# Agenda

## Solent NHS Trust In Public Board Meeting

Date: Monday 2nd August 2021
Timings: 9:30 – 12:50

| Item | Time | Dur. | Title & Recommendation | Exec Lead / Presenter | Board Requirement |
|---|---|---|---|---|---|
| 1 | 09:30 | 5mins | **Chairman's Welcome & Update**<br>• **Apologies to receive** | Chair | To receive |
| | | | **Confirmation that meeting is Quorate**<br>*No business shall be transacted at meetings of the Board unless the following are present;*<br>• *a minimum of two Executive Directors*<br>• *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 | 30mins | **Patient Story** | Chief Nurse | To receive |
| 3 | 10:05 | 30mins | **Staff Story – International Recruitment** | Chief People Officer | To receive |
| 4 | 10:35 | 10mins | **Reflections and progress made following Patient Stories- 12 month review** | Chief Nurse | To receive |
| 5 | 10:45 | 5mins | ***Previous minutes, matters arising and action tracker** | Chair | To approve |
| **Quality and safety first** | | | | | |
| 6 | 10:50 | 5mins | **Safety and Quality first & feedback from Board to Floor Visits** | Chair | Verbal update |
| 7 | 10:55 | 5mins | **Freedom to Speak Up - Any matters to raise to the Board** | Chief Nurse | Verbal update |
| **Items to approve** | | | | | |
| 8 | 11:00 | 20min | **Green Plan** | Strategic Transformation & Estates Director | To approve |
| **Items to receive** | | | | | |
| 9 | 11:20 | 20min | **Chief Executive's Report** | CEO | To receive |
| 10 | 11:40 | 30min | **Performance Report**<br>*Including:*<br>• *Operations*<br>• *Workforce* | Executive Leads | To receive |

Our values are: Honesty, Everyone counts, Accountable, Respectful, Teamwork

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| | | | • *Quality*<br>• *Financial*<br>• *Research*<br>• *Self-Declaration* | | |
| 11 | 12:10 | 10min | **Safe Staffing- 6 monthly Report** | Chief Nurse | To receive |
| 12 | 12:20 | 10min | **Information Governance and GDPR Update and Annual Report** | Deputy CEO & Chief Finance Officer | To receive |
| **Reporting Committees and Governance matters** | | | | | |
| 13 | 12:30 | 15mins | **Workforce and OD Committee -** *Exception report from meeting held 15th July 2021* | Committee chair | To receive |
| 14 | | | **Engagement and Inclusion Committee –** *Exception Report from meeting held 8th June 2021* | Committee chair | To receive |
| 15 | | | **Mental Health Act Scrutiny Committee-** *Exception report from meeting held 22nd July 2021* | Committee chair | To receive |
| 16 | | | **Audit & Risk Committee –** *No meeting held since last meeting. Next meeting- 5th August 2021* | ---- | ---- |
| 17 | | | **Quality Assurance Committee-** *Exception report from meeting held 22nd July 2021*<br>Including:<br>• Infection Prevention & Control Annual Report *(supplementary paper- item 17.2)*<br>• Safeguarding Annual Report *(supplementary paper- item 17.3)* | Committee chair | To receive |
| 18 | | | **Governance and Nominations Committee** – *Exception report from meeting held 4th June 2021* | Committee chair | To receive |
| 19 | | | **Non-Confidential update from Finance & Infrastructure Committee–** *non confidential verbal update from meeting 27th July 2021* | Committee chair | To receive |
| 20 | | | **Charitable Funds Committee –** *No meeting held since last meeting. Next meeting- 5th August 2021* | ---- | ---- |
| **Any other business** | | | | | |
| 21 | 12:45 | 5mins | **Any other business and reflections**<br>• *lessons learnt and living our values*<br>• *matters for cascade and/or escalation to other board committees* | Chair | - |

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| 22 | 12:50 | --- | **Close and move to Confidential meeting**<br>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:<br>"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 4th October 2021***

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Item 4.1

# Board and Committee Cover Sheet

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| Item No. | 4.1 |

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| Presentation to | Solent NHS Trust Board Meeting | | | |
| Title of Paper | Patient Story Summary | | | |
| Purpose of the Paper | The purpose of this is paper is to provide a brief summary of the patient stories presented to Board over the last 12-month period (2020/21) alongside a summary of discussions held. It outlines a proposal for a review of impact and provides recommendations for the future development of stories at Board as a vehicle for facilitating improvement. | | | |
| Author(s) | Sarah Balchin, Associate Director of Community Engagement and Patient Experience | Executive Sponsor | Jackie Ardley, Chief Nurse | |
| Date of Paper | July 2021 | Committees/Groups previously presented | N/a | |
| Action Required | For decision? | Y | For assurance? | Y |
| Recommendation | Following an initial review of Patient Stories presented to Board throughout 2020/21, the Board is asked to note and support the following recommendations:<br>1. Explore the impact on Board members of hearing patient stories thus far, identifying any specific changes in Board members practice or approach undertaken in response to the stories shared.<br>2. Explore with Board members, their aims for hearing stories at Board – asking *why do you want to hear patient stories, what is it you want to find out?*<br>3. Develop a framework for the gathering, telling and use of patient stories at Board, defining the role, purpose and expected outcomes of hearing the gift of feedback from patients, families and carers.<br>4. Establish the actions suggested from the stories, their delivery and outcomes, identifying how, in the case of gaps, we may ensure follow up and closure of issues raised. | | | |

## For presentation to Board and its Committees: - To be completed by Exec Sponsor

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

Item 4.2

# Patient Stories presented to Solent NHS Trust Board 2020/21 – A Summary

**Background**

Patient stories are an established method of gaining valuable insight into people's experience of using health care services. An in-depth narrative provided by a patient, family member or carer, has the potential to provide a window into the workings of a service, a Trust and potentially a whole system. Stories have been described as enabling an emotional connection to be made with the person hearing and listening and can assist in improving the experience of people who use services.

Solent NHS Trust In-Public Board has a patient story as an integral part of the agenda. This is an executive led process, with the Chief Nurse leading the gathering and sharing of the stories. The stories are usually shared with the Board through a presentation from Service leads across the Service Lines and can sometimes include the patient and patient's family. The Trust has described its ambition to ensure the voice of the patient and the community is at the centre of everything we do, and this is an opportunity to support that.

**Purpose**

The purpose of this is paper is to provide a brief summary of the patient stories presented to Board over the last 12-month period (2020/21) alongside a summary of discussions held. It outlines a proposal for a review of impact and provides recommendations for the future development of stories at Board as a vehicle for facilitating improvement.

**Summary**

A total of five stories have been shared in Board in 2020- 21 (see App 1). The stories have included those describing a positive experience of care, some a combination of positive and poor experiences and most describing a complexity which reflects the pathways of our patients and the community we serve. Some had actions suggested and support requested, all appear to have been well received by the Board. Currently however, there is limited evidence of the stories explicitly driving change. We need to further understand the impact of stories at Board, and to consider how we strengthen our approach to sharing patient experience in this way, to inform and drive improvement.

**Recommendations:**

1. Explore the impact on Board members of hearing patient stories thus far, identifying any specific changes in Board members practice or approach undertaken in response to the stories shared.
2. Explore with Board members, their aims for hearing stories at Board – asking *why do you want to hear patient stories, what is it you want to find out?*
3. Develop a framework for the gathering, telling and use of patient stories at Board, defining the role, purpose and expected outcomes of hearing the gift of feedback from patients, families and carers.
4. Establish the actions suggested from the stories, their delivery and outcomes, identifying how, in the case of gaps, we may ensure follow up and closure of issues raised.

**App 1**

**Summary of Patient Stories to Solent NHS Board (2020/21)**

A summary of Patient Stories presented to In-Public Board over 12-month period is detailed below (April 2020 – March 2021):

| **Date** | **Patient Story Presented** |
|---|---|
| April 2020 | **Patient Story not presented to Board on this occasion** |
| June 2020 | **Patient Story not presented to Board on this occasion** |
| 3rd August 2020 | **Podiatry Service** |
| *Summary* | Specialist Podiatrist attended alongside a patient representative to present experiences within the Podiatry Service.<br>Clinician provided an overview of their role and emphasis on ensuring patient mobility.<br>Patient rep shared their story and the difference made to their life having received insoles to assist with walking.<br>Discussion held around the following:<br>- Service continued to be prompt for patients despite Covid-19 challenges.<br>- Board sought to understanding service for replacement of insoles going forward<br>- Patient representative noted the challenges providing feedback to the trust<br>- Waiting list challenges ahead following impact of Covid-19<br>- Additional resource sought to ensure continuation of pivotal work around innovative pathway redesign and potential research opportunities. |
| 5th October 2020 | **Tissue Viability Service** |
| *Summary* | Tissue Viability Lead attended, providing an overview of their role and the services delivered in clinic and out in the community. Patient representative attended (with support) to present their service experience.<br>The patient representative shared their story, including an overview of circumstances leading to their referral in October 2019. The patient shared the mental health challenges and commended the treatment and support received from the service.<br>Discussion held around the following:<br>- Exploration of potential communication improvements – noting the development of virtual comms and support to change dressings at home.<br>- Understanding the impact of experiences throughout Covid pandemic.<br>- Exploration of previous support received and ongoing support for the patient's Mental health disorder<br>- Communication between services following surgery |
| 7th December 2020 | **Mental Health Service** |
| *Summary* | Senior Community Mental Health Nurse and Mental Health Practitioner attended to present on behalf of the patient, their experience within the service.<br><br>The team presented an overview of the background to this complex case, including a referral to the Crisis team. An overview of the challenges in relation to diagnosis, engagement, wheelchair access and housing placements was shared.<br><br>The Senior Clinician presented an overview of the care pathways followed by the service to manage behaviours and build a therapeutic relationship. The following areas were discussed: |

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| | - Issues around current service challenges were also explored.<br>- Learning from working as an integrated service was also shared.<br>- Complex process for high cost placements discussed. Action taken to consider how to streamline with Board members support.<br>- Support to our teams when working in high stress environments.<br>- IT challenges and discussion of plans to address<br>- Potential peer/voluntary sector support within the system |
| 1st February 2021 | **Specialist MSK Service** |
| *Summary* | Service lead shared complexities of the service and high level of teamwork and care demonstrated.<br><br>The Board confirmed pride and value of the team, emphasising the importance of celebrating excellence. |
| 29th March 2021 | **End of Life Care Service** |
| *Summary* | Service Line Clinical Director, Head of Quality and Professions and CCG Quality lead attended to present the patient story.<br>The representatives emphasised the importance of sharing the patients experience of the end of life care service to reflect on care improvements and internal and system wide learning.<br><br>The events of the patients final 24 hours of life were shared with the Board including the lack of effective joint care across multiple organisations. The impact these experiences had on the family were shared, emphasising the prolonged and devastating effect this experience had on the patients family. The Board were informed of the full support provided to the family alongside the feedback and support provided to individual teams.<br><br>The challenges were shared around a fragmented pathway, particularly related to weekend care.<br><br>In response to the circumstances presented, multiple provider investigations had been undertaken and lessons identified. Consideration had been taken of how the outcome of these investigations should be shared with the patients' family to reduce further distress.<br><br>The Board were briefed on the actions and ongoing reviews being undertaken.<br><br>Questions were raised by Board members as follows:<br>- Consideration of cultural challenges across the NHS and partner organisations.<br>- Exploring impact and potential introduction of further risk due to high level of controlled and regulated processes.<br>- Understanding of contact with the family, prior to care issues being reported.<br>- The importance of ensuring ongoing review of clear and effective processes<br><br>The Board noted the need for continued Board oversight of patient experiences to support continued learning and improvement of care provision, as well as enabling executive challenge across the NHS. |

Item 5.1

# Minutes

## Solent NHS Trust In Public Board Meeting

Date: Monday 7th June 2021
Timings: 9:30 – 13:30

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| **Chair:**<br>**Catherine Mason,** Trust Chair (CM) | |
| **Members:**<br>**Sue Harriman,** Chief Executive Officer (SH)<br>**Andrew Strevens,** Chief Finance Officer (AS)<br>**Jackie Ardley**, Chief Nurse (JA)<br>**Dan Baylis**, Chief Medical Officer (DB)<br>**David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN)<br>**Suzannah Rosenberg**, Chief Operating Officer Portsmouth (SR)<br>**Jas Sohal**, Acting Chief People Officer (JS)<br>**Mike Watts,** Non-Executive Director (MW)<br>**Stephanie Elsy,** Non-Executive Director (SE)<br>**Thoreya Swage**, Non-Executive Director (TS)<br>**Gaurav Kumar**, Non-Executive Director (GK)<br>**Calum Mercer**, Non-Executive Director (CMe) | **Attendees:**<br>**Gordon Muvuti**, Director of Strategy & Partnerships (GM)<br>**Gordon Fowler**, Strategic Transformation Director & Director of Estates (GF)<br>**Rachel Cheal**, Chief of Staff & Corporate Affairs (RC)<br>**Sam Stirling**, Corporate Affairs Administrator (SS)<br>**Ashley Rowlands,** Rotational Physiotherapist (AR) *(item 2)*<br>**Nigel Bowes**, Physiotherapy Service Patient (NB) (item 2)<br>**Dan Winter-Bates**, Freedom to Speak Up Guardian (DWB) *(item 3)*<br>**Leon Herbert**, Head of Diversity & Inclusion System Wide (LH) *(item 3)* |

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| **1** | **Chairman's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests** |
| 1.1 | CM welcomed all to the meeting, including AR and NB for the Patient Story (item 2) and DWB and LH to present the Big Conversation (item 3). |
| 1.2 | There were no apologies to note. The meeting was confirmed as quorate. |
| 1.3 | The Board were asked to declare any new interests. There were no further updates to note. |
| **2** | **Patient Story – Physiotherapy Service** |
| 2.1 | NB shared his experiences with the Physiotherapy Service, following hospital admission for treatment of Covid-19. Effective triage process was highlighted and exemplary care across all services emphasised.<br>The Board were informed of physiotherapy care programme provided and AR commented on invaluable wider PRRT support, as well as holistic and mental health perspectives considered. |
| 2.2 | JA asked about support received to manage long Covid, particularly in relation to mental health and wellbeing. NB emphasised strong quality of care and compassion provided. |
| 2.3 | SH queried communication between the hospital and service. AR explained fluent contact, support and use of SystmOne. |

