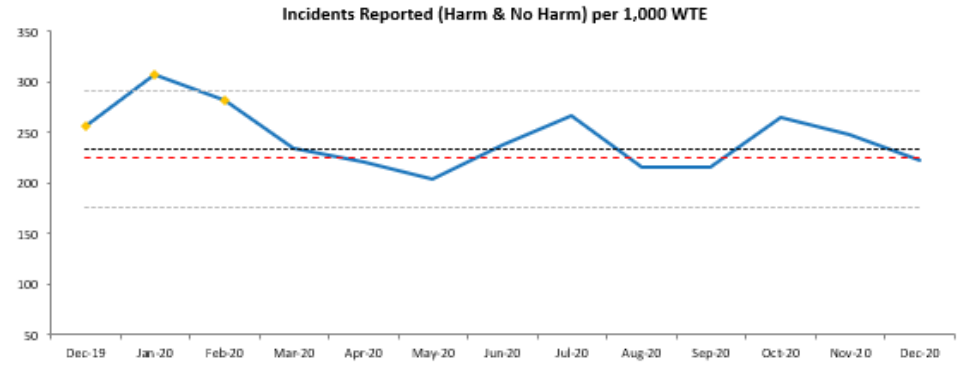
	Metric	Benchmark
Benchmarking	Workforce Ethnicity (WRES) - % of staff who are BAME	Peer median based on the trusts within our STP at March 2018
	Stability Index – Staff retention rate	Peer Median based on the trusts within our STP at January 2020
	Turnover In Month	Peer Median based on the trusts within our STP at January 2020
	Sickness Absence Rate (Annual)	Peer Median based on benchmarking against trusts of the same type at November 2019
	Proportion of Temporary Staffing	Peer Median based on benchmarking against trusts of the same type at November 2019
	Appraisal Rates	Peer median based on the trusts within our STP at March 2019
	Statutory & Mandatory Training Compliance	Peer median based on the trusts within our STP at March 2019

3.1 Quality Performance Dashboard

Month: Dec-20

Safe

Incident Reporting Rates



YTD	Moderate & Above Incidents	
2020-21	205	
2019-20	193	▲ 6.2%

YTD	Serious Incidents (SI) Raised	
2020-21	10	
2019-20	43	▼ 76.7%

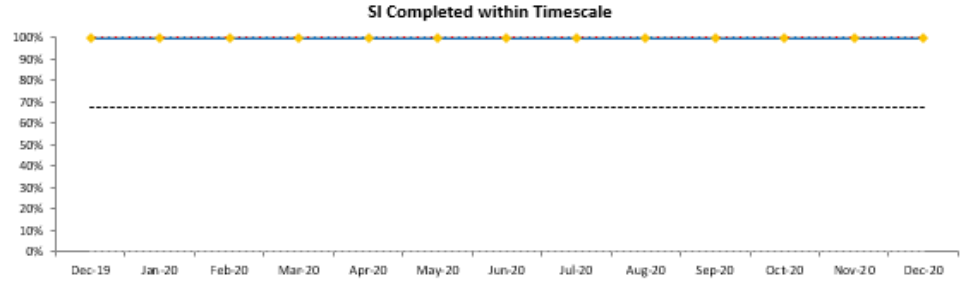
YTD	Physical/Verbal Assaults to Staff	
2020-21	323	
2019-20	519	▼ 37.8%

Narrative

The increase in moderate incidents when compared to the same time period in 2019/20 is in relation to Pressure Ulcers. Eight High Risk Incidents were declared during this time period. No themes or trends were identified. Five Serious Incidents were declared; three of these relate to COVID-19 outbreaks on seperate wards. The reduction in the reported physical and verbal assaults to staff is subject to a review by the Local Security Management Specialist.

Effective

SI Investigation and Closure



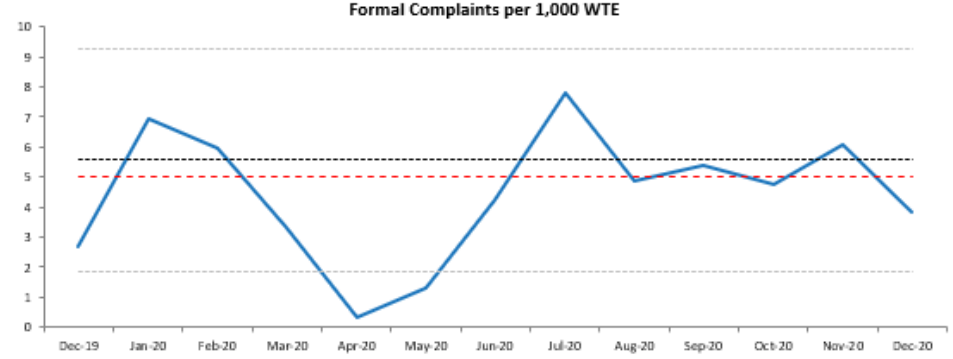
No associated data feed

Narrative

The Quality and Safety Team continue to work with Services to maintain 100& compliance.

Experience

Formal Complaint Rate



YTD	Complaints Received	
2020-21	110	
2019-20	114	▼ 3.5%

Complaints Closed to Timescale		
Target	Actual	
80%	67%	●

YTD	Unsolicited Plaudits	
2020-21	580	
2019-20	1150	▼ 49.6%

Narrative

Primary Care and Mental Health received the highest amount of complaints during November and December with Children's recording a significant reduction. Eleven complaints have been reopened. The PALS and Complaints Service Team reviewed the process for reopening complaints, this now involves a discussion with the complainant and the Service as of January 2021. The PALS and Complaints Team continue to work closely with services to ensure the complaint response date is recorded following the Services initial review and where this is not recorded, there is an escalation process. The reduction in plaudits is indicative of the changes to services during the Pandemic.

Key: Data | Benchmark | Mean | Upper / Lower Control Limit | 6 Points Above/Below Mean | 6 Points Continuously Rising/Falling

3.2 Chief Nurse Commentary

Current Events to Note

- The Infection Prevention & Control (IPC) team continue to support all services across the Trust to follow safe IPC practice and to follow the national guidance in relation to PPE.
- There have been outbreaks of COVID-19 in both our inpatient ward areas and our community teams. This is in large part due to the increase in cases seen across the region and is a feature across all NHS organisations currently. All actions required have been taken and the staff and patients are managed and supported in line with best practice. Two staff members have been hospitalised during the current outbreaks, but all are now home and recovering.
- The new variant COVID-19 strain is being seen in transmission across our region and the pressures on all NHS and Social Care services is significant. In response, plans are currently being mobilised to create additional bed capacity within the Trust and to redeploy staff within Solent services, as well as supporting our acute care colleagues.
- The increased bed capacity and the availability of staff to provide care is increasingly challenging as more staff are needing to self-isolate. Therefore, it has been necessary to review the safe staffing model through the Quality Impact Assessment (QIA) process and this is currently in train.
- In November 2020 we commenced the roll out of Lateral Flow testing (LFT) for staff, starting with priority areas, frontline staff and then support services. To date we have distributed 3,234 kits and have a waiting list of 261 people who we do not currently have kits for. This has been escalated to the national team.

Freedom to Speak Up

The Quarterly Freedom to Speak Up (FTSU) Oversight meeting, chaired by a Non-executive Director (Chair of the Audit and Risk Committee) and attended by the Chief Executive, Chief People Officer, Chief Nurse and our Independent Lead FTSU Guardian is now well-established. The Chief Nurse and Chief People Officer brief members and provide assurance that appropriate actions are being taken where any matters concern patient and staff safety and /or wellbeing.
Year to date, our Guardians have worked with the following cases:

- Quarter 1 – 12 cases
- Quarter 2 – 9 cases
- Quarter 3 – 7 cases

Whilst there has been a reduction this financial year in case numbers, the guardians have seen an increase in non-FTSU enquiries leading to guardians providing many informal supportive conversations.

Thematically the cases vary but more commonly involve behaviours and cultural issues rather than patient safety concerns. The added pressure of COVID-19 this year has seen a rise in wellbeing, infection prevention and flexibility related concerns.
The Oversight Committee has recently developed and agreed upon the future objectives for the department to focus on 3 key workstreams as follows:

- Review model for Freedom to Speak up/Cultural improvement delivery
- Widening agenda to connect with Service lines
- System work, external offer to wider system

Professional Leadership & Clinical Standards

Allied Health Professional (AHP) Job Planning

The work continues to deliver AHP job planning in time for the 1 April deadline. The COVID-19 second wave is however having an impact on the progress of this work which may lead to a delay in formally launching on 1 April. This will be reviewed considering the redeployment and response required currently as the system is in a major incident.

International recruitment

There has been significant positive progress in relation to international recruitment particularly to our Mental Health services. The Trust team have also been successful as part of a system bid, in securing additional resources to support the new recruits from a professional and a personal perspective, ensuring good pastoral care when they join us.

Community Engagement & Diversity and Inclusion Arm

Resource Groups

Interfaith week was celebrated in November and the multifaith resource group planned a week of activities for staff of all faiths and none. Highlights included the online Remembrance Day Service which was extremely well attended and the multifaith Question and Answer session. There have been numerous requests for this session to be repeated.

The Disability Resource Group coordinated the International Disabilities Day Conference on 3 December. This featured internal speakers as well as contributions from SimComm Academy and a specialist in disability hate crime. The forum theatre sessions facilitated by SimComm Academy were highly interactive and led to animated conversations and debate. The sunflower lanyard scheme was launched for those with invisible disabilities and allies.

Monitoring

An LGBT audit has been developed by the Diversity and Inclusion team. This is to be completed by the team and the LGBT resource group to identity gaps in practice and align the focus of work in this area. Work continues developing Sexual Orientation monitoring within Solent and engagement work is carrying on through the service lines.

Children's Services are progressing with their work to consistently record protected characteristics of their patients in order to provide better care and targeted services. Plans are underway to develop a short, animated, video on the importance of patient data collection which will be shared across Solent.

Coaching and Mentoring

Solent were successful in being selected to participate in the NHS Leadership Academy's Reciprocal Mentoring Programme. Onboarding call is scheduled for February before programme rollout. Pamela Permaloo-Bass has been working closely with Hennessey coaching to develop a group coaching programme for staff with protected characteristics. This is a pilot programme, but if successful it is anticipated that this will be reflected in our WRES and WDES data.

Performance

Incident Updates

We have continued to see more incidents being reported in November and December 2020 compared with 2018, but fewer compared with 2019. A trend first highlighted in the last report. There were 8.8% fewer incidents reported in November and December 2020 compared to 2019 but 4.5% more than in 2018. This is also replicated when looking at the year to date with 6972 incidents reported April to December 2020, compared to 6353 in 2018 and 7427 in 2019.