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| 2.4 | SE asked about support received from other services and potential further requirements. NB informed of ongoing visits and monitoring. Support with mental recovery was discussed and NB emphasised strong family support system in place.<br><br>AR highlighted signposting to various services and commented on potential further requirement for specialist resource. DB agreed and acknowledged challenges in relation to understanding of long Covid and funding requirements. System level work was shared, including self-help techniques and signposting. |
| 2.5 | The Board thanked NB and AR for attending the meeting. *NB and AR left the meeting.* |
| **3** | **Big Conversation** |
| 3.1 | LH explained the purpose of the Big Conversation concept in supporting identification of issues related to discrimination, as well as co-design interventions to deal with the issues noted.<br><br>Work by Sheffield Health and Social Care NHS Foundation Trust, Solent's WRES Taskforce and local staff resource groups were highlighted and LH shared aims and current phased activity underway, including consideration of communication requirements for individual groups. |
| 3.2 | DWB acknowledged the importance of ensuring plans were appropriately adapted for the Trust and explained group sessions held to consider accessibility and working for improvement. DWB emphasised the need to demonstrate clear planning and manage expectations.<br><br>Alignment to Workforce Race Equality and the Disabilities Equality Standards was highlighted. |
| 3.3 | TS queried identification between social norms and discrimination within groups. DWB agreed ongoing challenge and work required to distinguish the true representative voice.<br><br>TS asked about consideration of gender and DWB confirmed extensive considerations and learning. JA agreed and commented on work to review all areas recognised, including generational perspectives. |
| 3.4 | GM emphasised the role of the Board and senior leaders in driving change and encouraging participation at all levels of the organisation. |
| 3.5 | GK asked about work to cover individuals that do not associate with any of the groups to ensure inclusivity of all staff members. DWB agreed and highlighted consideration of 'group allies' and communications to ensure more expansive delivery of the concept. |
| 3.6 | CMe commented on the language used and consideration required in relation to alignment to Trust values.<br><br>The Board formally thanked DWB and LH for presenting the initiative. *DWB & LH left the meeting*. |
| **4** | **Minutes of the meeting held 29th March 2021, matters arising and action tracker** |
| 4.1 | The minutes of the last meeting were agreed as an accurate record. |
| 4.2 | The following actions were agreed as closed: AC003390, AC003527 |
| **Public Disclosure Documentation** | |
| **5** | **Audit Results Report for the year ended March 2021** |

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| 5.1 | AS shared the report, as presented to and recommended by the Extra Ordinary Audit & Risk Committee. Ongoing procedures and amendments were highlighted.<br><br>**The Board approved the Annual Results Report for the year ended March 2021, acknowledging that the audit remains ongoing.** |
| 5.2 | **The Board approved the Annual Audit Letter of Representation 20/21.** |
| **6** | **Annual Accounts** |
| 6.1 | AS highlighted key areas of the accounts, as presented to and recommended by the Extra Ordinary Audit & Risk Committee.<br><br>**The Board approved the draft accounts as presented. However, it was acknowledged that as the audit on the accounts remains ongoing, that there may be further amendments. The Board therefore delegated authority to the CEO, Deputy CEO & CFO, Audit & Risk Committee Chair and the Trust Chair to approve the accounts, following the finalisation of the audit and before the required submission date of 15 June 2021.** |
| **7** | **Annual Report – including the Annual Governance Statement** |
| 7.1 | RC provided an overview of the report and explained that there were no material changes.<br><br>**The Board approved the Annual Report and Annual Governance Statement. However, it was acknowledged that as the audit on the accounts remains ongoing, that there may be further amendments to the Summary Financial Statements. The Board therefore delegated authority to the CEO, Deputy CEO & CFO, Audit & Risk Committee Chair and the Trust Chair to approve any amendments following the finalisation of the audit.** *RB left the meeting.* |
| **8** | **Quality Account** |
| 8.1 | JA informed of comments awaited from Southampton CCG, however confirmed that there was no material updates. Formal thanks to those involved in creating the report were noted.<br><br>**The Board approved the Quality Account.** |
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| **9** | **Safety and Quality first & feedback from Board to Floor Visits** |
| 9.1 | CM provided feedback from recent face to face Board to Floor visit. JA explained revised format and effective in-depth detail provided.<br><br>TS raised concerns in relation resourcing within the Southampton Diabetes Service, following Board to Floor visit held on 11th May 2021. DN explained ongoing work to balance and improve pathways and the Board were assured of business case being established to address concerns. |
| **10** | **Freedom to Speak Up - Any matters to raise to the Board** |
| 10.1 | It was confirmed that a contemporary update would be provided within the CEO Report. |
| **11** | **Final Draft – The Solent Clinical Framework** |
| 11.1 | DB presented the draft Clinical Framework for Board approval. DB explained the purpose of the framework and reviewed the enablers, guiding principles and associated immediate priorities. |

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| | The Board were briefed on next steps and the importance of ensuring embeddedness across the organisation. |
| 11.2 | CM suggested including the term 'kit' when considering enablers. DB agreed and commented on the need to ensure clear articulation of terminology throughout the strategy. |
| 11.3 | Regarding research aspects, TS asked about consideration of links to academia. DB agreed importance and shared aspects of ongoing work, including collaboration with universities. |
| 11.4 | SE commented on the need to ensure consistency across the system and asked about potential system wide frameworks. DB explained review with executive teams across the ICS and clear ambitions to ensure collaborative working across organisations.<br><br>SH highlighted the importance of an overarching organisational strategy and confirmed that the ICS Strategy Director would be joining an upcoming Board session to consider and learn, in an attempt to ensure collaborative approach. The role of the Trust Strategy Partnership Committee was discussed. |
| 11.5 | GM commented on the importance of terminology clarification to ensure correct use of the term's 'strategy' and 'framework'. |
| 11.6 | **The Board approved The Solent Clinical Framework and endorsed for further development.** |
| **12** | **Chief Executive's Report** |
| 12.1 | SH briefed the Board on Covid-19 activity and the mass vaccination programme. Positive work across Hampshire and Isle of Wight was highlighted. |
| 12.2 | SH reported positive Freedom to Speak Up results, with the Trust in the top 10 for a third year and number three of all NHS Trusts in the country. SH confirmed that the Trust were 'best in class' when compared with similar organisations. |
| 12.3 | SH explained risk in relation to unprecedented waiting lists in key areas. The Board were assured of full governance process and detailed review through Sub-Committees. SH also commented on review of business intelligence and knowledge management.<br><br>Review into further support requirements for vulnerable patients and appropriate mitigations across services were discussed. It was confirmed that a full update would be presented to the Board in due course.<br><br>Wider considerations in relation to elective recovery fund use and balance of risk across the system was shared. |
| 12.4 | Positive feedback following the launch of the new Learning Management System was provided. |
| 12.5 | SH summarised the our key strategic and trust wide operational risks, as per the Operational Risk Register and Board Assurance Framework. |
| 12.6 | The Board received a contemporary update in relation to the National Operating Planning Guidance. Potential changes were discussed and it was confirmed that the Trust was awaiting further information. |

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| 12.7 | DN informed the Board of new estate at the Swan Centre for a combined children's therapy unit and sexual health clinic. Positivity of the development and significant improvement was shared.<br><br>AS commented on potential blueprint and replication across other areas. |
| 12.8 | SH reported concerns in relation to the Wheelchair Service and confirmed that a full update would be provided at Confidential Board.<br><br>**The Board noted the CEO Report.** |
| **13** | **Performance Report** |
| 13.1 | <u>Operations- Southampton</u><br>• DN provided an overview of waiting list challenges across Southampton services, including Children's, Dental, MSK and Podiatry.<br>• Challenges within the 0-19 and health visiting service were also reported. |
| 13.2 | <u>Operations Portsmouth</u><br>• SR shared challenges in relation to medical cover on Jubilee Ward. The Board were briefed on mitigations in place and work to continue bed occupancy.<br>• Positive bed stock management within the mental health service was reported, including mutual aid in place between Isle of Wight and Southern Health Trusts.<br>• AS commented on expectation to achieve Elective Recovery Fund target for first month of April and explained potential challenges moving forward.<br>• MW emphasised the importance of awareness of staff pressures for those returning to an element of business as usual. SR assured of full recognition across services and enthusiasm of staff to start working on waiting lists and caseloads.<br>• SR briefed the Board on waiting list challenges effecting FFT results. SH commented on the importance of in-depth executive review to understand actions and further work required. |
| 13.3 | <u>Workforce</u><br>• JS informed the Board that the stability index remains strong at 88%. It was confirmed that the stability index peer median, based on Trusts within the ICS, had increased and the Trust was therefore not currently reporting as an outlier comparatively.<br>• JS reported an increase in international recruitment however highlighted small effect on recruitment from India, due to Covid-19.<br>• It was confirmed that statutory and mandatory training was currently at 83.5% compliance.<br>• JS shared an increase in the number of apprentices recruited and discussions with services to encourage consideration of apprenticeships, particularly when appointing to Band 2 posts.<br>• High vacancy rates in Estates and FM services were highlighted and review of the use of bank and agency held.<br>• JS explained restructuring within the People Services team in order to provide more partners to assist services with leadership and management skills.<br>• It was confirmed that 91% of staff had received their Covid-19 vaccinations and 85.3% for BAME staff.<br>• The Board were briefed on activity from Discovery Month, designed to offer careers guidance, awareness of apprenticeships and training opportunities and meet a range of health and social care employers/voluntary services.<br>• TS asked about work to encourage BAME colleagues to take up the vaccination. JS informed of discussions and initiatives taking place and extensive discussions were held regarding to |

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| | balance between requirements, choice, and patient safety. JS explained ongoing work with the BAME Group and assured of active risk assessment processes.<br>• Regarding deep dive on discrimination of BAME staff, SE queried work to improve scores. JS emphasised ongoing activity by the Diversity and Inclusion Team, including use of The Big Conversation. |
| 13.4 | <u>Quality</u><br>• JA informed that block booking agencies were no longer being used and request for services to consider alternative approaches to resource, for example the use of apprenticeships.<br>• Review of FFT data was highlighted, in order to ensure correlation and effective consideration of potential trends.<br>• CM commented on potential improvements to complaints data presented within the report. It was agreed that JA and CM discuss further outside of the meeting. |
| 13.5 | <u>Finance</u><br>• AS informed of ongoing discussions following agreement of funding for the hospital discharge programme for Hampshire and Isle of Wight.<br>• It was confirmed that the Trust were still waiting for guidance from NHSE in relation to the H1/H2 plans. Ongoing internal planning was highlighted.<br>• AS reported a high number of IT risks and emphasised comprehensive and diligent consideration on the risk register. CM asked if further information would be reported at a future Confidential Board/Board Workshop and AS highlighted further executive oversight required to understand the impact of risks. It was agreed to include a statement within the next report for appropriate Board assurance. **Action- AS.** |
| 13.6 | **The Board noted the Self-Declaration and Research Update.** |
| 13.7 | **The Performance Report was noted.** |
| **14** | **Clinical Professional Engagement and Leadership Report (inc. professional strategic framework and nurse revalidation) [Nursing, AHPs and medical workforce]** |
| 14.1 | **The Board noted the Clinical Professional Engagement and Leadership Report.** |
| **Exception Reports** | |
| **15** | **Workforce and OD Committee-** *Exception report from meeting held 20th May 2021* |
| 15.1 | MW shared the report and provided key highlights from the Committee. |
| **16** | **Engagement and Inclusion Committee** |
| 16.1 | *No meeting held since last meeting. Next meeting- 8th June 2021* |
| **17** | **Mental Health Act Scrutiny Committee** |
| 17.1 | *No meeting held since last meeting. Next meeting- 22nd July 2021* |
| **18** | **Audit & Risk Committee-** *Exception Report from meeting held 21st May 2021* |

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| 18.1 | **The Board noted the Clinical Audit and Service Evaluation 2021-2022 Plan.** |
| 18.2 | CMe presented the exception report and highlighted ongoing work regarding a joint Trust and Counter Fraud Strategy.<br><br>Extensive discussions in relation to IT Asset Management were also reported. |
| **19** | **Quality Assurance Committee-** *Exception Report from meeting held 20th May 2021* |
| 19.1 | Reports presented to the Committee were highlighted.<br><br>TS briefed the Board on the Medicines Management Deep Dive and assurance received, particularly in relation to high reporting and near misses. |
| **20** | **Governance and Nominations Committee**– *Verbal update from 4 June 2021 meeting* |
| 20.1 | CM informed of proposed changes to the scope of the Strategic Partnership Committee, including considerations of additional membership and meeting maturity to discuss strategy as well as strategic partnerships.<br><br>Ongoing discussions in relation to AHM visits and associated governance were held. |
| **21** | **Non-Confidential update from Finance & Infrastructure Committee-** *from meeting 24th May 2021* |
| 21.1 | There were no updates to provide. It was agreed to include the exception report at the In Public meeting going forward to ensure transparency. |
| **22** | **Charitable Funds Committee-** *Exception Report from meeting held 21st May 2021* |
| 22.1 | • GK provided an overview of the reports received by the Committee.<br>• The Committee discussed potential plans for an official opening of the memorial gardens.<br>• It was noted that £50,000 had been received into the charity's account in February 2021 from NHS Charities Together, enabling to proceed with the creation of the Multi Use Games Area (external gym) for mental health patients. |
| **23** | **Annual Review of Board of Directors Terms of Reference** |
| 23.1 | **The Board of Directors Terms of Reference were approved.** |
| **Any other business** | |
| **24** | **Reflections** |
| 24.1 | There were no items of reflection to note. |
| **25** | **Any other business & future agenda items** |
| 25.1 | No other business was discussed and the meeting was closed. |
| **26** | **Close** |

# Action Tracker

| Overall Status | Source Of Action | Date Action Generated | Minute Reference/ Additional URN | Action Number | Title/Concerning | Action Detail/ Management Response | Action Owner(s) | Latest Progress Update |
|---|---|---|---|---|---|---|---|---|
| On Target | Board meeting - In Public | 07/06/2021 | 13.5 | AC003746 | BOD1- Performance Report - Finance | AS reported a high number of IT risks and emphasised comprehensive and diligent consideration on the risk register. CM asked if further information would be reported at a future Confidential Board/Board Workshop and AS highlighted further executive oversight required to understand the impact of risks. It was agreed to include a statement within the next report for appropriate Board assurance. **Action- AS.** | Andrew Strevens | AS has been through the risks with the ICT team and following discussion has revised a number of the residual scores downwards. However, the number of risks identified is an outcome of using the risk register appropriately, given the complexity and multitude of systems. |

# Board and Committee Cover Sheet

Item 8.1

NHS Solent NHS Trust

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Item No. | 8.1 | | | | | | |
| Presentation to | Trust Board | | | | | | |
| Title of Paper | Green Plan | | | | | | |
| Purpose of the Paper | To share with the Board the Green Plan that has been developed for Solent NHS Trust to ensure delivery of the strategy and targets set out. To seek approval of the Green Plan from the Board.<br><br>A Green Plan is a Board approved, current live strategy document outlining the organisation's aims, objectives, and delivery plans for sustainable development. This includes implementation of the NHS Long Term plan deliverables and the guidance to achieving net zero. | | | | | | |
| Author(s) | Chris Box, Associate Director of Estates and Facilities<br>Jo Warwick, Building & Environmental Compliance Manager<br>Philip Duddell | | Executive Sponsor | Gordon Fowler, Strategic Transformation Director and Director of Estates | | | |
| Date of Paper | 23 July 2021 | | Committees/Groups previously presented | Finance & Infrastructure Committee/Executive Group Officers/Sustainability Action Group | | | |
| Statement on impact on inequalities | Positive impact (inc. details below) | | Negative Impact (inc. details below) | | No impact (neutral) | | |
| Summary of key messages / findings | The Green Plan has been developed in collaboration with a number of services and key staff across Solent NHS Trust to ensure it reflects the trajectory and strategy for the whole trust in terms of sustainability and achieving Net Zero.<br><br>The Green Plan is a live strategy document and is valid for a period of 3 years, the plan will be reviewed at least annually or when any significant changes in guidance is published and/or there are any significant changes in the way that Solent delivers its clinical services.<br><br>The Green Plan has a series of actions that will be required to ensure the strategy and targets are met and these are reflected in the detailed action plan; this can be shared upon request by Board members if required. This is a live document and will be regularly updated as actions are closed and new actions are identified. | | | | | | |
| Action Required | For decision? | Y | For assurance? | Y | | | |
| Summary of Recommendations | The Trust Board is asked to:<br>• Approve the Green Plan | | | | | | |

## 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 is asked to consider whether this paper provides:<br><br>Sufficient assurance<br><br>And, whether any additional reporting/ oversight is required by a Board Committee(s) | | | | | | | |
| Executive Sponsor Signature |  | | | | | | | |

Item 8.2

# Our Green Plan

2021/22 - 2024/25

**‘Care - for the future’**

# Contents



| Green Plan version | Publication date | Review date |
|---|---|---|
| 1.01 | August 2021 | August 2022 |

| **Contributors to this plan included our Solent NHS Trust:** |
|---|
| • Executives<br>• Care teams<br>• Estates and Facilities teams<br>• Procurement team<br>• Travel and transport team<br>• Communications team<br>• HR, Learning and Development teams<br>• Community liaison |
| ***With expert input from our external partners including community representatives*** |

If you have any comments on or questions about Our Green Plan please contact us at:

sustainability@solent.nhs.uk

# Care- for the Future

## Executive Summary

The Climate Health Emergency is real and will impact the health and well-being of us all.

We have a collective responsibility to do more, and while we've made progress we can and should go further.

This includes thinking about how we can sustainably deliver all of our services, right down to the patient-facing models of clinical care that we deliver.

Our environmental impact, measured in our carbon footprint for 2020/21, amounted to 4,069 Tonnes $CO_2e$. Our Green Plan sets out our approach to minimising, measuring and monitoring this impact. It focuses on:

**Our Care** – how we reduce our environmental impact by improving the way we deliver care e.g. offering digital care pathways where clinically appropriate, inhaler recycling, medicines and anaesthetic gases management.

**Our Estate**- to reduce the carbon emissions from our buildings, improve recycling and continue to adapt our buildings to future needs.

**Our Supplies**- to ensure that environmental standards such as emission reduction, are reflected in all of our contracts alongside introducing more social value.

**Our Travel**- to reduce our environmental impact by changing the way we deliver care, travel to work and in our day to day lives.

**Care – for the future**

Our community health is dependent on a healthy environment.

We can be smarter in how we use resources when delivering high quality healthcare, so that we are environmentally, economically and socially sustainable.

Working together will help ensure that we are helping create the best future environment for our community, patients and staff.

We are committed to setting the leadership standard where we can.''

Sue Harriman

**Chief Executive Officer**

Delivery of this plan means a collective approach by all our people, together with our local community, and partners. As part of our role in the Integrated Care System for Hampshire & Isle of Wight, our Green Plan will be consolidated into a wider system- plan for 2022.

# Glossary – some key terms used in this plan

| | |
|---|---|
| **Active Travel** | Active travel simply means making journeys by physically active means - like walking, cycling, or scooting. |
| **Carbon Dioxide – $CO_2e$** | '$CO_2e$', or Carbon Dioxide equivalent, is a standard unit for measuring carbon footprints - this expresses the impact of each different greenhouse gas in terms of the amount of $CO_2$ that would create the same amount of warming. |
| **Circular Economy** | A circular economy is an economic system aimed at eliminating waste and enabling the continual use of resources. This includes 'reuse', 'repair', 'refurbishment', 'remanufacturing' as well as 'recycling', where relevant. It moves away from the current linear economy where we 'make, use and dispose', which results in significant waste and related emissions. |
| **Greenhouse gases** | The Earth's greenhouses gases (GHGs) trap heat in the atmosphere and warm the planet. While this is a natural process, the greater the concentration of greenhouse gases the higher the temperature. They have increased significantly due to human activities and are continuing to do so, leading to major impacts on society, economy and the environment. The main GHGs (those focused on within international Climate Change agreements) are: Carbon Dioxide ($CO_2$), Methane ($CH_4$), Nitrogen Dioxide ($N_2O$) and Hydro-fluorocarbons (HFCs), while others also apply. |
| **'Net Zero'** | The UK Government has set a goal to be 'carbon zero' by 2050, which is enshrined in law. The NHS has set a goal to reach net zero by 2040.<br><br>'Net Zero' emissions means: any emissions remaining, after all possible efforts to mitigate them have been undertaken, would be balanced by *verified* schemes to offset an equivalent amount of greenhouse gases from the atmosphere, such as planting trees or using technology like carbon capture and storage. *Only after all possible emissions have been mitigated, reflecting relevant cost benefit analysis, should offset be considered.* |
| **NOx and PM $_{2.5}$** | Nitrous Oxides and fine particles, a major source of which is road traffic, can cause air pollution and death and ill-health among communities. |
| **UN Sustainable Development Goals (SDGs)** | The 17 Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by all United Nations Member States in 2015 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030. |
| **Green House Gas Protocol (GHGP)** | Greenhouse Gas Protocol is the global standard for companies and organizations to measure and manage their Green House Gas emissions and become more efficient, resilient, and prosperous. |

# Our Impacts – the need for change

The link from climate change to public health impacts and NHS resource pressures is clear. We have a significant impact on the environment, and we must seek to reduce this while delivering quality healthcare for our community.

While we affect the environment in various ways, our impact on the environment and that of the NHS is measured in our Carbon Footprint (Tonnes $CO_2e$).

## NHS Carbon Footprint

Directly controlled emissions arise from the use of energy and water, the generation of waste, the use of travel for Trust business and anaesthetic gases. These emissions account for our carbon footprint.

Our total NHS carbon footprint for **2020/21** was **4,069 Tonnes $CO_2e$**, based on sites we control. That is the equivalent volume of 14,000 double decker buses.

In **2013** our carbon footprint was **5,596 Tonnes $CO_2e$** (this excludes emissions from anaesthetic gases as data is not available and some date is estimated).

The significant reduction since 2013, in part reflects a 19% reduction in the size of the estate and a 32% change in the way clinical services are delivered, due to changes in the community and mental health services provided, as well as efficiency measures undertaken.

The footprint for 2020/21 also reflects the impact of COVID-19 on healthcare service delivery. For example, there was a significant reduction in emissions from business travel in 2020/21, due to greater use of digital consultations.

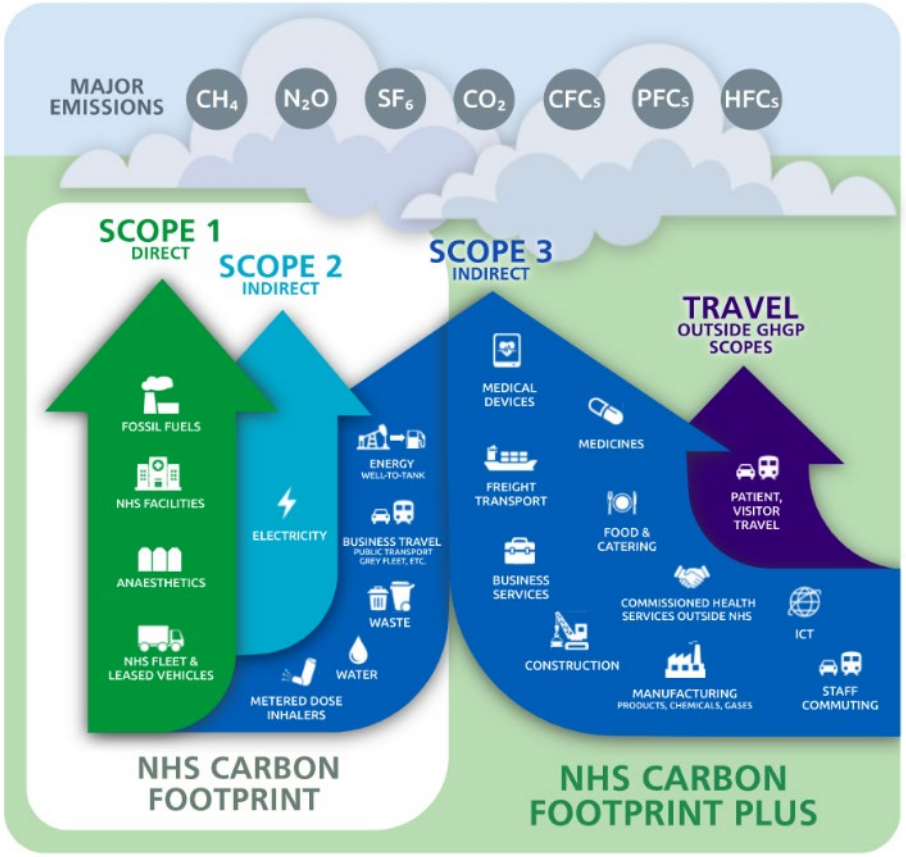
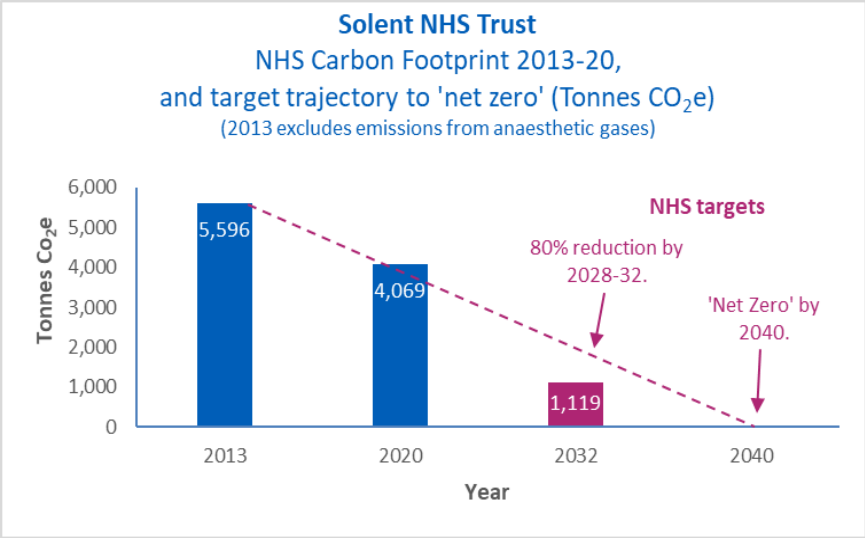



*Figure 1: NHS Carbon Footprint and Carbon Footprint Plus (source: NHS)*

## NHS Carbon Footprint Plus

Other emissions arise from our supply chain (from goods and services procured) and within our community, such as those arising from staff commuting and patient and visitor travel to our sites. While these are not all quantified, we recognise the necessity of seeking to influence a reduction in relevant emissions where we can.

| | | |
|---|---|---|
| | **Energy** | 2,492 Tonnes $CO_2e$ |
| | **Water** | 30 Tonnes $CO_2e$ |
| | **Waste** | 9 Tonnes $CO_2e$ |
| | **Business Travel** | 384 Tonnes $CO_2e$ |
| | **Anaesthetic gases** | 1,184 Tonnes $CO_2e$ |
| | **Total** | **4,069 Tonnes $CO_2e$** |




# Our NHS Carbon Footprint (2020/21)

## Setting targets

The NHS aims to be the world's first 'Net Zero' national health service (Greener NHS) and has set the following target:

For emissions directly controlled (the **NHS Carbon Footprint**), to reach;

1. Net zero by 2040
2. An 80% reduction by 2032.

We have adopted this target, using 2013/14 as our baseline year against which to measure and report progress, as this reflects the year Solent NHS Trust took ownership of properties across our Estate.