The upward trend in incidents categorised as Moderate has also continued, with 43 reported in 2020 compared with 37 in 2019 and 39 in 2018. Of the 43, 39 are Pressure Ulcers, category 3 and above - 9 reported by Adult Services Portsmouth and 30 by Adult Services Southampton. A review of Pressure Ulcers reported within the trust will be completed in January. Of the remaining four Moderate incidents, three concerned COVID-19 outbreaks on inpatient wards, which will be investigated as Serious Incidents, and the fourth concerned a patient of the Mental Health Service which is being investigated as a High-Risk Incident.

There have been 8 High Risk Incidents requiring investigation declared in November and December. One of note was an incident which highlighted the challenges our teams can face communicating with patients, in this instance the patient and carer were deaf, whilst adhering to the correct PPE guidance. Advice and innovative solutions have been shared across the Trust as an immediate action.

Our Learning from Incidents and Deaths Panel has also introduced an item reviewing incident data to identify trends or hotspots which require further investigation. November's Panel agreed to investigate the increasing number of incidents involving verbal or physical violence against staff, whilst December's saw the newly appointed Falls Prevention Lead for Solent, launch a project looking at Falls Prevention across the Trust in 2021. The aim of the investigations is to understand the individual experiences of staff and patients in these two areas and to determine what actions we can take that will make a difference in the future.

Serious Incident (SI) Update

In November and December, we declared five Serious Incident investigations. This compares to three in November/December 2019 and four in 2018.

One investigation concerned the death of a child who was a patient of the Children's West Service Line and is unconnected to the current COVID-19 outbreak.

However, the remaining four Serious incidents are all linked to COVID-19. One is an investigation into 7 distinct patients who require 24-hour, 7 day a week postural care. As a result of lockdown, this couldn't be provided in the normal way and each of the children has deteriorated as a result, with some requiring corrective surgery.

We have also declared three separate SI's as a result of COVID-19 outbreaks on inpatient wards at Jubilee House (Adult Services Portsmouth), Hawthorn Ward (Mental Health) and the Kite Unit (Adult Services Southampton). On each occasion the wards had to be closed to admissions and there were examples of Nosocomial Infection of patients. Immediate learning from these will be shared across the Trust to ensure our IPC procedures are robust as we move into the third wave of COVID-19 infections. The Quality & Governance Team are also reviewing the investigation process relating to multi-patient outbreaks, with the intention of streamlining this to ensure recommendations can be implemented rapidly and the outcome shared with patients or their next of kin.

The outcomes and learning from these investigations will be shared and discussed at the Learning from Incidents and Deaths Panels in February and March. The themes and identified learning will also be reported in the Patient Safety Quarterly Reports.

Experience of Care: Complaints Update

In November and December 2020, the Trust received a total of 29 formal Complaints, an increase of 4 from the previous two months. Primary Care and Mental Health received the highest amount of complaints with Children's Services recording a significant drop in complaints (from 11 to 3). The

complaints by service line are in the table below:

Service Line	November 2020	December 2020
Adults Portsmouth	1	1
Adults Southampton	1	2
Children's Services	1	2
Primary Care	5	3
Sexual Health	2	2
Adult Mental Health	4	2
Special Care Dentistry	2	0
Corporate	0	1
Total	**16**	**13**

Of the complaints received during November and December 2020, the themes relate to clinical (10; 4 PC, 2 SDS, 1 SH, 1 AMH, 1 ASP, 1x C&F), Communication (9; 3 PC, 2C&F, 1, AMH, 1, ASP, 1, ADS, 1, SHS) attitude of staff (7; 3 AMH, 1, Corporate, 1, PC, 1, ADS, 1, SHS) appointments (2; 1 AMH & 1 SHS) and general procedures (ADS).

One service concern was escalated to a formal complaint, at the request of the complainant. 64 Service Concerns were received this period, the same as the previous two months. Most of these concerns were for Children's Services relating to communication, and in Sexual Health, relating to appointments and communication. Four Professional Feedbacks were received, 2 for Primary Care and 2 for AMH, relating to Communication, attitude of staff or general procedures.

A total of 21 complaints have been closed during this period. Four were upheld, 13 partially upheld and 1 not upheld. As of the end of December, the team have 22 open Complaints. Following a review of the process for re-opening complaints by the PALS and Complaints team and following a discussion with the Service and the Complainant it has been agreed that eleven complaints have been reopened. A deep dive into the re-opened complaints is in progress.

One case is currently at the PHSO preliminary assessment stage. This case was brought to the PHSO in July. We have provided the information they require.

The PALs and Complaints team have achieved 97% acknowledgement of new complaints within 3 working days.

Friends and Family Test (FFT)

NHS England announced the relaunch of the new FFT with survey collection to resume on 1 December 2020, with figures due to be submitted the first week in January 2021. Urgent work related to the COVID-19 pandemic has led to a delayed target date for national submission, now rescheduled to February 2021. Further arrangements are detailed below:

- For **community and mental health services** data for the submission system will open on 1 February for both December and January data submissions.
- From February onwards, the process for all these settings will revert to the normal submission deadlines.

Month	No of responses	Recommend	Not recommend	Issues re "not recommend"
Nov 20	269	259	2	• Having to wait a considerable time for the phone to be answered. • Waiting list for appointment,
Dec 20	307	297	6	• COVID-19 situation caused delay in getting an urgent appointment • Appointments cancelled • No appointments available • Waiting time during pandemic

Overall, the total number of responses has increased during November - December (576) compared to the previous months of September - October (510). A breakdown of the responses received during this period is detailed below:

Number of responses received via each mode of collection							
SMS/ Text/ Smartphone app	Electronic tablet/ Kiosk	Paper/ Postcard in care/at discharge	Paper survey sent to home	Telephone survey	Online survey	Other	
0	0	557	0	0	19	0	576

4.1 Chief Finance Officer Commentary

Month 9 Results

The Trust is reporting an in-month adjusted deficit of £103k, £258k favourable plan and YTD adjusted surplus of £188k, £590k favourable to plan. The in-month and YTD variances are predominantly due to a reduction in COVID-19 costs and lower pay costs for investments due to continued delays in recruitment. The expectation is that COVID-19 costs will increase in response to the second wave.

COVID-19 Expenditure

The Trust has incurred additional revenue and capital expenditure linked to COVID-19. YTD revenue expenditure reached £7.6m 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, extra cleaning protocols and Grab & Go bags for frontline staff.

The Trust received reimbursement of actual COVID-19 expenditure for M1-M6 which has been replaced by an allocation of block funding for COVID-19 for M7-M12.

Of the £1.5m COVID-19 capital projects covering work in March-September, the remaining £0.1m not yet approved is awaiting final DHSC approval, which is expected by the end of January.

Capital

The Trust's CRL for 2020-21 is £9.5m, consists of £5.2m of internally generated funding and £4.3m PDC and COVID-19 funding.

YTD spend is currently tracking behind plan due to delays on several projects, but they are all expected to catch up during quarter four. The remaining forecast is being closely monitored to ensure the Trust's capital spend is on plan at year end.

In addition to the above the Trust has received approval of a further £2.4m mental health funding to be utilised on Orchards Ward improvements project in this financial year.

Cash

The cash balance was £37m at 31 December, £8.0m favourable to plan. The increase is due to further receipt of advance top up and COVID-19 funding following changes to financial regime arrangements in the second half of this financial year and slower than expected capital spend YTD. The cash flow balance is due to reduce to £17m at the end of this financial year as the advance arrangement of income receipts is assumed to end in February 2021.

Financial regime for 2021/22 is not yet known and therefore, the current rolling 12-month cash flow forecast assumes that the cash inflow and outflows will continue at this year's level subject to inflationary increase as appropriate.

Aged Debt

The Trust's total debt was £8.5m at the end of December, an increase of £4.9m on November which was largely due to several invoices becoming 31-60 days overdue, expected to be settled in January. 91+ day overdue debt at the end of month was £0.4m.

5.1 NHS Provider Licence – Self Certification 2020/21 – January 2021

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 currently substantively filled, however our Audit & Risk Committee NED chair leaves at the end of their tenure, 31 March 2021. We have therefore successfully recruited in accordance with succession planning – and our incoming colleague commences 1 February 2021 as Associate NED to ensure appropriate handover before commencing in role substantively from 1 April 2021. NED Committee membership and composition will therefore be reconsidered accordingly. In September 2020, the Board considered and amended its executive composition and that of its Committees following interim leadership changes

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 M1-M6 2020/21 all providers will be supported to produce a breakeven position, with all reasonable expenditure reimbursed. Focus for M7-M12 had been on the Phase 3 Recovery and Restoration system plans with block payments. The main change was the removal of additional top-up payments to breakeven, replaced by allocation of block funding for Covid-19, basic top-up and growth income. Solent had been asked to deliver greater activity to support the various ICPs it covers which resulted in a planned investment of c£2m above the funding arrangements. However, since late December, the national pandemic situation has worsened and therefore Solent has reprioritised its plans to focus on vaccination centres, urgent response services, inpatient facilities, mental health and mutual aid to partners; to increase capacity staff are able to carry forward more leave, or sell it to the Trust. This will have an impact on our finances, which is being worked through.

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.

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 currently substantively filled, however our Audit & Risk Committee NED chair leaves at the end of their tenure, 31 March 2021. We have therefore successfully recruited in accordance with succession planning – and our incoming colleague commences 1 February 2021 as Associate NED to ensure appropriate handover before commencing in role substantively from 1 April 2021. NED Committee membership and composition will therefore be reconsidered accordingly. In September 2020, the Board considered and amended its executive composition and that of its Committees following interim leadership changes

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.

Board and Committee Cover Sheet

Item 7.3.1

NHS Solent NHS Trust

Item No.	7.3.1					
Presentation to	Solent NHS Trust Board					
Title of Paper	Infection Prevention and Control Board Assurance Framework (BAF)					
Purpose of the Paper	To provide assurance to Board of Solent NHS Trusts compliance with PHE and other Covid-19 related infection prevention and control guidance following an updated self-assessment of compliance within the national "Infection Prevention and Control Board Assurance Framework". This update was finalised in January 2021 following feedback from QIR and Assurance Committee. A final review by all Heads of Professions has informed this final submission. This paper represents a trust wide summary with details of Service Line level evidence available as needed.					
Author(s)	Angela Anderson, Associate Nurse Director, Chief Nurse Directorate		Executive Sponsor	Jackie Ardley, Chief Nurse		
Date of Paper	01/02/21		Committees/Groups previously presented	QIR and Assurance Committee		
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	x
Summary of key messages / findings	**Background** As our understanding of Covid-19 has developed, national guidance has continued to be refined and updated to reflect this learning. Recognising this, NHS England have developed a framework to enable providers to assess themselves against the latest guidance as a source of internal assurance that quality standards are being maintained. This process also enables the identification of areas of risk and corrective actions to be taken to mitigate. This is a continual process. Solent have adopted this process to evidence how as an organisation we have implemented the national guidance in relation to Covid-19 to ensure the safety of our patients, service users and staff are maintained. The IPC Board Assurance Framework (BAF) following review was last submitted to Board in May 2020. Following publication of a revised version of the IPC BAF (version 1.4), Solent have worked with services to review adherence, potential gaps in assurance and actions to mitigate. It should be noted that based on the national adjustments in guidance, the parameters outlined within the framework do change following publication of a later version. Therefore, the review completed includes a number of new parameters for assessment in line with revised guidance. The findings of this latest assessment are detailed within the attached IPC BAF. This represents a summary presentation of evidence identified, with Service specific IPC BAFs and associated evidence held by Service Lines. The content of this framework continues to be reviewed at a Service Line level and oversight maintained through Service Line Governance meetings. **Findings** Based on the revised version 1.4 recently published, Solent IPC team have worked with Service Lines and associated corporate services to review the adherence to all key lines of enquiry, documenting evidence within alongside potential gaps in assurance and mitigating actions. The summary of findings is detailed within with evidence provided against each of the key lines of enquiry. A series of 12 actions have been identified to provide additional assurance with Service Lines and IPC team overseeing delivery of these. The IPC BAF has been shared with QIR and Assurance Committee following which Heads of Quality and Professions were asked to review the revisions again to ensure our latest actions are captured accurately. **Recommendations** The Board are asked to note and review the attached IPC BAF to: • Fully support the contents of the self-assessment					

	• Fully support the actions/priorities identified within • Based on current self-assessment, acknowledge the IPC BAF as a record of assurance			
Action Required	For decision?	Y	For assurance?	Y
Summary of Recommendations	The Board are asked to note and review the attached IPC BAF to: • Fully support the contents of the self-assessment • Fully support the actions/priorities identified within • Based on current self-assessment, acknowledge the IPC BAF as a record of assurance			

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 Board are 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	Jackie Ardley, Chief Nurse							

Publications approval reference: 001559

Item 7.3.2

Infection prevention and control board assurance framework

Draft (January 2021)

Not yet been approved by Solent NHS Trust Board (scheduled for Board 1st February 2021)

January 2021, Version 1.4

Completed by Solent NHS Trust

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

• **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. Outcomes of risk assessments are recorded within the patient records. In our inpatient areas all new admissions are swabbed and isolated. Inpatient areas have completed risk assessments and have provided written information for visitors. Some areas have introduced visitor contact sheets. Out-Patient based services have introduced telephone screening. If they answer 'Yes' to any of the questions, they are spoken to by a clinician remotely and their care deferred unless not clinically appropriate to do so. In some services, e.g. sexual health, if specific patients do need to attend, a pathway is in place to ensure they can be isolated in one room and all care than can be done remotely ahead of their attendance, will have been done. 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 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.	There are some challenges with staff adhering to PPE guidelines. Practice can vary 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. Audits are not completed consistently across all service lines 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 National guidance is available to all staff via the Trust intranet (including clear written guidance available to specific clinical areas where needed) Expert infection, prevention and control (IPC) advice is available to all services. Specific sessions have been offered to staff by Chief Nurse and IPC lead. Some services have established regular meetings with the IPC champions alongside weekly audits to demonstrate staff are adhering to the PPE.

	All staff have access to PPE within the home All clinic activity that is due to be restarted will be have a full risk assessment conducted in collaboration with estates and links have been established with the non-emergency patient transport provider. Specialist dental services have clear pathways of care in place across all sites In collaboration with IPC lead, patient admission criteria and cohorting of patients are developed to enable Covid positive ward, covid recovery ward and negative patients.		All non-Covid patients continue to be swabbed as per trust guidance.
Further actions:	- **To review Standard Operating Procedures (SOPs) across all Service Lines to ensure consistency of approach where appropriate.** - **To enable audits to be completed across all areas to demonstrate compliance with requirements**		
• **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 Relevant QIA's for variances to national 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	In some cases, Service lines are not completing all swabs prior to acute transfers of care Not all areas provide written guidance in the form of a SOP for staff	All national guidance has been shared with the relevant inpatient areas for reference. IPC team provide advice and support to services

Further actions:	- **To review Standard Operating Procedures (SOPs) across all Service Lines to ensure guidance in place.** - **To audit completion of swabs to identify any additional actions to be taken**		
• **monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice**	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) 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	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. Service lines have IPC Link leads established for further dissemination of information. The Head of IPC attends regular meetings with the HQPs to update and answer queries. Zoom calls with Head of IPC & CN/CEO are provided regularly for frontline staff to ask questions Bespoke update training sessions provided to teams by IPC team
• **monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety**	PPE stocks are monitored through our procurement team and is used in line with 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	One Service Line has identified that the link nurse role varies across their services. Need to establish a robust cohort of experienced IPC link nurses.	Regular reminder messaging is sent out and any updates also shared.

champions to embed and encourage best practice	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 Matrons, Ward managers and team leaders undertake clinical walk around and spot checks to monitor compliance and pick up breaches, communicate with teams to sustain culture of compassionate peer challenge if they identify poor practise.		Daily communications out to all staff and IPC have interpreted the guidance and provided on site advice and support Don & Doff videos made for staff and there is a PPE hub available to staff to collect additional PPE if running out. This is also available at weekends Regular audits now established by IPC link advisors to inform actions taken and provide assurance of adherence to guidelines. Staff have been trained in use of PPE by IPC in skills slots which are continually cascaded. IPC visit wards to ensure adherence weekly and any gaps are addressed immediately. Guidance is displayed around ward areas to ensure staff are aware of what PPE to use in every area and any interventions.
• **staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase**	Strategies in place through trust guidance and occupational health regarding testing symptomatic staff. Some Service Lines have a remote working SOP in place for staff needing to isolate or who are well enough to work from home.	No gaps in assurance identified.	National guidance is available via Trust intranet There is access to the full suite of Trust IPC policies

	Within relevant services, staff have been supplied with lateral flow testing kits. Training in the use of testing kits and process of reporting in place. IPC are made aware of any staff or patients of concern/at risk Covid19 and this information is cascade via a Daily Operations and Escalations call.		IPC team provide advice and support where required and review practice against all relevant guidance
• **IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training**	All wards have an induction program in which IPC is covered Staff induction packs at Service Line level have been updated to include Covid-19 precautions and use of PPE	Covid 19 is not covered in mandatory training. Local services are covering IPC measures although there is not a standardised induction programme	Managers ensure staff have an induction process which includes IPC and Covid 19 IPC link nurses available to support IPC team provide advice where required.
Further actions:	- Consideration of trust wide induction training associated with Covid-19 to support Service line level actions.		
• **all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work**	Staff are reminded through a range of communication mediums – Q&A sessions, Locality Team Meetings, Education sessions, trust wide and local newsletters, Solent Comms, Zoom calls and sessions. The trust follows national guidance. Environmental changes have been implemented to support social distancing and revised ways of working such as home working to reduce staffing numbers Guidance is apparent throughout service areas and team discussions and skills slots address any difficulties staff have experience with using PPE in and out of work. Staff are actively encouraged to challenge poor practice.	No gaps in assurance noted. Due to the nature of the In-Patient workload assurance cannot be fully given that physical distance is maintained	Various methods and frequency of communication. Service lead walk rounds Peer Challenge and support. IPC link nurses and IPC spot checks Where physical distance is compromised the correct use of face masks is complied with.
• **all staff (clinical and non-clinical) are trained in putting on and**	PPE stocks are monitored through our procurement team and is used in line with national guidance	No gaps identified	IPC team carry out spot checks and visits, escalation of non-adherence is reported, and poor

removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per 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 which is used to ensure services always have enough PPE available including at weekends Staff have been trained in 'Donning & Doffing' through trust training material. In addition, IPC link nurses have covered this within service for individuals needing additional support.		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 identified.	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 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**	Full briefing provided in the Chief nurse report to Board and the Q3 & Q4 IPC report taken through usual governance routes	The BAF includes an overarching risk associated with Covid which the Board are sighted on. Local governance processes	Daily access to executive Directors for escalation of risks and concerns

	mitigating actions are highlighted	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	within service lines and through IPC group will continue to consider, record and mitigate risks as they arise	
•	**risks are reflected in risk registers and the Board Assurance Framework where appropriate**	There is a risk identified on the BAF relating to Covid and its impact on services. Specific Service risks have also been identified including "Lack of suitable handwashing facilities, staff currently use the patients sinks" within Adults Portsmouth.	No gaps identified	See above
•	**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.	No gaps identified	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 have been identified. The appropriateness of these link advisors has recently been reviewed.
•	**NEW - that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing**	The Trust emergency planning lead and our Head of IPC review all guidance and submissions and any changes are signed off by the Chief Nurse/DIPC and CMO.	No gaps identified	Daily access to executive Directors for escalation of risks and concerns

of patient protocols are activated in a timely manner.			
• **NEW - ensure Trust Board has oversight of ongoing outbreaks and action plans.**	Within specific areas an Outbreak group has been mobilised to assess, plan, implement and evaluate any nosocomial infections. Service lines report and escalate concerns up through quality improvement, daily operation and escalation and risk group via Gold Command where required/appropriate	No gaps identified	Daily access to executive Directors for escalation of risks and concerns
• **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 November 2020 was 90% and hand washing was 88% 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 In collaboration with IPC lead, patient admission criteria and cohorting of patients are developed to enable Covid positive ward, covid recovery ward and negative patients. There are designated ward 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

• **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. Scheduled audits undertaken by FM Supervisors FM Support Services, Audit and Compliance Manager	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.
• **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	For non-Solent sites we have increased the frequency of cleaning where we manage the cleaning service If issues are raised to the premise manager our FM Manager will undertake an audit and co-ordinate increased cleaning frequencies where necessary