While significant progress has been made to date, this target is challenging. We will seek to build on reductions in emissions achieved in 2020/21 and minimise as much as is possible any 'rebound' in emissions post COVID-19. Progress against the target will be reported within our Annual Sustainability Report.

Changes in our carbon footprint will also be monitored relative to the gross internal floor space of our premises, as well as patient activity numbers, to ensure we understand how changes reflect real progress.

We acknowledge our Carbon Footprint will be affected by external factors such as the UK's energy supply mix (the increase in UK renewable energy supply has, for example, significantly reduced emissions from electricity) and the ban on new diesel and petrol cars from 2030.

For the emissions that we can influence (our **NHS Carbon Footprint Plus**), the NHS has set a target to reach net zero by 2045, with an ambition to reach an 80% reduction by 2039. We have and will set actions to influence a reduction in these emissions, where relevant.

# Our Green Plan 'Care - for the future'

**We aim to:**

- Reduce emissions
- Reduce waste
- Improve local air quality, and the health and well-being of our communities
- Ensure our services are future-ready and able to adapt to a changing climate.
- Deliver good value

**We will reduce our environmental impact in:**

**OUR CARE**
By improving the way we deliver high quality care.

**OUR ESTATE**
By reducing carbon emissions from our buildings and facilities.

**OUR SUPPLIES**
By working with our suppliers to reduce emissions and enable us to deliver more social value.

**OUR TRAVEL**
By reducing how we travel to deliver care, travel to work and in our day to day lives.

**Working with:**

**OUR COMMUNITIES**
We will play our part in improving local air quality, and the health and well-being of our communities.

**OUR PEOPLE**
We will work with everyone in our local health & care system to deliver the best outcomes for the our local community and the NHS.

# ‘Care – for the future’

Our plan drives initiatives that focus on efficiency and deliver environmental and related social improvement in our community.

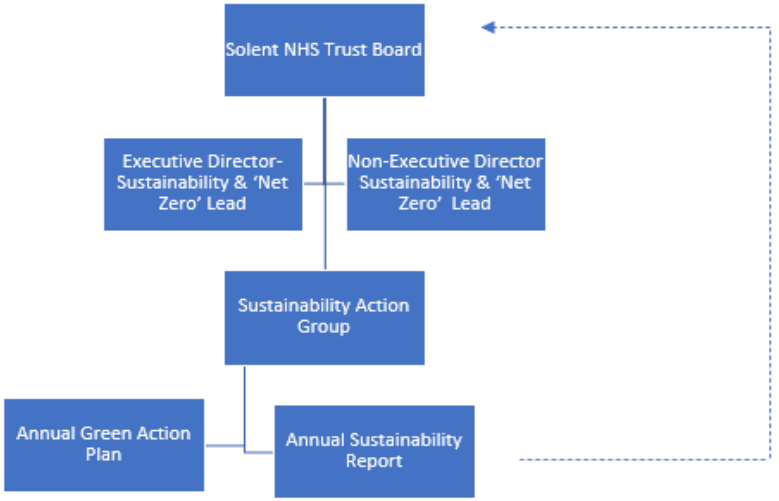
How we deliver high-quality healthcare, manage our estate, procure and use our supplies and how we travel, afford us opportunities to:

- **Transition to ‘Net Zero’** carbon emissions, enshrined in our legal obligations within the UK Climate Change Act and NHS targets.
- **Spend public money wisely** by being efficient in the use of finite resources and avoiding waste.
- **Improve local air quality**.
- I**mprove the health and wellbeing** of our people and local communities
- **Plan for the impacts of climate change** and adapt to improve the resilience of our services and estate.

As well as meeting NHS requirements as set out in the NHS Long Term Plan, NHS Standard Contract, the Greener NHS programme and national policy and legislation, our Green Plan supports delivery of the UN Sustainable Development Goals. We are aligned with the aims of our partners in the Hampshire and Isle of Wight Integrated Care System, other NHS Trusts and public bodies, community groups and our suppliers.

## ‘SMART’ Actions

In order to meet our carbon reduction, air pollution and waste targets, our plan is supported by a comprehensive set of initial SMART and dynamic actions, captured within a separate ‘Green Action Plan’, which will be updated every year.




## Management of the integrated Green Plan

The Strategic Transformation Director and Director of Estates is the Executive lead for Sustainability and ‘Net Zero’, but recognise we must take a ‘whole Trust’ integrated approach to our Green Plan. We need to consider how the decisions we make will affect our environmental impact, how we should capture data and learn from good practice. We have therefore established a Sustainability Action Group to plan and deliver our Green Plan, monitoring and report on progress against targets and actions within our mandatory Annual Sustainability Report.

# Our Care

**Executive sponsor: Medical Director**

Reduce our environmental impact by improving the way we deliver care and manage medicines.

## What we know

Historically, care rightly focused on patient outcomes but didn't always account for and consider environmental impacts.

There are opportunities to be more efficient in the management of medicines and anaesthetic gases. The use of anaesthetic gases has a significant environmental impact. The carbon footprint of anaesthetic gases used in 2020/21 is, for example:

| | |
|---|---|
| **Entonox** | 262 Tonnes $CO_2e$. |
| **Nitrous Oxide** | 922 Tonnes $CO_2e$. |
| **Total** | **1184 Tonnes $CO_2e$.** |

## What we have done

When we design and deliver care, we endeavour to optimise the location of care, to facilitate earlier and faster diagnosis, reducing unnecessary treatments and delivering best clinical practice.

The Covid-19 pandemic has accelerated our deployment of telephone and online consultation technology, alongside more online appointment booking and home testing services.

## What we will do next

**Care models** - when we consider how best to deliver care we will:

- Use digital technology where appropriate to reduce unnecessary travel and deliver care more conveniently.
- Think about the environmental impact of how and where we deliver services

**Medicines** – we will identify opportunities for waste prevention including through good stewardship, smart stock control and consolidation of storage of medicines.

**Anaesthetic gases** – where appropriate we aim to reduce nitrous oxide wastage.

**Inhalers** - we will support, where clinically relevant, a shift from the use of metered dose gas driven inhalers to dry powder inhalers to reduce emissions.

We will encourage users to return their inhalers to pharmacies for appropriate recycling and disposal.

# Our Estate

**Executive sponsor: Director of Estates**

Reduce carbon emissions from buildings and facilities and adapt our estate to the effects of climate change.

## What we know

Our buildings and facilities represent a significant source of our carbon emissions. Known and anticipated changes in climate will impact on our estate so we will need to plan for such changes.

### Energy and Water

The carbon footprint from energy and water in 2020/21 was:

| | |
|---|---|
| Electricity | 1,066 Tonnes $CO_2e$. |
| Gas | 1,395 Tonnes $CO_2e$. |
| Water | 30 Tonnes $CO_2e$. |
| Total | **2,492 Tonnes $CO_2e$.** |

As indicated in 'Our Impacts' section this has reduced significantly since the 2013 baseline year.

This reflects in part changes in the Trust estate and services, changes in the UK energy mix and efficiency measures implemented.

In addition, indicative emissions in 2020/21, from waste treatment, based on waste quantities, are **8 Tonnes $CO_2e$**. Waste arises from the use and disposal of products, materials and equipment procured by us and our suppliers. This includes clinical, nursing, buildings, pharmacy and others. All waste represents a loss of financial and resource value. Reducing the financial and environmental impact of waste means identifying the source of the waste and what interventions are feasible, in collaboration with relevant teams and our contractors.

## What we have done

- Undertaken a range of improvements to the Estate, including the refurbishment of St Mary's Community Hospital Campus - enabling significant improvements energy efficiency including reduced emission rates of Block B and C by 45%.
- Installed LED lighting across much of our estate - reducing costs and emissions.
- Committed to 100% green energy supply in 2021/22.
- Introduced degree day data to ensure economic efficiencies and to track consumption of our utilities usage.
- Introduced 500 additional dry mixed recycling bins and improved segregation, helping to **reach our target of zero waste to landfill** (it is recycled, or sent for energy recovery/composting or incinerated in the case of clinical waste).
- Enabled the reuse of 20 tonnes of otherwise redundant furniture by local charities, in conjunction with our waste contractor.
- Standardised design fittings as set out in our Accommodation Guide, such as light fittings.

## What we continue to do

We work closely with our facilities providers to minimise environmental impact of their services and collaboration with contractors, including creating opportunities for local jobs and skills development. This is monitored through regular contract review meetings.

We regularly discuss the opportunities to consolidate our Estates with partners in the NHS, local authority and others.

We assess and seek to mitigate short-term risks from extreme weather events and climate change, including premises resilience planning, with the aim to also consider the effects on services of a changing climate on the most vulnerable within our communities, in conjunction with local partners, such as the Hampshire and Isle of Wight Local Resilience Forum.

We have a Nutrition Group which aims to ensure all food is healthy and locally sourced, our standard operating procedures ensure that all of our food provided meets the relevant NHS nutrition guidance. We aim source even more food locally through our catering suppliers.

Collaboration continues regarding facilities management sustainability with the Hospital Caterers Association (HCA), Health Estates and Facilities Management Association (HEFMA), WRAP and local sustainability groups.

## What we will do next

**Collaboration** - Working with Hampshire & Isle of Wight Integrated Care System partners, we will identify opportunities to reduce our estate and collaborate on decarbonisation.


**Decarbonisation review** – Using the principles set out in the Healthcare Engineering Roadmap to delivering Net Zero Carbon we will identify actions to reduce our impact. This includes;

- Potential upgrades to our buildings (lighting, heating and cooling, building fabric, ventilation and hot water),
- Optimising building usage include real-time monitoring and control
- Potential use of roofs and space for renewable energy and heat.

**Pan-organisation approach to waste** - we will prioritise opportunities to reduce or recycle waste. Using the waste hierarchy principles we will avoid single use plastic, and work with procurement, estates and facilities, clinical teams and our waste services contractor to reduce and re-use.

**Standardisation of fittings** - we intend to expand the standardisation of fittings, where relevant, and enable lessons to be applied in clinical and non-clinical areas, to save costs and reduce wastage.

**Nutrition and food waste** - we are seeking reductions in food waste through a Catering Management System, to improve food ordering on wards. We will also continue to focus on healthy, seasonal and, where possible, locally sourced food provision in conjunction with catering partners.

**Adaptation to climate change** – our focus on mitigating short-term risks to our estate, patients and staff from extreme weather, such as flooding and heatwaves, will continue. We will also reflect known and anticipated changes in climate in estate and service planning.

# Our Supplies

**Executive sponsor: Director of Strategy**

We will work with suppliers to reduce emissions and deliver more social value e.g. prioritise procurement requirements according to relevant emission reduction.

## What we know

Our expenditure on the procurement and supply of goods and services accounts for a significant quantity of carbon emissions; those that impact on our carbon footprint as well as those within supply chains.

The indicative carbon emissions, based on expenditure, arising from the procurement of goods, services and drugs in 2020/21 was **14,878 Tonnes $Co_2e$**. Major contributors to this include buildings related procurement and office equipment. While this is an estimate only, it does highlight the importance of reducing, where possible, carbon emissions in the supply of goods and services.

The Future Operating Model for NHS Procurement, focusing on enhancing procurement efficiency and economies of scale, means that the majority of our procurement is through NHS Supply Chain.

## What we have done

Our procurement policy includes requirements that all procurements should include relevant sustainability requirements to ensure the Trust is contributing to environmental targets.

Sustainable procurement principles must be considered in commercial decisions based on whole life costs and value for money.

We support Supply Chain's efforts to reduce emissions in conjunction with suppliers, while also seeking reduction from those who supply directly to us.

## What we will do next

**Emissions reduction** - we will require prioritised suppliers to support our 'Net Zero' ambitions through their contract delivery and encourage innovative solutions. This includes:

- Reducing emissions and waste
- Avoiding single use plastics where possible
- Decarbonizing construction
- Maximizing high-quality recycling
- Reducing emissions from supplier logistics.

**Social value** - we will include social value in our tender requirements, especially those that support our focus on community health and wellbeing, as required by the Social Value Act 2012 and in accordance with procurement regulations.

**Opportunities for local supply** - we will seek to ensure local SMEs and third sector organisations have opportunities to be involved in our supply chains. We also aim to help SMEs understand how they can be more resource efficient.

**Emphasize the link from procurement to waste** - the link from the procurement and use of products and supplies to the true cost of waste (financial and environmental) will be reinforced across the Trust, to focus waste minimisation efforts.

**Supply chain resilience** - we will ensure risks to supply chain resilience from climate change are understood and managed, as much as is possible, in contingency planning.

**Deliveries** - while we do not have a large number of daily supplier deliveries to our sites, we intend, in conjunction with other Trusts, to identify how to further reduce vehicle movements through a 'Delivery Service Plan'.

# Our Travel

**Executive sponsor: Director of Estates**

Reduce environmental impact through how we deliver care, travel to work and in our day to day lives.

## What we know

Our community healthcare requires essential travel. This involves significant costs and carbon emissions. We need to be smarter in the use of travel, while continuing to provide high quality healthcare.

In 2020/21 our business travel Carbon Footprint was **384 Tonnes $CO_2e$,** this reduced by 35% in 2020/21 relative to 2019/20, partly as a result of greater use of digital care pathways during COVID-19.

Travel from staff commuting, patient and visitor travel and travel by contractors. currently results in emissions that contribute to climate change and poor air quality (NOx and PM2.5 pollution), impacting our local community on a daily basis.

## What we have done

**Business travel -** our leased vehicles are low emission. We have introduced a business travel Car Club at our St Mary's site.