• **NEW - cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses**	National guidance has been implemented across the Trust. The IPC are in regular contact with the 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 Solent use Actichlor and the requirement is included on the Actichlor touch point cleaning schedule and cleaning are formally recorded. Services are using Green Clinell wipes as per guidance in clinical areas. Yellow Clinell wipes are used in non-clinical / non-patient areas as per IPC guidance received.	No gaps in assurance	All teams have the support of the IPC team as well as materials management.
• **NEW - Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance**	Manufacturers COSHH Assessment sheets are followed and training is undertaken at induction and at regular toolbox talks and training is recorded for each staff member within estates. Solutions made daily and labelled by staff with expiry date for decontamination use	No gaps in assurance	
• **NEW - frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when**	Requirement is included on the cleaning schedules and recorded on the cleaning checklist. In clinical out-patient areas all surfaces are cleaned between patients;	To confirm twice daily decontamination is in place for non-clinical areas.	Monitoring through walk arounds and checklists IPC team carry out regular ATP scoring and feedback to teams.

known to be contaminated with secretions, excretions or body fluids			
Action to be taken	To confirm twice daily decontamination is in place for non-clinical areas.		
• **NEW - electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily**	Staff are cleaning equipment twice daily / before and after individual use.	No gaps identified	Staff carry out regular cleaning of 'hot spot items or areas. IPC team carry out regular ATP scoring and feedback to teams.
• **NEW - rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)**	All areas where disposal of PPE occurs, are thoroughly cleaned between patients and at the close of clinic. For dental services, either in surgery where cleaning is after each patient; visor and FFP3/respirator or in corridor outside of surgery and immediately place in waste or box to go for decontamination. Hands are decontaminated immediately after Across remaining Service Lines, 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 Clinical staff have cleaning schedules to ensure patients areas are cleaned.	Assurance cannot be provided that the patients rooms are decontaminated after removal of PPE due to the layout of the rooms. Staff clean the room before leaving and will Doff PPE at that point. Due to staff sickness it has been difficult to provide additional cleaning staff on a regular basis.	PPE is removed as per Doffing technique. This is then placed in a clinical waste bin. Advice and support are available from H&S as well as IPC Staff carry out regular cleaning of 'hot spot items or areas.
• **Linen from possible and confirmed COVID-19 patients is managed in line**	FM staff order, receive and distribute the linen stock Linen is stored in line with local policy and national guidance.	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

with PHE and other national guidance and the appropriate precautions are taken	The Trust has not had any identified cases of cross infection in clinical areas at this time		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 IPC before releasing for use	No gaps in assurance	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
• **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
• **NEW - ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment**	A schedule for regular audit inspections is in place and reports provided following each inspection with clear actions identified. Actions are re-inspected to ensure they have been completed satisfactorily. Clinical staff have cleaning schedules to ensure patients areas are cleaned	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 Matron quality rounds and IPC review of cleaning standards in place to highlight when standards are below expected and rectified at the time. Staff have quick access to Domestic

			supervisor via mobile phone for urgent cleaning
• **NEW - ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air**	Areas are kept well ventilated. Where windows exist, they are open; waiting areas are being minimally used for out-patient services (waiting in own cars) Ventilation is maintained when appropriate in patients' rooms.	In some cases, patients are not always able to tolerate the window open during the winter months (in patient areas mainly).	Advice from health and safety and IPC.
• **NEW - there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants**	Solent NHS Trust follows the medium risk pathway using approved solutions as per National Guidance	No gaps in assurance	Continue to follow National Guidance
• **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 completed within dental services - Dental A/B use similar to pre Covid, repeat audit confirms low A/B prescription frequency
• **mandatory reporting requirements are adhered**	Usual reporting systems and processes remain in place and reported through IPC Q3 & Q4 IPC reports to QIR and full update shared with QIR quarterly.	No gaps in assurance	Incident report monitoring Governance reporting

to and boards continue to maintain oversight			
• **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.	No gaps in assurance	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 organisation 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 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
• **NEW - there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.**	Covid-19 posters available through all clinical sites Visitors are briefed before entering the clinical area and escorted to the patients' room.	No gaps in assurance- information may however change rapidly.	Walk arounds from Lead Clinicians, IPC Leads to ensure compliance
• **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: • **NEW - screening and triaging of all patients as per IPC and NICE**	Covid-19 screening questions are asked to all patients on booking an appointment. This is scripted to ensure all potential symptoms are enquired about. Patients are re-screened when arriving for appointment	No gaps in assurance	IP units are now using a white board and recording when swabs are due.

Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	For Sexual Health, there is a process for managing walk-in patients who may display symptoms of Covid-19 All services have adapted the guidance to work for their clinical environment in line with national guidance, i.e. swab on D/c from acute setting, swab on admission to community bed, swab day 3 and day 6.		QIA process in place to support decision making IPC advice available to all services. Only essential work is carried out face to face and staff have guidance and access to the appropriate use of PPE.
• **front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection**	Covid-19 screening questions are asked to all patients on booking an appointment. This is scripted to ensure all potential symptoms are enquired about. Patients are re-screened when arriving for appointment For Sexual Health, there is a process for managing walk-in patients who may display symptoms of Covid-19 All services have adapted the guidance to work for their clinical environment in line with national guidance, i.e. swab on D/c from acute setting, swab on admission to community bed, swab day 3 and day 6.	There is no formal SOP in place to guide staff where we start to reopen services, decision is multi-factorial and may be made by MDT, estate and domestic and housekeeping services.	IP units are now using a white board and recording when swabs are due. QIA process in place to support decision making IPC advice available to all services. Only essential work is carried out face to face and staff have guidance and access to the appropriate use of PPE.
Action to be taken	**To review need for SOP to guide staff when re opening services.**		
• **NEW - staff are aware of agreed template for triage questions to ask**	Questions are scripted to ensure parity and that no symptoms are missed For in-patient services, an admission process in place with a pathway referral form	Referral forms are not always completed to a good standard, key areas of information are missing	Ward teams contact referrer and hub to clarify any missing information Ward managers and Matron liaising with partners
• **NEW - triage undertaken by clinical staff who are trained and competent in the clinical case definition**	Patients admitted to Wards, admission criteria and pathway discussed prior to acceptance into community beds	Asked frequently to flex criteria due to flow pressures, this results in patients who are not suitable for a community bed being admitted	Ward mangers now attend capacity and flow meetings to provide the clinical voice to the operational system.

and patient is allocated appropriate pathway as soon as possible	Face masks are available for any patients wishing to use them For out-patient services, pre-appt check list by receptionist with clinician as back up		
• **NEW - face coverings are used by all outpatients and visitors**	Face Coverings are available, and visitors are requested to use them and dispose of them appropriately in the bins provided	No gaps in assurance	Some visitors decline to wear face coverings for health or belief reasons. An individual assessment of the risk to the patient or clinician would be carried out to see if benefit outweighs risk of transmission.
• **NEW - face masks are available for patients with respiratory symptoms**	Face masks are available at all sites. Dental would only be seeing pt. with respiratory symptoms (related to Covid) for emergency treatment if remote advice etc not appropriate. Pt would be seen in hot slot with all appropriate mitigations in place e.g. increased risk assessed staff not present, not meeting other pts etc, however for dental treatment face masks could NOT be worn	No gaps in assurance	Face masks are available at all sites.
• **NEW - provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care**	Patients with a cough are requested to wear a facemask during personal care if it can be tolerated All patients are encouraged to use facemasks when in communal areas including bays and side rooms when receiving personal care	Some patients find the mask intolerable and unable to wear them	Staff attempt to maintain physical distance and will wear face masks and face shields/goggles for all patients.
• **NEW - ideally segregation should be with separate spaces, but there is potential to use screens,**	All waiting areas ensure social distancing is maintained. Reception areas are screened in all Sexual Health clinics within Solent sites	Not all areas have been able to comply due to layout of buildings/content of rooms.	Where estates does present a challenge this has been

e.g. to protect reception staff.	All patients with the community in patient setting are isolated in individual rooms until a negative result. Reception staff are protected with a plastic screen from visitors and staff Staff within office space has been reduced and working from home encouraged if possible		escalated and reviews underway to seek to address
• **NEW - for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative**	National guidance is followed, patient symptoms are assessed by competent clinician, patient tested, and contact tracing investigated. Patient remains isolated until negative swab and 72hours asymptomatic. Patients who contact the clinic to advise of Covid-19 positive result, and seen within 72hrs prior to onset of symptoms – If staff in correct PPE, isolation not advised	No gaps in assurance	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-19 are segregated and promptly re-tested**	National guidance is followed and where indicated patients re-tested All patients transferred into the wards are isolated in single rooms for a minimum of 72hrs post transfer	No gaps in assurance	IPC team available to advise and support clinical decision making
• **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	There is no formal SOP in place to guide staff where we start to reopen services (action noted above)	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

	where indicated for example, via depot clinics and home treatment in mental health services		
• **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: • **NEW - separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas**	Seating is marked to ensure social distancing is maintained in waiting rooms. Staff areas are set up to ensure social distancing during break times. PPE and sanitizing stations are available at all entrances and exits. Signage displayed indicates any flow required through buildings. All areas have the number of persons allowed displayed before entry. One-way system in place at clinics that can, with clean nurse escorting patient out, patient's wait outside. Reference in-patient services, patients are placed in cohorts of Covid positive and Covid negative. Shared areas closed to Covid positive patients. Patients enter and egress ward areas by using separate entrances when appropriate. Meals are taken in their rooms to prevent transmission	Due to building layout risk assessment and entry and exit points it is not completely possible to ensure there is a flow.	All Solent staff and patients are treated under the medium risk pathway
• **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 90% at end of November 2020 for infection control across all services – clinical and non-clinical.	Potential impact of PPE fatigue noted.	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

	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		
• **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	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
Action to be taken:	Review training needs of substantive staff and take action as required.		
• **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**	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

	monitored and appropriate action taken	During this time there have been no incidents reported relating to the need to re-use PPE in the Trust		incident review meeting is undertaken
•	**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 IPC link nurses audit monthly as per IPC team. Hand hygiene is assessed 6 monthly in view of pandemic	No gaps in assurance	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
•	**hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: hand hygiene facilities including instructional posters**	Annual hand hygiene competency is completed by all clinical staff in ward and community settings. Hand hygiene observational audits (bare below the elbow etc) are also completed. Information and guidance are available in the clinical settings Following discussion at IPC group it has been agreed that hand hygiene audits will be 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	No gaps in assurance	

	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		
• **NEW - good respiratory hygiene measures**	Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care Patients with a cough are requested to wear a facemask during personal care if it can be tolerated Nebulisers and oxygen masks are cleaned after each use, or changed if appropriate Regular cleaning of all areas and increased cleaning of hot spots. Wherever possible windows are opened to allow good ventilation. Public information encourages respiratory hygiene e.g. Sneezing into crook of elbow	Full response from all Service lines required.	Staff attempt to maintain physical distance and will wear face masks and face shields/goggles for all patients.
• **NEW - maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct care**	Physical distancing of 2 metres is maintained wherever possible unless wearing PPE as part of direct care Advice on correct PPE when and where to use it available as skills slots, IPC bespoke sessions, 1:1 supervision.	Limitations due to the nature of the work in In-patients means 2 metres is not always possible. Additional need to ensure staff adhere to the 2 meters during meal breaks.	Spot checks and identifying and challenging any inappropriate use of PPE in a clinical setting
• **NEW - frequent decontamination of equipment and environment in both clinical and non-clinical areas**	Please see comments above	Please see comments above	Please see comments above

• **NEW - clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas**	ALL our staff wear Fluid resistant surgical masks (FRSM) unless alone in room with door shut, pt./visitor advice see above comments Staff in reception areas wear face coverings as per national and local guidance. All patients are encouraged to use facemasks when in communal areas including bays and side rooms when receiving personal care	Some patients find the mask intolerable and unable to wear them	Staff attempt to maintain physical distance and will wear face masks and face shields/goggles for all patients
• **NEW - staff regularly undertake hand hygiene and observe standard infection control precautions**	Teams have nominated Link Advisors and champions in place. Hand hygiene competency assessments are undertaken with staff and a competency record sheet is signed by staff and retained for record purposes. Link Advisors deliver training to full staff and a record of training is maintained. Hand hygiene competency completed by all clinical staff. Hand hygiene audits also completed on ward twice per year. Information and guidance also available in the clinical settings Annual hand hygiene compliance is 88% at the end of November 2020	Face to face training for staff working remotely.	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
• **NEW - the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance**	Evidence provided from all Service lines that hand air dryers are no longer in use in all areas in line with national guidance	No gaps in assurance	

• **NEW: guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas**	Information displayed in all toilet areas for staff, patients, and visitors. Paper towels provided for pts; there are sites with air dryers in toilets (dental) and information displayed advising use of hand towels.	No gaps in assurance.	Messaging has been issued to staff and information displayed clearly in patient and staff toilets about the use of hand towels. Action taken to have no hand dryers in place or in use across Service lines.
• **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	Previous lack of familiarity with the policy particularly by staff who don't usually wear uniform now improved.	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 fully understand. However, staff have more confidence in understanding symptomology and Comms provide regular update particularly where the new strain of Covid19 has emerged.	Advice and support from manager are available to staff OH, and IPC team available to advise where required

• **NEW - a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)**	Solent NHS Trust Chief Nurse and Medical Director with H&S and IPC manage oversight and collection of data and review latest rates. In patients have guidelines to follow in the event of an outbreak alongside a flow chart available to all staff displayed in ward offices Emergency planning and outbreak daily sit rip meetings are held to identify any urgent issues and actions required. Covid-related sickness, other sickness, self-isolation is monitored within service and updated on a daily basis to give WTE figures and % of sickness.		Systems in place to escalate where guidance changes rapidly or there are concerns around compliance or dispute. W 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 provided regularly for frontline staff to ask questions
• **NEW - positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.**	Cases are identified and information is recorded as an event on Trust Risk Management system- Ulysses. IPC monitor viral swab results and are in close contact with wards when there are one or more positive cases in line with management of outbreak (IPC) policy.	No gaps in assurance	Daily IPC outbreak meeting chaired by CN or nominated deputy.
• **NEW - robust policies and procedures are in place for the identification of and**	Government guidelines are supported by process and procedure.	No gaps in assurance	

management of outbreaks of infection	SolNet has a suite of policies to support and guide staff In patients has an outbreak guideline and flow chart available to all staff and is displayed in ward offices		
• **Provide or secure adequate isolation facilities**			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: **NEW - restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff**	All patients requested to attend alone unless unforeseen circumstances or vulnerable Within in-patient areas, patients are placed in cohorts of Covid positive and Covid negative. Shared areas closed to Covid positive patients. Patients enter and egress ward areas by using separate entrances when appropriate. Meals are taken in their rooms to prevent transmission	No gaps in assurance	
• **NEW - areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas**	All patients with the community in patient setting are isolated in individual rooms until a negative result. To maintain patient's dignity only signpost is an infection risk door sign. Reception staff are protected with a plastic screen from visitors and staff	No gaps in assurance	Guidance in place and IPC advice followed
• **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 are compliant with the environmental requirements set out in the current PHE national guidance**	Staff where possible use sessional PPE in line with national guidance. Cleaning schedules are in place and cleaning staff have access to appropriate PPE If patient required to be seen, area would be kept isolated until deep clean carried out. Products in use are compliant and have been checked by IPC and H&S lead	No gaps in assurance	
• **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
• **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: • **NEW - ensure screens taken on admission given priority and reported within 24hrs**	All patients admitted into the In-Patient setting have screening in accordance with local and national policy. On discharge from acute trust all patients are swabbed for Covid and on arrival to a Solent bed the patient is swabbed again and at 72hrs. For other services, the national guidance has informed practice in relation to patient testing.	No audit data collated Results are not always available within 24hours, however all patients who have been admitted an assumed	Ward testing SOP in place. Whiteboard indicating swab taken Record in patients notes
• **NEW - regular monitoring and reporting of the testing turnaround times**	All patients admitted into the In-Patient setting have screening in accordance with local and national policy.	No audit data collated	Incident reporting monitoring.

with focus on the time taken from the patient to time result is available	No delays have occurred during this process.		IPC Outbreak meeting held daily to enable escalation of issues. Chaired by CN or nominated deputy.
• **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
Action to be taken:	To review requirements and implement process for competency assessment and training records.		
• **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. Solent are rolling out lateral flow testing and compliance processes across the organisation. To further support assurance, where required twice daily lateral flow tests are being completed. Reporting mechanism developed.	There have been incidents where the national guidance has not been followed Staff using the national hubs rather than the Trust testing facility **ACTION: Increase staff comms and awareness around trust testing facility.** Lateral flow process roll out underway across the trust.	Incident reporting and monitoring IPC feedback when being contacted for advice and support Escalation of variation in practice To further support assurance, where required twice daily lateral flow tests are being completed.
• **NEW - regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)**	There is a robust system in place to enable staff to monitor and record results in patient records. In patients have a system of recording data on a whiteboard which is updated daily. Patients are cohorted and monitored according to national guidance	No gaps in assurance	Incident reporting and monitoring IPC feedback when being contacted for advice and support

• **screening for other potential infections takes place**	The Trust continues to work to current Trust policy	Nil noted	No mitigating actions
• **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 COVID-19 cases is handled, stored and managed in accordance with current national guidance**	Trust policies are available for staff to support their practice and have been updated in May 2020 to reflect the changes to waste disposal in the community. There is regular comms provided including update's for safe disposal in clinical and community environment and patients' homes	No gaps in assurance	Spot checks incident reporting and patient feedback

• **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. **ACTION: Audits to be completed to ensure PPE is stored appropriately within clinical areas.**	Physical checks before PPE being used. Reporting defects to H&S and IPC, as well as Procurement
• **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 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	No gaps in assurance.	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 via CARA. Greater clarity of processes now in place.

	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 have been encouraged to complete their CARA risk assessment and individuals at high risk discussed within leadership team with input from OH. National guidance is followed, and management ensure consistent and fair decisions. Wellbeing is monitored in service and by OH.		
• **that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff**	See above. Risk assessments competed and saved to personnel files in line with national guidance regarding at risk groups. These were updated as situation changed and shared with OH if staff consented to share. Ahead of wave 2, staff completed CARA self-assessment and shared score with managers who discussed any at risk staff members confidentially within senior leadership team.	No gaps in assurance	Staff offered re deployment if their risk assessment is high. When unable to provide a suitable covid secure placement then working from home is offered and computers and phones provided
• **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 (including FFP reusable respirators) have received training provided by the IPC/EiPs teams	In some cases records of training are not complete. **ACTION: All service lines to review training records for additional assurance.**	System for agreeing who should be tested agreed Incident reporting and monitoring
• **staff who carry out fit test training are trained and competent to do so**	The IPC team provided training for community testers to complete fit testing. Train the trainer approach taken so that ward staff always have staff who can complete. If there is a gap the IPC team complete.	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
• **all staff required to wear an FFP respirator have been fit tested for the**	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	System for agreeing who should be tested agreed

model being used and this should be repeated each time a different model is used		Lack of assurance that agreed system to approve staff for Fit testing	Incident reporting and monitoring
• **NEW - a record of the fit test and result is given to and kept by the trainee and centrally within the organisation**	Once fit tests are completed, certificates are issued for both pass and fails to all staff and records are held centrally by the Service Lines.	No gaps in assurance.	
• **NEW - for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods**	Once fit tests are completed, certificates are issued for both pass and fails to all staff and records are held centrally by the Service Lines.	No gaps in assurance.	
NEW - for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	As a Community provider the requirements for use of FFP3 is minimal. Should FFP3 be required this is led by the IPC team. Assurance can be provided regarding all staff with a CARA score of over 70 discuss risks/shielding options with line managers.	No gaps in assurance	
• **NEW - a documented record of this discussion should be available for the staff member and held centrally within the**	A record of all discussions are held centrally within the Service Lines who seek support from OH as required, in line with the fit test process.	No gaps in assurance. **ACTION: To undertake an audit to ensure no gaps in assurance.**	

organisation, as part of employment record including Occupational health			
• **NEW - following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record**	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
• **NEW - boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board**	The oversight, regular reporting and escalation of issues are tabled and discussed at the IPC Monthly meeting with subsequent reporting and escalation via Solent's governance structure to QIR and then onto Assurance and Board.	No gaps in assurance	