**Commuting** - we have promoted active travel, including through the provision of new secure bike sheds, active travel events, the cycle to work scheme, exploring new methods such as e-cargo electric bikes and a shared bike servicing scheme with other local Trusts. We are also trialling the safe use of e-scooters in conjunction with local authorities.

**Couriers** - our shared-service non-patient transport courier, which undertakes over 800,000 miles every year, has changed routes to reduce the miles and therefore emissions from blood samples collection and delivery.

## What we will do next

**Electric charging** - we are reviewing the potential installation of electric car charging points, following a feasibility analysis.

**Business travel low emission car club** - we will seek to build on the car club, currently operated at St Mary's. We will ensure these vehicles are low emission and aim to transition to electric vehicles.

**Staff use of own vehicles (business travel and commuting)** - we are reviewing the suitability of a salary sacrifice scheme for priority staff to purchase electric cars, drawing on lessons from other public bodies.

**Business travel analysis** - we will review the reasons for business travel and understand the impacts on business travel when reviewing digital care pathways. We will aim to capture the impact on reducing local emissions and improving community health.

**Commuting** – the staff travel survey will help identify opportunities to reduce the impact of travel and improve health and we will continue to promote active travel in conjunction with Occupational Health.

**Changes in care models** - relevant impacts on business travel and travel by patients as a result of changes in care models will be identified.

**Couriers and suppliers** - we will continue to collaborate with other Trusts and suppliers, including in shared services, to identify how supplies can get to us in a more sustainable way.

**Patient and visitor travel** – we will survey patients and visitors to better understand opportunities to reduce environmental impacts and promote health and well-being.

# Our Communities and People

**Executive sponsor: People Officer**

Enable staff to adopt sustainable practices at work and home, by developing our people and clinical leaders to understand their role in our Green Plan.

Involve community representatives in the delivery, review and update of this plan and enable communities to apply lessons, improving health and well-being and reducing health inequalities.

## What we know

To reach net zero all staff in Solent NHS Trust have a vital role to play in our Green Plan. Measures that improve our care, save money, and reduce our emissions also offer lessons and opportunities within our communities and in our day-to-day activities.

We also know that collaboration with strategic partners is essential if our ambitions are to be achieved.

Our environmental impact has a clear link to the health of our community e.g. children and the vulnerable who experience the impact of poor air quality. '[Alongside Communities]' – the Solent approach to Engagement and Inclusion, outlines our overall aim to *'keep more people healthy, safe and independent at or close to home'.* Our Green Plan is just one of the ways that we will do this.

## What we have done

Past campaigns have raised awareness and delivered environmental improvement such as preventing 100% of our waste going to landfill, increasing waste recycling and reducing energy consumption.

We know that **investing in this area of our plan has the biggest potential to deliver the most benefit to our people and our communities.**

## What we will do next

We will **communicate** the actions we are taking in our Green Plan with our people and our communities, as we know the best ideas can often come from the people who deliver and use our services.

**Engagement plan** - we will develop a comprehensive plan that works with our people and our communities to continually evolve and develop our Green Plan. We want to encourage everyone to participate in caring for the future.

**Develop our people** - we will develop online Green Plan induction, training and awareness and pledge platforms for staff.
We will develop our people, including our clinical leaders to help them take a more active role in developing sustainable models of care.
And we will ensure we have the resources in people to support our sustainability goals.

**Collaboration** - we will continue to collaborate with strategic partners to support delivery of plan objectives and pool good practice ideas.

This includes staff and Trade Unions, Hampshire and Isle of Wight ICS partners, Clinical Commissioning Groups (CCGs), Local Authorities, other NHS Trusts, Universities, schools, colleges and businesses, suppliers, Supply Chain Coordination Limited (SCCL), charities, community interest companies and other community partners.

Item 9

# CEO Report – In Public Board

Date: 22nd July 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 3 National Emergency, contemporary updates will be provided where appropriate in relation to our continued response****

## Section 1 – Things to celebrate

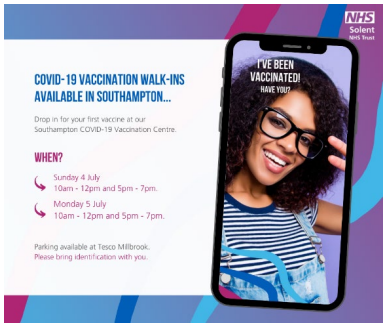
### Kelly Pierce MBE

Our Head of Service for Early Health and Prevention, Kelly Pierce, has been awarded an MBE for a service she helped create that came to the aid of expectant mums and their families during COVID-19.

### From Royal Navy Nursing to the NHS

We are delighted that Sharon McCann, Acting Operational Director for Adults Services Portsmouth, who was a nurse in the Royal Navy for 27 years before transitioning to the NHS in 2017, has been named the winner of the Role Model of the Year category in the Ex-Forces in Business Awards for her forward-thinking approach to recruiting nurses and attracting Armed Forces veterans as part of that work.

### COVID-19 vaccination walk-ins




As well as continuing the phased rollout of COVID-19 vaccinations as per the JCVI cohorts, we have been carrying out our outreach work by running walk in sessions in different communities to help increase uptake as much as possible. As part of this work, we collaborated with HIOW partners to host walk-in vaccination clinics (Grab a Jab), including at Southampton Guildhall and at two local fire stations.

### Saints Foundation partnership

We have come together with Saints Foundation to produce a visual campaign to raise awareness of COVID-19 and its long-term side effects, (also known as 'Long Covid') especially amongst the male population. In the video produced by us, Saints Foundation ambassador and former Southampton and international footballer, James Beattie, speaks to our Physiotherapist, Oli Holt, about ways in which people can stay fit and healthy during the pandemic and beyond. The pair also discuss Long Covid, how to spot the signs and demonstrate exercises to help people with their COVID-19 recovery, as well as general health and wellbeing.

### Awareness Weeks

Over the last few weeks, we have been highlighting several key awareness weeks, including Volunteers' Week; Learning Disability Week; Pulmonary Rehab Week; and Armed Forces Week. Details of our activities can be found on our website.

### NHS Big Tea

Our catering department did an amazing job of making over 3000 cupcakes, which we delivered across the organisation as a token of thanks and appreciation to our teams. We encouraged staff to take a moment of reflection and to connect with each other as part of the NHS' 73rd birthday celebrations. Even the Board, socially distanced, participated on 5th July at our away day and our celebrations were featured in NHS Charities Together's content.

## Section 2 – Internal matters (not reported elsewhere)

### Covid-19

While we are naturally shifting our focus to the reset and recovery of our services, it remains clear that the virus is still a threat. Infection rates are (at the time of writing) climbing across the HIOW area. There is clear evidence that vaccination does weaken the link between infection and hospitalisation, and while sadly there remain a few people who do require hospital intervention as a result of infection, the numbers are currently much reduced.

Strong Infection Prevention and Control protocols remain in place across our services - however this necessary precaution does restrict our ability to return to pre Covid service capacity. For example; we are currently unable to conduct group therapy sessions, our all our services are impacted by additional IPC practice that requires more time in-between interventions.

Front line services are being impacted by increasing numbers of staff being called to isolate as covid contacts. This is at a time when we have encouraged staff to take leave to rest and recuperate and the beginning of the summer holidays. Referrals are rising, particularly of note is Child and Adolescent Mental Health Services (CAMHs) and Adults Mental Health. Waits are also increasing in our Specialist Dental Services. The Board will be aware of the recent work completed by the Clinical Directors on waiting lists. This is an issue which rightly continues to demand attention from both clinical risk and operational perspectives. There are a number of inter-related pieces of work in play including enhancing our business intelligence & data quality; proactive triage and re-triage of patients waiting, and conversations with commissioners which will identify additional actions required and improvement trajectories.

Regarding CAMHS in Southampton we are naturally seeking to mitigate the risk in a number of ways – including the implementation of a childrens mental health liaison team at University Hospital Southampton NHSFT, the implementation of the childrens care at home team and augmented mental health in schools teams. In addition, we are in discussion with local commissioners and council colleagues about the potential to re-purpose surplus estate to create a local short term residential intervention facility. CAMHS Portsmouth has received additional investment from the CCG and recruitment is underway but challenging in a nationwide shortage of qualified CAMHs Practitioners.

For Special Dental services the concern is the number of patients waiting now more than 52 weeks for treatment. We have had a very positive discussion on this issue at the System Planned Care Board and as a result these patients will be included alongside acute waiting lists for patients waiting for other elective care via the clinical prioritisation processes.

### Workforce implications

We are monitoring on a daily basis, the impact of Covid on our staff absence, whether due to having Covid or having to isolate (and not attend work) as a result of isolation. Services most impacted are Adults Southampton, Mental Health and Sexual Health. With schools closing for summer soon, and with the anticipated further announcement on 16 August regarding double-vaccinated adults, we expect that will mean less staff needing to isolate.

Following the government announcement that fully vaccinated frontline NHS staff will be exempt from contact isolation in exceptional circumstances, we have reviewed the new guidance for frontline health and social care staff. A process for requesting an exemption has been designed requiring sign off from the Chief Nurse.

Staff wellbeing continues to remain top of our agenda as workforce pressures mount. We continue to provide a comprehensive support package to our staff and remain working with our partners in the Hampshire and IOW Integrated Care System on a range of growing offers.

### Hawthorns Fire incident

On the evening of 15 July 2021 we evacuated Hawthorns. Hampshire Fire and Rescue were promptly on the scene and whilst damage was limited, we did need to close the unit temporarily.
Staff and patients were all safely repatriated to an alternative location and there were no injuries.
Our staff were commended for their prompt and professional response, and our estates, facilities management and support teams were on site the following morning to assess damage and commence repairs.

Further detail of operational pressures is found within the Performance Report.

### Mass Vaccination Centres

We continue to deliver Covid vaccinations from the four mass vaccination centres across HIOW (at the time of writing – 22 July we had delivered almost 470,000). Our focus remains on delivery and concluding this phase of the programme well. We have started to plan for the drawdown of the current delivery phase as well as the transition arrangements in relation to what our role will be in the next Phase of boosters. We have also been able to do useful contingency planning, including working with the teams from across the community who have supported the programme so far, hosting careers events at each location and starting to build a bank of people who would be interested in working with us into the future.

We have recently seen a downturn in the number of booking at each of our centres and as such we rapidly reconfigured and have returned to offering vaccination on a walk-in basis, as we successfully trialled earlier in the year. We supported the successful Southampton Central PCN walk-in weekend at the Southampton Guildhall on July 10th and 11th and continue to deploy our mobile/pop-up capability targeting hard to reach groups and areas.

### Appointments

#### Chief People Officer Appointment

I am delighted to announce that Jasvinda Sohal has been appointed as Chief People Officer here at Solent in a substantive role.
Jas is a valued member of our team, more recently in the Acting Chief People Officer role since September 2020. Jas is incredibly passionate about living our values, making work a full experience for each individual and she brings with her a wealth of knowledge and skills which will help continue to support our teams and develop Solent as a great place to work.

#### Requirements for a designated exec lead - Net Zero

Our Green Plan is presented for approval separately to the Board this month.
In addition, and in accordance with a letter from NHSE/I and the requirements *Delivering a net zero National Health Service* strategy, the Board are required to nominate a Board-Level net zero lead (and confirm to NHSE Regional Team by 1 October 2021) with accountability for this work. The environmental and sustainability agenda sits within the Director of Transformation and Estates portfolio (a Board advisor and Board attendee) – it is therefore proposed that net zero responsibility also falls within this remit. **The Board are asked to formally agree this recommendation.**

#### Requirements for a designated exec lead – Violence Prevention & Reduction Standard

The new NHS Violence Prevention & Reduction Standard, launched earlier this year, states "*A designated board-level (director) manages the violence prevention and reduction workstream and ensures*

*appropriate and sufficient resources are allocated to the function".* NHSE have requested a designated lead to be identified,

The security agenda sits within the Director of Transformation and Estates portfolio (a Board advisor and Board attendee) – it is therefore proposed that the violence prevention lead also falls within this remit**. The Board are asked to formally agree this recommendation.**

### Appointment to the national Hospital Food Review Expert Panel

Following the Independent Hospital Food Review launched on 26th October 2020 where it was announced that an expert panel would be created to progress and monitor the recommendations of the review, NHSEI have now concluded their recruitment process to this group comprising nine core members.

We are delighted to be able to announce that our Solent catering manager, Iain Robertson, has been appointed to the expert panel following a rigorous selection and interview process. This is a significant opportunity for Iain to add real value to this important piece of work. The expert panel will deliver the following key actions over the next 3 years;

- Maintain momentum and provide support to hospital caterers, dietitians, and nurses.
- Be responsible for propagating the core principles of good food service throughout the NHS.
- Be accountable to NHS England & Improvement, for the delivery of the recommendations, reporting to Department for Health & Social Care periodically.
- Publish a post-implementation review.

### Organisational Strategy

Solent's current strategy was developed and published in 2016, underpinned by the "three greats". We set out an ambitious vision to deliver great care, make Solent a great place to work and deliver great value for money. The strategy was framed in context where the NHS had developed the 5- year forward view, sustainable transformation plans (STP) were emerging, and a blueprint had been set out for the creation of new care models. In March of 2020 the board refreshed the strategy, shortly after, the COVID-19 pandemic has brought an extremely challenging 18 months for the organisation and the system we operate in.

On the 5th of July 2021 the board held a workshop focused on reframing our position for the refresh of our strategy, taking into the account the post pandemic impact, the NHS white paper, the emerging Hampshire and Isle of Wight Integrated Care system and internal risks and opportunities. In addition, the need to address the health inequalities within our communities that have been uncovered by the pandemic, meaning it is important for us to refresh our organisational strategy to reaffirm our mission, vision, strategic priorities, and values we will use to navigate the next 5 years and maximise strategic opportunities. The appendix (1) to this report sets out the timeline we have set for phase 1 of the strategy refresh. Phase 2 will be focused on extensive co-production with our staff, communities, and system partners to ensure that we undertake the clinical transformation required to deliver our strategy over the next 5 years.