• **NEW - consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidancee**	Cross site cover has been prevented within Sexual Health services unless necessary and appropriately risk assessed. Consistency is maintained by cohorting staff to designated in patient units, within respective unit's team nursing is adopted. Special care is taken to ensure BAME or other high-risk staff are allocated to those patients who do not have Covid 19. MH Services - Staff movement across wards is restricted. Strict PPE guidance don and doff in the event of having to attend an emergency on another ward.	This is difficult for Specialist Care Dentistry as staff do work across clinic and GA sessions. High numbers of high-risk staff across service, it can prove difficult to follow this in full.	Staff have been offered re deployment to coved secure settings. Staff are provided with PPE. There are no shortages of PPE. Advice sought form IPC, health and safety as well as occupational health and human resources. In the event of outbreak, staff have been cohorted to only work in exposure area only and not to cross contaminate other ward areas and staff within.
• **NEW - all staff should adhere to national guidance on social distancing (2 meters) if not wearing a facemask and in non-clinical areas**	Message regularly reminded to all staff and break time areas set up to ensure 2m distancing. Break times staggered to also promote distancing Facemasks are worn in both clinical and non-clinical areas.	No gaps in assurance	
• **NEW - health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone**	All guidance in place to minimize risks and ensure as safe a workplace and clinic setting as possible. Audits carried out, increased cleaning, social distancing, PPE, screens at reception etc.	There may be gaps in assuring that workplace risks are mitigated in buildings that Solent NHS Trust operate from but do not own. **ACTION: Estates team to advise further.**	Health and Safety, IPC, Heads of Quality and Governance regularly review and mitigate for risk and put on risk register
• **NEW - staff are aware of the need to wear facemask when moving through COVID-19 secure**	All staff are aware the need to wear facemask when moving through COVID-19 secure areas. Eating areas have been designated as Coved secure and	Noncompliance of correct facemask placement such as wearing beneath the nose has been witnessed	Staff challenged at the time.

areas.	staff are able to eat and drink whilst maintaining a minimum of 2 metres		Posters in situ on ward area demonstrating the correct way to wear a facemask
• **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

Board and Committee Cover Sheet

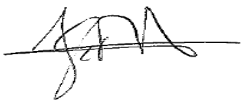
Item 8.1

NHS Solent NHS Trust

Item No.	8.1					
Presentation to	In-Public Board meeting					
Title of Paper	Workforce and OD Committee Exception Report					
Purpose of the Paper	To summarise the business transacted at the Workforce and OD Committee held on 21 January 2021					
Author(s)	Jayne Jenney, Corporate Support Manager and Assistant Company Secretary		Executive Sponsor	Jas Sohal, Acting Chief People Officer		
Date of Paper	21 January 2021		Committees/Groups previously presented	N/A		
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Summary of key messages / findings	• Changes were made to the planned agenda to reduce the meeting duration and allow time to receive a **contemporary update on Trust activity** in response to the current pandemic. • The Committee was informed of work in progress to look at workload and resource to allocate staff to the agreed key areas of priority including vaccinations, community urgent health, mental health, inpatient services and mutual aid. • A list of People operational plans that are to continue were noted as well as projects to be delayed. • The Committee noted that the POD Group is to be stood down and the JCNC will continue with a shortened agenda with service line members not being required to attend. • The Committee was briefed on progress with the vaccination roll out to staff and the positive uptake achieved so far. • The Committee was informed of changes to mandatory training timescales to speed up the recruitment process. • Multiple recruitment sources for both clinical and non-clinical roles to support the mass vaccine centres, PCNs and hospital hubs were shared, including deployments from Southern Health and CCG collaboratives. A disappointing flow of staff received through the HIOW System Workforce Bureau was noted. Areas within the voluntary sector providing workforce both nationally and regionally were also shared. • Assurance was provided with regards to staff wellbeing support initiatives in place. • Changes to annual leave arrangements to buy / sell or carry over were explained. • Recognition was given to the volunteers located outside of Oakley Road aiding arriving visitors. • An increase in Covid absences post-Christmas was highlighted. Cases on Fanshawe, Brambles and Tannersbrook and outbreaks in Portsmouth were noted. • The Committee discussed incidents relating to staff not following the infection control and social distancing guidelines and of plans to address through the HR process going forward. • Assurance was provided with regards to a comprehensive process followed for the redeployment of staff and of improvements in the support provided following lessons learnt from the first Covid wave. The possibility of redeployment to areas that are not a first choice and therefore staff feeling uncomfortable was acknowledged. • Minor amendments to the **Terms of Reference** were approved. • The Committee noted the **BAF.** • The Wellbeing Guardian launch event is be attended by MW in his new role as Wellbeing Guardian. It was noted that the event is to be attended by the NHS Chief People Officer to talk about vision and scope of the role. • There had been no meetings held of the **POD Group, JCNC and DDNC** to report. • There had been no **HIOW People Board** meeting held since the last update provided. • The **Occupational Health and Wellbeing, AMH Workforce Progress** and **Primary Care Workforce Progress reports** and the **NHS People Plan** were all noted with no comments or questions raised.					

Action Required	For decision?	N	For assurance?	Y
Summary of Recommendations	The Board is asked to: • Note the exception 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 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								

Item 8.1.1

Solent NHS Trust Workforce and Organisational Development Committee

TERMS OF REFERENCE

1 Constitution

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

2 Purpose

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

3 Duties

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

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

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

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

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

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

4 Membership

4.1 The membership of the committee shall comprise the following:

Members	**In attendance**
Non-Executive Director (Chair)	Director of Partnerships
Non-Executive Director (Vice Chair)	Acting Chief Finance Officer
Acting Chief People Officer (Lead Executive)	Associate Directors/Heads of People & OD
Chief Nurse and Acting Deputy CEO	Service/Corporate reps as required
One Chief Operating Officer	
Acting Chief Executive	

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

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

5 Chair

5.1 The Committee will be chaired by a Non-Executive Director. In the absence of the Chair, another NED colleague will be nominated.

6 Secretary

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

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

7 Quorum

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

8 Frequency

8.1 The Committee will meet bi-monthly.

9 Notice of meetings

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

10 Minutes of meetings

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

11 Authority

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

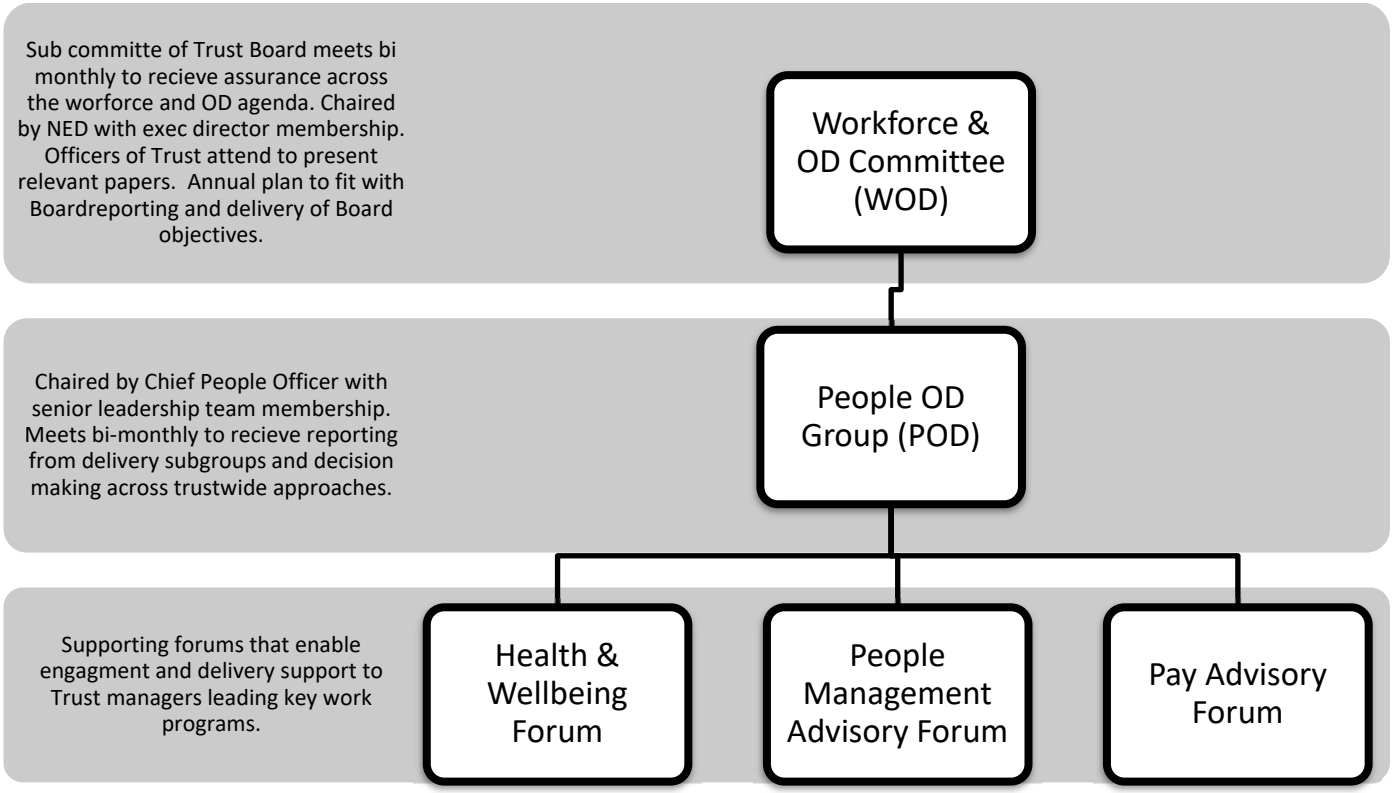
- To seek any information, it requires from any employee of the Trust in order to perform its duties
- To call any employee to attend a meeting as and when required
- Seek external expertise where required

12 Reporting

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

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

Appendix 1 – Committee Structure



Version	7
Agreed at	WOD Date: 21 Jan 2021
Date of Next Review	Date: Jan 2022

Item 8.2

Board and Committee Cover Sheet

Item No.	8.2

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 21st January 2021			
Author(s)	Sam Stirling, Corporate Affairs Administrator	Executive Sponsor	Thoreya Swage, Non-Executive Director (Committee Chair) Jackie Ardley, Chief Nurse & Acting CEO	
Date of Paper	January 2021	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:

- Due to the level 5 national emergency, the Committee streamlined meeting governance in order to receive contemporary updates in relation to Covid-19 activity. This included, importantly, updates from the Chief Nurse and Chief Operations Officer Portsmouth, on matters of **quality, workforce, safe staffing, service operational status and pressures, as well as Infection Prevention & Control**.
- The following reports were taken as 'read' only and exceptions were noted:
  - **Freedom to Speak up Six Monthly Report**
  - **Safe Staffing Report (item 8.2.1- provided to Board by exception)**
  - **Exception Report:**
    - **COO- Southampton and Hampshire Care Groups**
    - **COO- Portsmouth Care Group**
    - **Quality Improvement & Risk (QIR) Group**
  - **Safeguarding- Quarter 2 Report**
  - **Infection Prevention & Control BAF (Item 7.3.1 & 7.3.2- presented seperatley to Board)**
  - **Ethics Panel Exception Report**
  - **Professional Leadership & Engagement Report**
  - **QA Committee Effectiveness Review/Appraisal**

Decisions made at the meeting:

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

Recommendations:

There are no specific recommendations to note.

Other risks to highlight (not previously mentioned):

There are no risks to highlight.

Safe Staffing Report, 01 June – 30 November 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 June to November 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. 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.

Within the reporting period June – November 2020, with reference to Covid-19, the following challenges that may have an impact on safe staffing provision were discussed and strategies to address explored:

- Levels of redeployment and the impact upon staff wellbeing
- Impact on service capacity to deliver within limited resources and expertise
- During Wave 1, significant levels of redeployment occurred within services which operate a predominantly routine caseload (activity having reduced within initial stages of Covid such as dental and sexual health). Need to ensure learning informs preparations for future.
- Linked to the above, during November services expressed concern around potential 2nd Wave and need to complete contingency planning to ensure enough staffing and expertise within services.

Services reported focussed efforts on the return to business as usual during August – September 2020 during which time bank and agency usage was manageable.

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. Mental Health was identified as the initial focus of Solent's international recruitment program resulting in 8 Whole Time Equivalent (WTE) registered nurses having been recruited alongside a further 5 WTE trained staff via the standard recruitment process (further details below). Toward the end of the reporting period the services also experienced the impact of Covid outbreaks among staff and the need for increasing numbers of staff self-isolating.

There continue to be challenges with effective roster management across all teams. From June, it was agreed that the safe staffing meetings would focus on five key elements:

1. Roster approvals within timescale – Additional training has been offered to challenged areas.
2. Net hours balance position
3. Bank & Agency usage
4. Annual leave/unavailability
5. Roster approval timescale has improved

The overall position is improving; however, we recognise the need to maintain focus on the outlier areas receiving specific targeted support. Therefore, we plan to have a continued focus within the safe staffing meetings to ensure improvements are fully embedded and oversight of performance is maintained.

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 had been delayed. Implementation was planned from July 2020; however, a further delay was incurred whilst the team sought to access the National Mental Health Optimal Staffing Tool. Plans are in place to pilot this in

January 2021 with formal roll out during Q1-Q2 21/22. The safe staffing meetings will be pivotal in monitoring delivery during the life of the pilot.

A priority from the last reporting period was to identify key indicators linked to the delivery of safe staffing provision referred to as "Red flag incidents" to be included within the safe staffing dashboard. Both Mental Health and In-Patient areas (Physical Health) have considered the key indicators to drive the red flag notification process. Some of these indicators are in place across established dashboards (e.g. falls, missed breaks, TOIL, complaints etc), with focus now placed on the co-ordination of these key indicators via the dashboard process to inform the safe staffing process and subsequent discussions and actions taken. This is linked to the principles of the safer care nursing tools, where work to establish red flags would support development and implementation of a Solent wide tool. It is anticipated that this work will further strengthen our ability to use appropriate indicators identified across various data sources to pinpoint potential areas of concern requiring further investigation.

International Recruitment Programme

As an organisation we have commenced our International Recruitment (IR) journey for registered nurses. Our first focus is within Mental Health who have been challenged to sustain recruitment for a period. It is anticipated that international recruitment could be extended in due course to support our rehabilitation inpatient wards alongside community and specialist services.

We are liaising with HEE Global Learners Programme who conduct initial recruitment on behalf of the organisation. A project team consisting of Clinical, Mental Health colleagues, HR, Estates & Facilities and Learning & Development colleagues then interview, conduct pre-employment processes and develop a robust programme of induction and orientation to support individuals to then register with the NMC and fulfil their role as a registrant within our clinical services. This includes working with our Diversity and Inclusion team to focus on support for our mental health teams to welcome their international colleagues.

We have successfully recruited 8 registered nurses to date. As part of the government drive to increase nursing numbers, Solent NHS Trust submitted a bid alongside STP colleagues for dedicated funding to support the development of international recruitment. We have recently been informed this bid was successful and we look forward to working with our STP colleagues to recruit to specialist posts which will work to implement an international recruitment induction programme locally. Alongside this, we have been successful in securing funding for a dedicated Educator in Practice role for HCSWs within Solent to support skills development and facilitate grater career progression.

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.

During the safe staffing meetings, it was evident that there was an impact on staffing provision across all services as a result of staff shielding. Co-ordinated by service lines, efforts were taken in line with national guidance to redeploy staff where possible and utilise skills and expertise remotely. However, we acknowledge that in some cases this wasn't always possible. Staff were supported through Occupational Health during this process to ensure they could return to work safely and appropriately.

Key themes impacting on safe staffing provision included:

- The need to adapt to fast changing clinical situation and subsequent skillset required
- Noted increase in acuity of patient caseload and upskilling required
- Managing redeployed staff effectively when joining existing challenged teams (ensuring they hold the relevant skillset and understanding of processes/procedures alongside access to supervision/support)
- Facilitating introduction, training and oversight of redeployed staff within existing teams and quickly established temporary teams
- Staff health and wellbeing remained a challenge recognising the changing landscape and particularly the national guidelines associated with Covid-19.

Over this reporting period in the main the data shows that staffing levels were either on or above plan with wards working more closely together to share resources and support.

In the latter three months of the previous period there was a 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. This was an improving picture within the next reporting period with resurgence of challenges becoming evident in the later parts of November 2020. This is particularly evident within Mental Health Wards and Portsmouth In Patient Wards following Covid-19 outbreaks in later part of Q3 20/21.

A series of principles were agreed which seek to support the safe staffing provision across our services, as follows:

- To engage with agencies to secure long lines of work in areas of need
- Additional focus on recruitment of bank staff (registered and unregistered)
- Close liaison with the IPC team to support actions taken
- International Recruitment focus targeted towards key areas
- Development of a proposed “Safer Care Nursing Tool” to strengthen monitoring of acuity and dependency
- Use of perfect ward as a quality assurance tool

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.

In anticipation of Wave 2 updated QIAs have been completed by Adult In-Patient areas. This included modelling of proposed staffing levels and skill mix to support additional bed capacity. The QIA process has enabled services to seek additional support and expertise to ensure the proposed models can support safe care. At time of writing Services continue to manage currently within their existing capacity.

The Perfect Ward Pilot

To further support in patient areas, a project has been initiated to implement a pilot of the perfect ward. The perfect ward is a smartphone application and supports / simplifies nursing (and other) audits to enable the review of the quality of care patients receive. Currently most audits are paper based which means staff spend a significant amount of time writing up findings and analysing results.

The app, which will be used primarily by nurses within our inpatient wards, will allow staff to capture ward inspections on their smartphones or tablets which provide instant feedback. Results can then be acted on immediately and shared with colleagues and teams who deliver care.

A project team consisting of Matrons, Infection Prevention, ICT and Performance Teams with support from the Perfect Ward Central team aim to undertake 3 initial audits within Q4, with further roll out of additional audits throughout 2021 / 22. It is anticipated that Perfect Ward App will enable the wards / Trust to consolidate quality and safety audits into one system and will enable results to be readily available, support the triangulation of quality data (such as incident, complaints and patient feedback) and provide assurance regarding the care delivery within each inpatient area.

Safer Nursing Tools

It is acknowledged that within acute hospital settings the acuity and dependency of patients is regularly assessed. This helps inform workforce planning including skill mix and identifying trends and themes.

Within the community setting we are currently participating in the national development of community nursing acuity and dependency tool and have secured a licence to introduce acuity & dependency monitoring within our Mental Health inpatient wards. There is a desire to develop a tool that can be utilised within our rehabilitation inpatient wards. An initial proposal has been shared with the national team and will be discussed within coming months.

Colleagues from Adults Southampton, Adults Portsmouth and Mental Health Service Lines are engaged to develop the projects further.

Incidents and Complaints

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. Table 1 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.

The review of incident data shows a reduction in the number of incidents in comparison to the previous period where 893 incidents were reported. The most notable increase is in the reports of physical assault and a further increase in the numbers of medication errors. This reporting period has seen a reduction in the numbers of reported slips, trips and falls with the most notable reduction within the Limes where reported incidents reduced from 124 to 32 during this reporting period. There has also been a noted reduction in reported physical assaults from 206 to 162, with the most significant reduction in Maples. During this reporting period there has been a reduction in bed occupancy in some areas as well as a need to close to admissions due to Covid outbreaks which accounts for some reduction in reported incidents.

The highest levels of medications errors continue to be in the acute metal health wards. Following actions previously taken which failed to evidence the improvements expected, a deep dive was presented to Quality Improvement & Risk (QIR) group which did not identify a causal link between the incidents and the safe staffing numbers. The deep dive report recommended a number of actions which include:

- Focussed 121 work with individuals
- Tailored training around controlled drug management
- Additional support from the Trust meds management team
- Daily monitoring of missed dose incidents
- Review of meds management competencies for all staff
- Targeted work with Medical team to reduce prescribing errors

During this reporting period there has been a noted reduction in medication errors for Hawthorn from 140 to 83, with a downward trend in reported medication errors from 22 in June to 8 in November 2020.

Table 1: Incident reporting

Ward/Cause Group	Assault - Non-Physical	Assault - Physical	Medication Errors	Pressure Ulcers	Slips, Trips, Falls	Grand Total
COVID19 Adelaide			4		9	**13**
Fanshawe Ward (RSH)	3	4	28	17	20	**72**
Jubilee House Continuing Care (JUBH)			19	6	6	**31**
Lower Brambles Ward (RSH)	-	-	-	-	-	**-**
Snowdon Ward (WCH)			8	3	21	**32**
Spinnaker Ward (SMH)		1	25	32	26	**84**
The Kite Unit (WCH)	11	26	8	2	13	**60**
The Limes (LIMES)	7	72	34		32	**145**
The Orchards Acute - Hawthorn (OCSJ)	11	15	83		10	**119**
The Orchards PICU - Maples (OCSJ)	25	44	35		6	**110**
Grand Total	**57**	**162**	**244**	**60**	**143**	**666**

Table 2 *below summaries the complaints and services concerns received and the themes by in-patient ward for June - November 2020:*

Service Area	Total Complaints	Total Service Concerns	Themes
Fanshawe Ward (RSH)	2	0	The themes identified relates to clinical treatment and communication.
Snowdon Ward (WCH)	0	2	The service concerns related to communication and clinical treatment.
The Limes (LIMES)	2	1	The themes identified in the formal complaints raised relate to general procedures and staff attitude. The service concern related to a social care invoice raised in error.