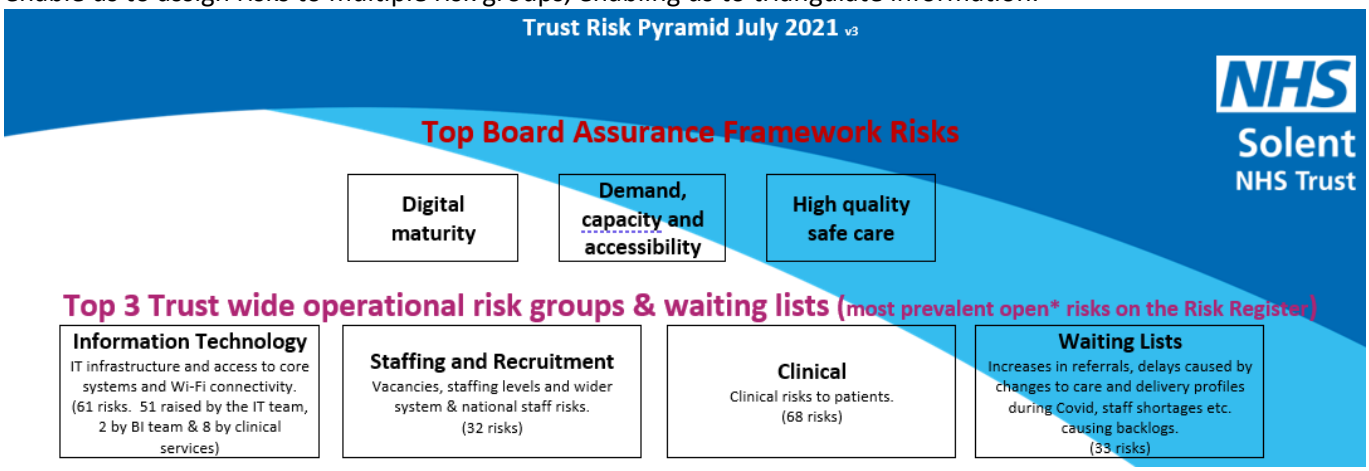
### Royal College Review

There has been recent media scrutiny in relation to Royal College reviews, as a result we took the opportunity to review the information relating to a previous review conducted. In 2017 we commissioned the Royal College of Paediatrics and Child Health to complete an extensive review following a Serious Incident Investigation in February 2017. The findings, our learning and the action we took in response to the review, were shared as part of a CQC engagement visit. There have been no further Royal College Reviews since.

## Operational Risk Register / Board Assurance Framework (BAF)

The risk pyramid summarises our key strategic and trust wide operational risks. Clinical, staffing and recruitment and IT are the top four risk groups, and are being actively managed through our care groups and assurance is sought at the relevant Board Committee.

We are developing and updating both our Risk Management Framework and our Risk Management System to enable us to assign risks to multiple risk groups, enabling us to triangulate information.




Further to the Board Workshop in May, our refreshed BAF is aligned to the newly agreed strategic risk themes as follows. The full BAF is provided to the Confidential Board.

| BAF Risk | Residual Score |
|---|---|
| Demand, capacity and accessibility | 5S x 4L = 20 |
| Digital Maturity | S5 x L3 = 15 |
| High quality safe care | S5 x L3 = 15 |
| Financial sustainability | S4 x L3 = 12 |
| 3rd party contractor assurance | S4 x L3 = 12 |
| Workforce sustainability | S4 x L3 = 12 |
| Strategic Partnerships | S4 x L2 = 8 |

## Armed Forces Covenant

The Armed Forces Covenant (AFC) is the nation's commitment to ensure that due to the unique nature of Armed Forces service, those who proudly protect our nation are not disadvantaged by Service and are properly recognised and represented both during and after their service. Following consideration, the executive team agreed to sign the Armed Forces Covenant Pledge.

For us, signing the Covenant will indicate to the Armed Forces Community our continued commitment to ensuring:

- They should enjoy the same standard of, and access to healthcare as that received by any other UK citizen in the area they live.
- Family members should retain their place on NHS waiting list, if moved around the UK due to the service person being posted.
- Veterans should receive priority treatment for a condition that relates to their service, subject to clinical need.
- Those injured in service should be cared for in a way which reflects the nation's moral obligation to them, by healthcare professionals who understand the Armed Forces culture.

- As an employer we proactively seek to attract a high calibre of candidates for roles within the Trust from the Armed Forces community with the skills and cultural values that armed forces personnel have and how these are compatible with working in the NHS.
- Support for staff who veterans, reservists or their family members is provided through mentoring through our Internal Veterans Network and with policies and practice that supports flexibility in granting leave both paid and unpaid.

Details of assurance to the board in relation to the pledge can be found within Appendix 2.

### Wheelchairs

As referenced in the previous CEO Report to Board, we recently escalated concerns regarding children wheelchair provision, including:

- In Southampton – regarding children awaiting input/treatment within specialist wheelchair school clinics. Following escalation, a formal investigation is now underway by the Provider. We have received assurance that all children identified within the escalation have either received an appointment or have an appointment booked no later than July 2021. Pending the outcome of the investigation, we will continue to escalate any potential concerns regarding the care of children concerned.
- In Portsmouth - regarding children awaiting assessment and provision of specialist wheelchair backrests. Following escalation, the commissioner has been working with the provider to investigate this further. We have received confirmation that all children identified within the initial escalation have now received their first appointment. Concerns remain to ensure the children receive a completed chair in all cases. Therefore, communication remains ongoing to ensure the children receive the further appointments required to facilitate handover of their new backrests/wheelchairs which are expected to meet their needs more effectively.

### Operation Cavell

Operation Cavell is the name given to a Local Joint Services Agreement in supporting emergency workers who become the victim of a crime, and addresses violence and aggression against NHS staff with a focus on hate crimes. Members of our estates, security and diversity and inclusion teams recently attended a meeting with local NHS Partners, Hampshire Constabulary, Sussex and the Met Police forces and Solent was commended for initiatives implemented. This includes:

- Modified way to capture breakdown of hate crime in Ulysses
- Victim service in place
- Anti-discrimination task force set up to address issues
- New headings included within Solent reporting using national hate crime reporting strands
- Working with victim care and restorative justice (an out of court scheme)
- Developing a digital reporting platform to cover hate crime - to be shared with partners across the ICS, and
- Completion of a case study – to be shared across the ICS

## Section 3 –System and partnership working

### Hampshire and Isle of Wight (HIOW) Integrated Care System (ICS) update

The HIOW Health and Care Leadership Group held its inaugural workshop on 23 June 2021 to consider the feedback received on from system leaders on the proposals for the development and formalisation of ICS arrangements. It was acknowledged at the meeting that further consideration be given following the publication of the ICS Design Framework

### Portsmouth and South East Hampshire (PSEH) System

PSEH system pressures are a continued concern, with occupancy at Portsmouth Hospitals University NHS Trust (PHU) routinely over 95% and Covid admissions rising. Ambulance delays have been escalated by South Central Ambulance Service (SCAS). System partners are working on a 6 week action plan in the hope that it will act as a circuit breaker. Bedded community capacity is being discussed as part of this plan, particularly in the light of a PSEH Regional shortage of domiciliary care.

### Southampton and South-West Hampshire System Update

We continue to play an active role in shaping the future model of system governance for the Southampton/South-West area, notably with our Chief Medical Officer hosting a valuable workshop with system partners in early July. Exactly what the future model looks like remains in discussion, and naturally is closely linked to how the wider Integrated Care System evolves.

In operational terms we have successfully gained financial support for our Childrens Hospital at Home model. This is a partnership proposal between ourselves and University Hospital Southampton NHS Foundation Trust, which seeks to implement a community based service for young children with respiratory illness in the area. Given that this (or very similar) models are already in place in the south-east and north/mid Hampshire geography, and the anticipated rise in such complaints that modelling indicates is imminent (notably RSV in the southern hemisphere), this has been recognised and funded as a priority for the system.

### Isle of Wight (IoW) Partnership Update

A workshop held on 19 July with IOW and Solent operational service directors generated a long list of possible joint working opportunities and a genuine enthusiasm and commitment to progress. Conversations about opportunities for joint working in Improving Access to Psychological Therapies (IAPT) services are already well advanced. The Mental Health and Community Partnership Boards will merge into a Partnership Management Group and the partnership will focus on improving quality, outcomes and effectiveness of our services by working together.

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

## Appendix 1 -Strategy Development timeline

## Appendix 2 – Assurances in relation to the Armed Forces Covenant

A number of the commitments in the Trust's pledge have been met or are nearly met and others will require an ongoing programme that continues to focus on the armed forces community. Inevitably some commitments may be challenging to fulfil and require further consideration by the Trust at a future date.

Through the leadership of the Chief Operating Officer (Southampton & Countywide services), supported by the Collaborative Programme Director and Armed Forces Lead Manager the programme will be robustly managed and any risks managed and mitigated as they emerge.

Assurance to the Trust that we are working towards our commitments, or they have been reached and are being maintained will, be in the form of a periodic report to the Board. This report will set out progress against each commitment, highlight risks to delivery indicating how these are being mitigated report the outcomes of external accreditation and reaccreditation by external bodies when this takes place.

The forthcoming 'due regard' legislation will place a new duty on the Trust to have due regard to the principles of the Covenant when formulating policy and taking decisions. The requirement will be similar to other duties to have due regard already in operation, such as the Public Sector Equality Duty. The legislation will not define exactly how the requirement to have due regard can be met however in due course accompanying statutory and wider guidance will include information to help the Trust better understand the principles of the Covenant, and how Service life can impact on members of the Armed Forces Community and their ability to access public services. It will be by taking such information into account in their decision-making that the Trust will be able to demonstrate and be assured that they have had due regard to the principles of the Covenant.

Accreditation under the standards of the Veterans Covenant Healthcare Alliance (VCHA) will recognise the Trust as a Veteran Aware exemplar of the best care for and support to the Armed Forces community. The process is funded by NHS Improvement Armed Forces Commissioning and is supported by the VCHA Regional Lead. Learning from other Trusts shows many are already meeting some or all of the standards and simply need to collect evidence to support them. To achieve accreditation the Trust will need to agree standards with the VCHA, nominate a VCHA Champion Dyad (clinical and management champions) and gather evidence to show the standards are being met.

The standards typically include: an understating of the Covenant; support for the Armed Forces community as an employer; established links to nearby veteran services; staff awareness of veteran's needs; identification of veterans to ensure they receive appropriate care; and pathways for onwards referral of veterans to other appropriate services. An initial informal assessment by the VCHA indicates they feel the Trust already meets many of these standards and will work with us to gather evidence and advise where further work is needed. The Trust's application will then be submitted to the VCHA Steering group for approval. After award, reaccreditation reviews take place in years one and three ad this will provide ongoing assurance to the Trust that Veteran Aware standards have been met.

Participation in the various employer programmes (Career Transition Partnership Forces Family Jobs and Step Into Health) will require promoting opportunities to work for the Trust on platforms targeted at those transitioning from service life, established veterans and the spouses and partners of both. The programmes will provide support to the Trust to ensure recruitment processes recognise military skills, qualifications and values as being compatible with working in the NHS and those of our Trust and our workforce policies recognise and support the Armed Forces community in line with our Covenant commitments. Assurance to the Trust that we have achieved the standards and practices required will come from the programmes through their acceptance of the Trust's participation and ongoing monitoring of our performance and adherence.

NHS Solent NHS Trust

# Board and Committee Cover Sheet

| | |
|---|---|
| Item No. | 10 |

| | | | | |
|---|---|---|---|---|
| Presentation to | *In Public Board Meeting* | | | |
| Title of Paper | Trust Board Performance Report – June 2021 | | | |
| 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 | 13/07/2021 | Committees/Groups previously presented | TMT | |
| Action Required | For decision? | N | For assurance? | Y |
| Recommendation | *The Board is asked to:*<br>• *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:<br>Sufficient assurance<br>And, whether any additional reporting/ oversight is required by a Board Committee(s) | | | | | | | |
| Executive Sponsor Signature |  | | | | | | | |

# Table of Contents

## 1.1 COVID-19 Response and Operational Performance Commentary

This iteration of the Trust Board Performance Report covers the period May to June 2021, when the Trust had resumed normal performance governance processes following a period of exception-based reporting due to the COVID-19 pandemic response.

### COVID-19 Integrated Dashboard (section 1.2)

The COVID-19 Integrated Dashboard is updated and utilised daily by Senior Managers and Executives 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 2 July 2021.

The COVID-19 Integrated Dashboard continues to replace 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. Planning has begun to create a range of more meaningful operational metrics for the Board to consider to demonstrate performance across the Trust, however this is being undertaken carefully to ensure no granularity of detail is lost when data is aggregated at a Trust level, and to ensure the Board receives appropriate assurance on areas of concern.

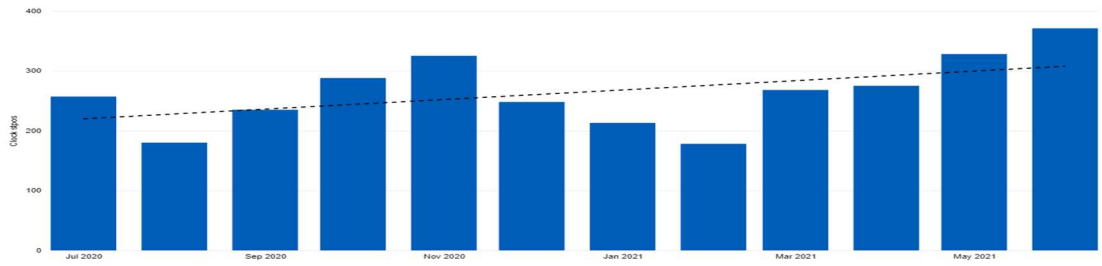
### Waiting Times

Waiting times continue to be the biggest areas of concern for the Trust. Services continue to utilise a new automated waiting list tool to regularly validate, manage and provide oversight and assurance on waiting lists. The quality of the information held on the waiting lists is continually improving, and the forthcoming recruitment to four Data Assurance roles will provide additional assurance on the validity and accuracy of this information.

The services which are causing the greatest concern remain in line with those reported in the last iteration of this report (April 2021), and are predominantly focussed on our Child and Adolescent Mental Health Services (CAMHS).

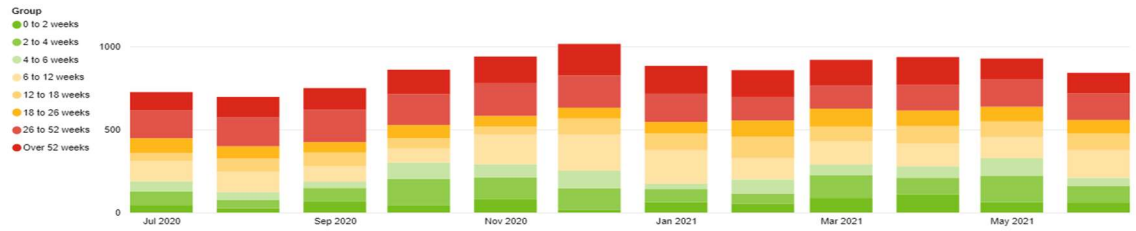
Referrals to our CAMHS services have remained consistent during May and June to the levels seen in the preceding 2 month period, however there has been an increase in the number of clock stops (first contacts) (figure 1) which has resulted in the overall waiting list size reducing slightly (figure 2).

Figure 1: Number of clock stops – CAMHS Services



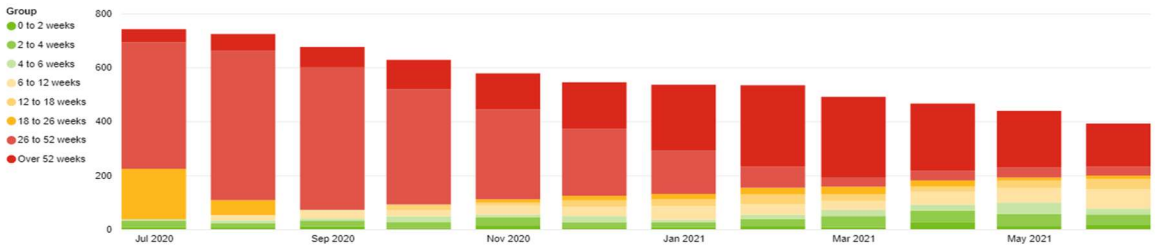

Despite this slight reduction overall (939 in April 2021, 851 in June 2021), there continues to be pockets of pressure within the CAMHS service offer. More detail can be found on this in section 1.3 Chief Operating Officers' Commentary and Performance Subcommittee Exceptions.

Figure 2: Snapshot of patients on the waiting list at month end – CAMHS Services




In our Special Care Dental Services, capacity to see patients for General Anaesthetic Procedures is still only at around 50% of pre-COVID levels due to infection prevention issues around aerosol generating procedures and lack of theatre availability. The overall waiting list size (figure 3) has however continued to reduce over the past two months because of referral rates continuing to be significantly lower than the pre-COVID average. This does however pose a concern for the service about the potential for an unknown amount of unmet need yet to make its way back into the service.

Figure 3: Snapshot of patients on the waiting list at month end – Special Care Dental Services

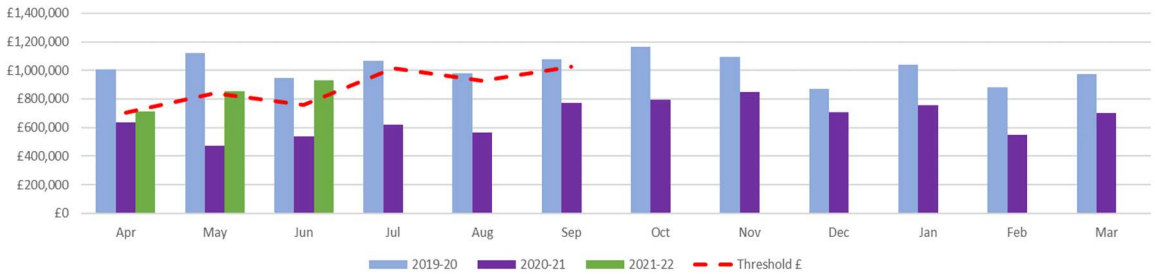



## Elective Recovery Framework (ERF)

Performance against the NHS Improvement Elective Recovery Framework has been more positive than we anticipated as a result of some targeted investment in increasing activity through our Physiotherapy service. This has been a positive example of where data has been used to make quick and reactive decisions to target resource.

Local data indicates that performance was above the required threshold for April, May and June. However, the data presented by the HIOW system showed a small under performance during April and May (June data not yet published). Solent have queried this variation and are awaiting response from HIOW ICS colleagues.

Figure 4: Performance against threshold for ERF eligible services (locally reported)

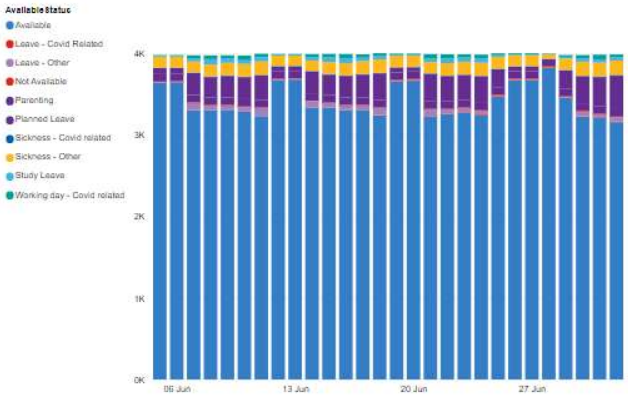



NHS Improvement have this month announced the target levels of activity required are increasing from those originally planned, from 1 July 2021. The original framework stated the target would be 85% each month for July to September, which has this has now been increased to 95%.

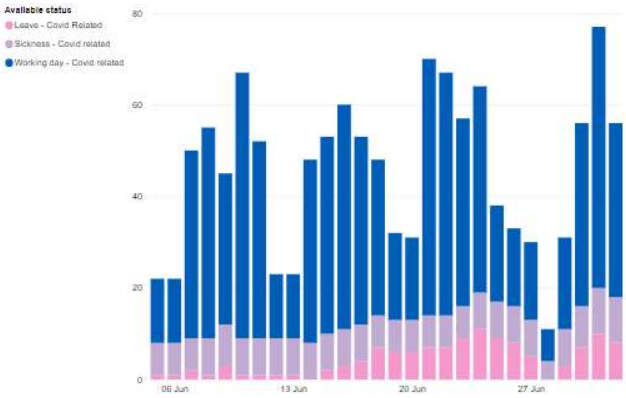
## 1.2 COVID-19 Integrated Dashboard

Solent NHS Trust

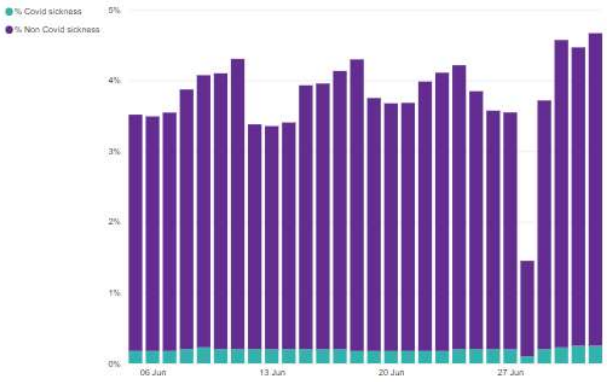
Workforce: Staff availability (ESR)




Workforce: Sickness and Covid related absence (ESR)




Workforce: COVID vs Non-COVID sickness as % of all staff (ESR)

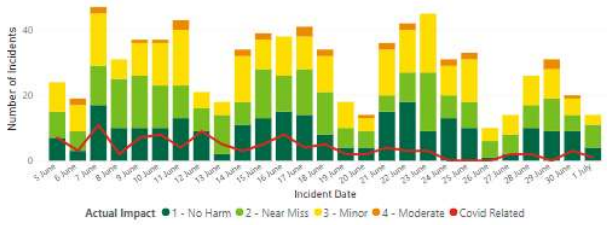



Operations: Inpatient Occupancy/ Capacity (SystmOne)

MOST RECENT POSITION

| Cost Centre | Total Capacity | Total Occupied | Total DToC | Available Beds | Occupancy % | Date Recorded |
|---|---|---|---|---|---|---|
| 402550 Orchards PICU - Maples | 14 | 6 | | 8 | 43% | 01/07/2021 23:00:00 |
| 402555 Orchards Acute-Hawthorn | 0 | 0 | | 0 | NaN | 01/07/2021 23:00:00 |
| 403074 Lower Brambles Ward | 23 | 16 | | 7 | 70% | 01/07/2021 23:00:00 |
| 403076 Fanshawe Ward | 19 | 19 | | 0 | 100% | 01/07/2021 23:00:00 |
| 403080 Snowdon Ward | 16 | 13 | | 3 | 81% | 01/07/2021 23:00:00 |
| 403088 The Kite Unit | 10 | 7 | | 3 | 70% | 01/07/2021 23:00:00 |
| 403130 Spinnaker Ward | 16 | 10 | 1 | 6 | 63% | 01/07/2021 23:00:00 |
| 403156 Brooker | 22 | 17 | | 5 | 77% | 01/07/2021 23:00:00 |
| 403160 Jubilee Hse Contnu Care | 12 | 11 | | 1 | 92% | 01/07/2021 23:00:00 |
| **Total** | **132** | **99** | **1** | | **75%** | |

Quality: Number of incidents (Ulysses)




Quality: Inpatient deaths

COVID 19 DEATHS ULYSSES

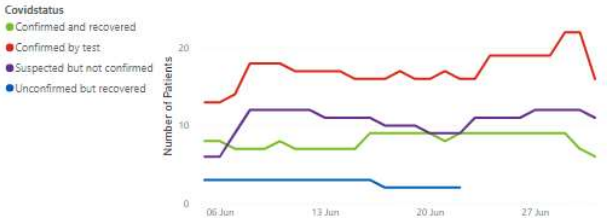
14

Quality: Community Deaths

COVID - 19 DEATHS (ULYSSES)

115

Operations: Patient-reported COVID-19 status (SystmOne)




Quality: RIDDOR

FROM 01/04/2020

4

Workforce: Clinical Supervision Compliance %

80%

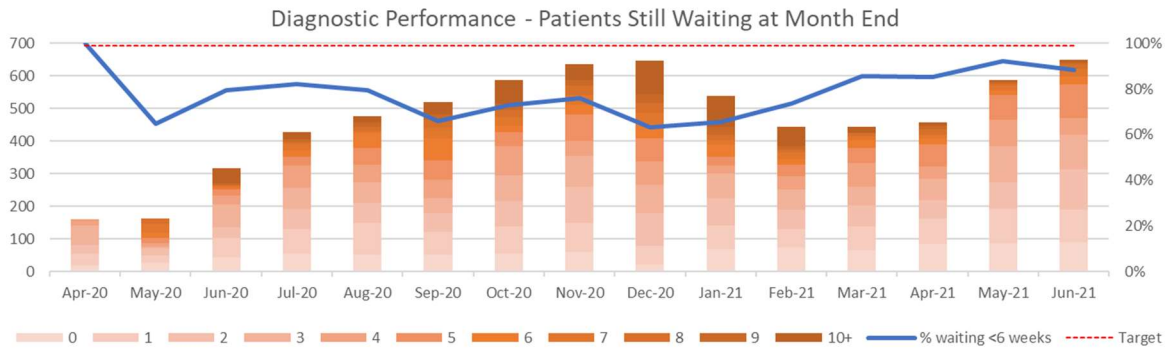
# 1.3 Chief Operating Officers' Commentary and Performance Subcommittee Exceptions

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

*Diagnostics Performance*

Performance against the national 6-week target for access to diagnostic services has been challenging since May 2020. This was due to periods of reduced capacity as a result of increased infection prevention measures and staff availability during the COVID-19 national lockdowns. This was reflected across all providers during this time.

Since December 2020 performance has been on an increasing trend, however there has been a slight dip in performance (88%) in June 2021 (from 92% in May 2021), which is reflective of the increasing size of the waiting list, demonstrated by the orange bars in the chart below. The waiting list has been increasing for the past three months, reflective of the increased referral rates to diagnostics services following a quiet period during the January to March 2021 lockdown.




Performance against this standard is being monitored regularly via Performance Review Meetings.

*Waiting Times*

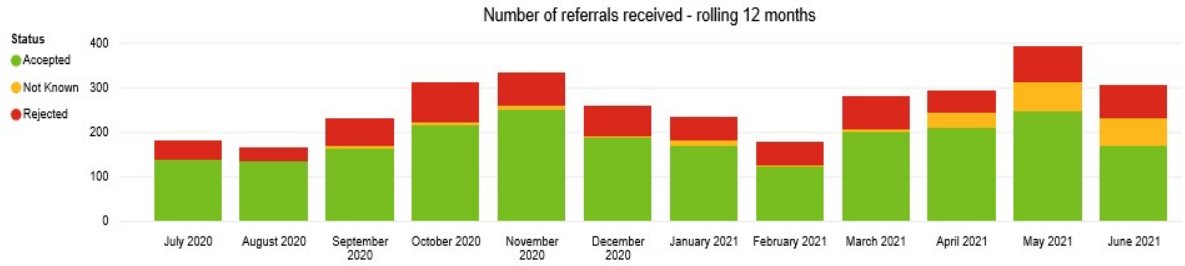
Our clinical service lines continue to experience large backlogs on their waiting lists and subsequently lengthy waiting times for patients. We are liaising with partner organisations to prepare a system-wide communication to patients to outline the current position, challenges and manage expectations around when service provision may return to normal. This is in part due to an increasing trend around complaints and incidents of aggression towards staff on this matter.