The Orchards Acute - Hawthorn (OCSJ)	14	3	The themes identified in the formal complaints raised relates to communication/attitude of staff (7), clinical treatment (5), medication error (1) and diagnosis problem (1). The service concerns related to clinical treatment (2) and communication.
The Orchards PICU - Maples (OCSJ)	1	2	The issue identified in the formal complaint raised to the trust relates to oral communication. The service concerns related to communication/attitude of staff.
TOTAL	**19**	**8**	

During the reporting period there has been a significant increase in the number of formal complaints received, 19 compared to 10 in the previous reporting period. The area which has received the most complaints is The Orchards Acute - Hawthorn, with 14 formal complaints and 3 service concerns. Of the 14 formal complaints reported, 9 were received in June 2020 and related to 3 patients concerns. Of the patient complaints received in June, all 3 cases related to clinical treatment and communication. The number of service concerns has seen a slight reduction from 13 to 8 in the same timeframe. 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. 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. It is also noted that the impact of Covid 19 pandemic on staff and services has been significant and is likely to be a contributory factor on both the patients and our staff. A full programme of health & wellbeing support has been available to staff who have been encouraged to avail of the support most helpful to the individual.

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. There continue to be challenges in the Southampton community nursing team in relation to both recruitment and retention of staff. This is being considered through the safe staffing meetings as well as at service line level.

There is a national drive to develop a community nursing safer care nursing tool, however due to the national impact of Covid on Community Nursing Services, this has currently been placed on hold pending and is likely to recommence in 2021. Solent will continue to support the development of the tool once this work is progressed.

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 have sought to initiate 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.

The primary care team face ongoing challenges in relation to recruitment and retention of their Advanced Nurse Practitioners which in part is affected by the competitive salaries offered in independent GP practices. Discussions are continuing in order to seek a solution which supports the retention of these key clinical staff. The team have liaised with HR to offer a retention premium to retain existing ANPs alongside benchmarking these roles with the Advanced Clinical Practice (ACP) framework to inform consistency across all providers working with ANP roles. This work remains ongoing.

Specialist Dental services have returned to Business as usual with some areas of service yet to reach pre-Covid levels. Plans in place to support this transition but will be reviewed as the wave 2 position develops.

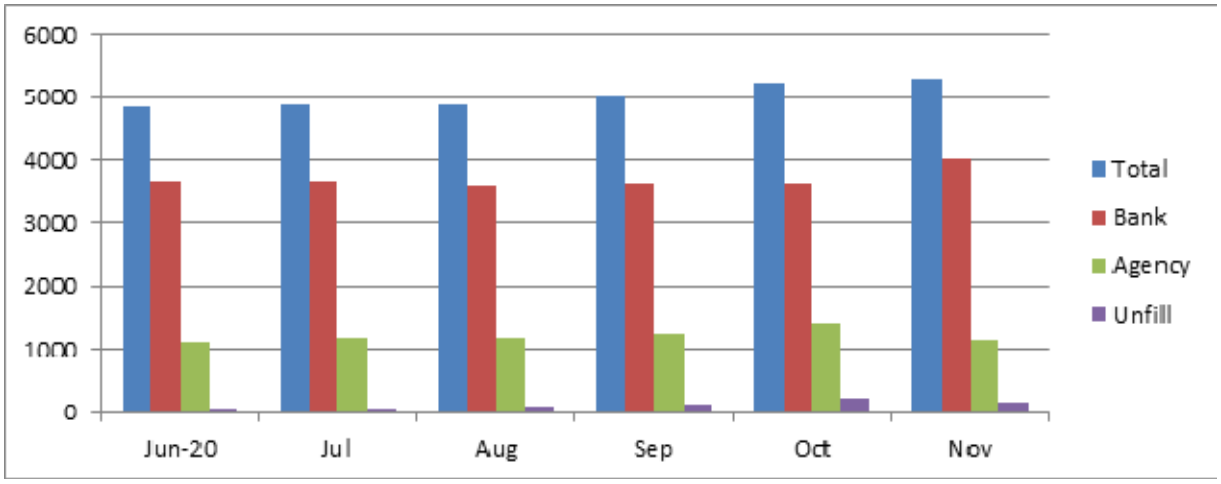
Bank and Agency Usage

Overall demand for bank and agency has reduced during the last 6-month period with the % of both bank and agency filled much higher than the previous reporting period. Whilst agency shift requests remain static, month on month the number of requested bank shifts is increasing with the highest level reported in November 2020.

The below table highlights level of Bank & Agency requests for clinical areas for June 2020 – November 2020

Clinical June 20 - Nov 20	Req	Bank	%	Agency	%	Unfilled	%
MHS SERVICES	5632	2441	43%	3033	54%	158	3%
PORTSMOUTH ADULT SVS	2529	1767	70%	512	20%	250	10%
PORTSMOUTH CHILDREN SVS	458	458	100%				
SOUTHAMPTON ADULT SVS	4234	2574	61.00%	1483	35.00%	177	4%
PRIMARY CARE	222	222	100%				
SOUTHAMPTON CHILDREN SVS	1316	1316	100%				
DENTAL SERVICES	38	38	100%				
SEXUAL HEALTH SERVICES	103	103	100%				
TOTALS	14532	8919	62.00%	5028	34.00%	408	4%

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 services respond in a dynamic manner to changes in both acuity and dependency, and in their response to the Covid pandemic and its ongoing impact.

Concern remains regarding the ongoing challenges in both recruiting and retaining staff, although Solent have been successful with the results of the initial international recruitment program and 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:

- Continuing to support the international recruitment programme of work – ongoing targeted recruitment, alongside facilitating and supporting the recently recruited postholders. Links to succession planning to be explored.
- Explore the development of appropriate acuity and dependency tools/safer nursing care tools for Community Nursing and In-Patient Services – following evaluation of the Safer Care Nursing Tool within Mental Health.
- Evaluate the introduction of the Perfect Ward which is due to commence in January 2021, enabling mechanisms to strengthen quality assurance.
- To review the existing safe staffing meeting format with the view to embedding learning from other NHS organisations (noted delay in implementation)
- To achieve sustained improvement on key aspects of roster management with oversight of targeted support

- To continue to develop the Red flag/safe staffing dashboard that service lines have proposed in liaison with safer nursing care tool development
- To continue to develop 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	Jun-20				Jul-20				Aug-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	149%	109%	100%	98%	144%	111%	100%	100%	137%	110%	104%	98%
ADS The Kite Unit	110%	120%	101%	206%	105%	125%	101%	199%	99%	117%	102%	165%
ADS Lower Brambles Ward												
ADS Fanshawe Ward	101%	113%	102%	100%	100%	118%	102%	116%	100%	115%	100%	100%
MHS Brooker	107%	117%	99%	102%	98%	103%	99%	99%	94%	118%	100%	111%
MHS The Orchards Acute - Hawthorn	92%	143%	91%	162%	94%	127%	93%	130%	86%	134%	89%	142%
MHS The Orchards PICU - Maples	96%	128%	92%	133%	95%	112%	94%	110%	87%	112%	86%	117%
ADP Spinnaker Ward	97%	110%	100%	107%	104%	104%	100%	97%	82%	52%	71%	42%
ADP Jubilee Hse Contnu Care	116%	67%	69%	65%	89%	62%	70%	56%	96%	106%	92%	101%

Ward Name	Sep-20				Oct-20				Nov-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	111%	135%	99%	113%	103%	115%	98%	99%	99%	120%	98%	100%
ADS The Kite Unit	102%	115%	101%	194%	96%	119%	108%	204%	103%	101%	101%	205%
ADS Lower Brambles Ward					100%	100%	100%	100%	100%	105%	100%	100%
ADS Fanshawe Ward	100%	108%	100%	103%	100%	102%	100%	100%	99%	100%	100%	100%
MHS Brooker	90%	105%	100%	103%	92%	98%	110%	100%	100%	102%	100%	109%
MHS The Orchards Acute - Hawthorn	84%	140%	82%	151%	83%	124%	90%	137%	88%	102%	92%	101%
MHS The Orchards PICU - Maples	89%	107%	86%	108%	86%	120%	92%	113%	87%	104%	118%	106%
ADP Spinnaker Ward	86%	75%	98%	75%	118%	102%	100%	100%	104%	106%	97%	107%
ADP Jubilee Hse Contnu Care	94%	111%	95%	116%	83%	50%	84%	30%	96%	95%	97%	97%

Board and Committee Cover Sheet

NHS Solent NHS Trust

Item No.	8.3				
Presentation to	In-Public Board				
Title of Paper	Governance and Nominations Committee				
Purpose of the Paper	To summarise discussions held at the Governance and Nominations Committee on 11 December 2020				
Author(s)	Jayne Jenney, Corporate Support Manager & Assistant Company Secretary	Sponsor	Catherine Mason (Committee Chair)		
Date of Paper	11 December 2020	Committees/Groups previously presented	-		
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	
Summary of key messages / findings	• The Committee noted the successful provider bid by Co-Create to deliver a **Board Development Programme.** Development plans and timescales were shared and it was noted that feedback would be provided at the January Board Workshop following interviews and Board observations. • **Succession Planning** arrangements were shared for the current executive Board structure with acting roles in place and a second following the return of the CEO from secondment. • An update was provided by the Mental Health Act and Mental Capacity Act Lead on the **Associate Hospital Manager management and governance** arrangements including training and support, Mental Health Act Scrutiny Committee attendance requirements and future planned developments to attend mental health ward visits. Changes to the AHM recruitment strategy was also noted. • A **Well Led Development Review draft specification** was presented and reviewed. The Committee discussed the commissioning of an external partner, the cost implications and timings. It was agreed to incorporate 360-degree reviews by stakeholders as part of the overall Well Led review. Members of the external bidder presentation panel were agreed. • The Committee received and noted a **Governance Review** paper summarising the updated Operational Governance Infrastructure including Board governance, committee membership arrangements and performance reporting. • **NED tenure and lead roles** were reviewed. The NED tenure log and timeline associated with the incoming NED interviews to replace Jon Pittam were noted. The Committee also noted Mike Watts' designated Wellbeing Guardian role in accordance with the NHS People Plan. • The **Committee Effectiveness Review** survey results were shared and recommendations discussed. The Committee was content with the report presented. • The **Mid-Year Review of Objectives** was presented and amended **Terms of Reference** were approved following changes to executive job titles. • A verbal update was provided on future vacancies. • The Committee considered the **BAF** risk #62 – Executive and Senior Leadership Team Capacity and was assured it was being actively managed.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The In-Public Board is asked to: • Note the exception 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 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