*CAMHS West*

The year on year growth rate 2020 – 2021 for Specialist CAMHS is currently 123% which would project a potential figure of 2,369 referrals received by the Service over the next 12 months. This equates to 197 referrals per month or 10 per working day. The increase in referrals is resulting in longer waiting times for first assessment, with worst-case scenario estimates showing a 20 week wait from referral to initial assessment if numbers continue at the current rate. The ADHD pathway reopened to referrals in May 2021 and this contributed to the highest number of referrals ever accepted by CAMHS (246) in May. Despite recent 12-month pathway streamlining, the current capacity does not meet demand and allocations are being made upon closures. There is an increasing theme of young people being referred to the Eating Disorders service at a late stage of presentation that require more intensive packages of care which removes consultant resource from

ADHD.

Recent recruitment was not successful but additional resource has been signed-off and active pursuit of a Non-Medical Prescriber, Specialist Dr & Consultant are under way. Junior medics on rotation are being utilised where safe and available.




*Eating Disorders Service*

There has been an 105% increase in the number of referrals received by the Eating Disorders team within CAMHS, putting significant pressure on the team and impacting waiting times. The current trajectory shows referrals to the Eating Disorders caseload are expected to reach 100 by the end of October. Complexity continues to be evident with ongoing high number of admissions to UHS and additional levels of need alongside the Eating Disorders Team. This growth is not just limited to the Southampton service, but is replicated across the Hampshire and Isle of Wight (HIOW) system. A paper is being put together to review the quality impact of this, and it will be shared with commissioners to plan how to address this in due course.

*Special Care Dental Service*

In 2019/2020 Solent NHS Trust completed 1,941 episodes of care under GA compared to 698 episodes in 2020/21. This reduction reflects the impact of Covid-19 on provision of elective surgery and associated reduction of theatre slots and throughput per session. This resulted in an increase in waiting times with a maximum wait of 47 weeks for children in 2019/2020, now increased to 126 weeks, and a maximum wait of 39 weeks for adults in 2019/2020 now increased to 117 weeks. The total numbers of waiters is reduced due to limited capacity to manage new referrals within the clinics and a reduction in referrals from General Dental Practice at a time when access has been limited.

Solent hold the waiting lists and allocates patients to a waiting lists in Acute Trusts for the site which meets their dental needs (comprehensive care or exodontia only), medical needs or reasonable adjustments required due to disability.

There was an agreement that Solent Special Care patients should be considered alongside patients waiting for other elective care via the clinical prioritisation processes. This is already underway at UHS with the first meeting with Solent representation planned for 19th July. There is a potential for ad hoc additional capacity at St Mary's, IOW and dates are being discussed. The process is being clarified with colleagues at QA and HHFT.

A paper went to the Planned Care Delivery Group on 6 July and it was agreed to provide the Dental Services with equal access to the Trusts priority review groups where priorities for theatre capacity are agreed. This would ensure that patients got equity of treatment along with patients on other waiting lists.

The Current waiting times for children and adults are presented by geography in the table below.

| | ICP Area | Total Waiters | Longest Waiter (weeks) | < 18 weeks | 18 – 51 weeks | 52 – 103 weeks | >= 104 weeks |
|---|---|---|---|---|---|---|---|
| Children | Southampton | 58 | 113 | 33 | 4 | 17 | 4 |
| | Portsmouth | 35 | 127 | 12 | 1 | 21 | 1 |
| | Isle of Wight | 36 | 86 | 21 | 8 | 7 | 0 |
| | North & Mid Hants | 131 | 110 | 50 | 19 | 59 | 3 |
| | New Forest | 21 | 95 | 3 | 3 | 15 | 0 |
| | East Hants | 56 | 116 | 37 | 1 | 17 | 1 |
| Adults | Southampton | 8 | 37 | 2 | 5 | 1 | 0 |
| | Portsmouth | 2 | 86 | 1 | 0 | 1 | 0 |
| | Isle of Wight | 7 | 89 | 2 | 0 | 5 | 0 |
| | North & Mid Hants | 8 | 115 | 2 | 2 | 3 | 1 |
| | New Forest | 10 | 117 | 2 | 0 | 5 | 3 |
| | East Hants | 8 | 91 | 5 | 0 | 3 | 0 |

*Sexual Health*

Vasectomy

During the first national lockdown, all vasectomy assessments and procedures stopped. The current waiting list shows:

- There are 181 patients booked for procedures with 26 on the waiting list for procedures
- 263 patients are waiting for pre-operative assessment
- The longest pre-operative assessment wait time is 4 weeks
- The longest operation wait time is 6 weeks.

Psychosexual Counselling

During the national lockdown, there was limited access to Psychosexual Counselling until patients were able to access video consultations.

Initial Assessment

- There are 82 patients in total waiting for an initial assessment – no one is waiting over 18 weeks
- In Portsmouth there are 31 patients with the longest wait 7 weeks and 3 days
- In Southampton there are 42 patients with the longest wait 8 weeks
- In the North there are 9 patients with the longest wait 6 weeks and 6 days

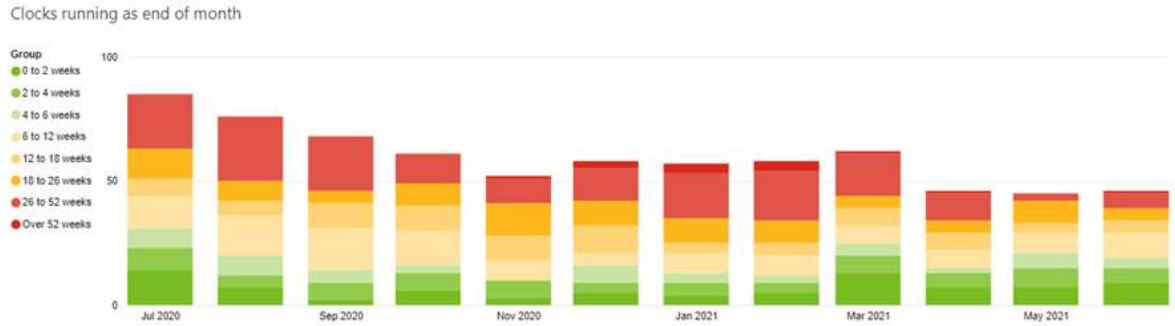
For 1st Therapy

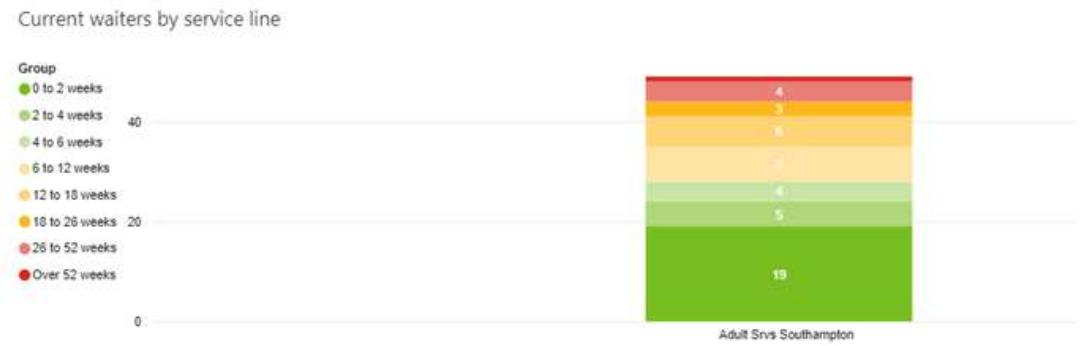
- In Portsmouth there are 5 patients with the longest wait 11 weeks
- In Southampton there are 21 patients with the longest wait 11 weeks
- In the North there are 6 patients with the longest wait 8 weeks

Both teams have done incredibly well to reduce their waiting lists to these levels.

*Speech and Language Therapy (SLT) – Southampton West*

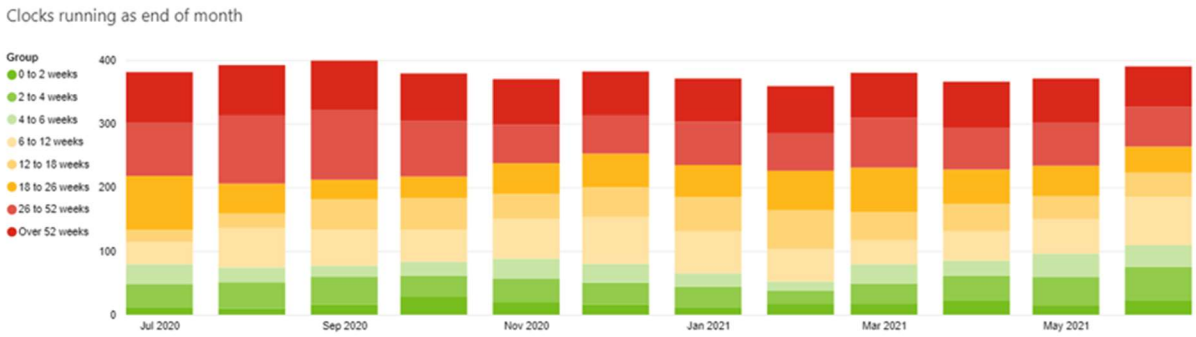
The recovery of the waiting list position within SLT is progressing as can be demonstrated in the graph below. The proportion of patients waiting, and particularly those with long waits, is reducing with only one patient waiting over 52 weeks at the end of the month. This demonstrates that additional workforce through the system investment process, is having a positive impact.




*Community Neuro Rehab Team (CNRT)*

There is an ongoing impact seen within the size of the waits within CNRT due to the extensive redeployment of this team during Covid. There are signs of recovery with the average wait at 16 weeks, and the numbers of patients wating over 26 weeks reducing. Mitigations are in place in the form of additional staff members secured through the system investment process, and plans are in place to address the longest waits.




*Neuro Psychiatry*

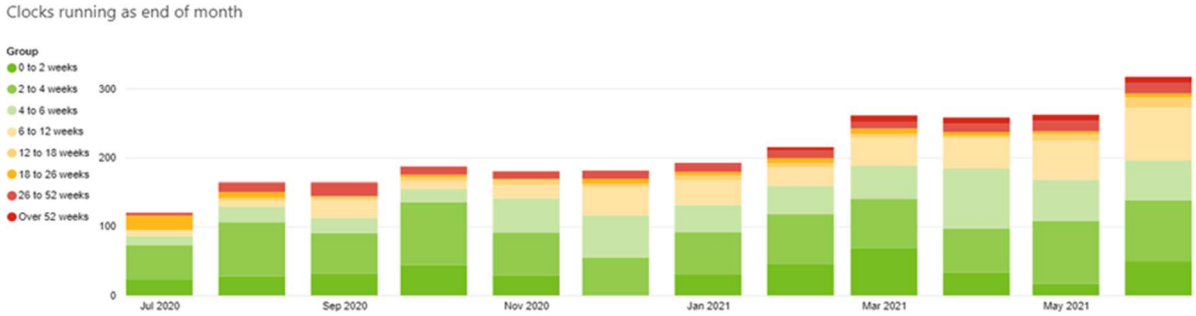
The Neuro Psychiatry team restarted virtual clinics in March 2021. This is a highly specialist and unfortunately vulnerable service with a single-handed practitioner which has suffered due to prolonged staff absence pre-Covid resulting in significant waits for patients. Due to the specialist nature of the provision, additional workforce is not available. A working group is being convened to review and consider options around the waiting list issues.

| Team | G | A | R | B | Total | Longest Wait | | G | A | R | B | Total | Longest Wait |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neuro Psychiatry | 3 | 5 | 1 | 34 | **43** | **2yrs 20 weeks** | | **2** | **6** | **1** | **32** | **41** | **2yrs 24wks** |

| G | A | R | B |
|---|---|---|---|
| up to 10 weeks | 10 - 17 weeks | 18 - 20 weeks | over 20 weeks |

*Cardiac Nurse (Rehab) Service*

The Cardiac Nurse Service has suffered due to sickness and absence on top of the impact of Covid, creating a growth in the numbers of patients waiting. Recruitment is under way to support the team to improve the position. There are 13 patients waiting 26-52 weeks and 8 waiting over 52 weeks.




*Primary Care & MPP Service Line*

**Single Point of Access**

SPA have seen a significant increase in call volumes as seen in the table below:

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2021** | 19142 | 17311 | 22681 | 22685 | 24996 | 28976 | 0 | 0 | 0 | 0 | 0 | 0 | 135791 | All Calls |
| **2020** | 18247 | 16269 | 15767 | 9309 | 11017 | 13918 | 20729 | 21058 | 25152 | 24861 | 20469 | 18428 | 215224 | |
| **2019** | 21510 | 19307 | 20595 | 19247 | 19213 | 16414 | 17663 | 17049 | 16596 | 17564 | 16672 | 14051 | 215881 | |
| **2018** | 22062 | 19908 | 23692 | 21187 | 21397 | 21158 | 22669 | 22255 | 17639 | 18841 | 18014 | 14473 | 243295 | |
| **2017** | 21579 | 18009 | 23412 | 18816 | 24365 | 21624 | 28159 | 25467 | 23670 | 26580 | 24561 | 16562 | 272804 | |
| **2016** | 19085 | 20885 | 22667 | 20673 | 20733 | 20297 | 18918 | 19864 | 22087 | 20514 | 20113 | 17046 | 242882 | |
| **2015** | 17632 | 16102 | 17410 | 17129 | 16808 | 18513 | 18630 | 17923 | 19277 | 18011 | 18090 | 15257 | 210782 | |
| **AVG** | **20019** | **18413** | **20591** | **17727** | **18922** | **18654** | **21128** | **20603** | **20737** | **21062** | **19653** | **15970** | **233478** | |

In 2021 we have received 19,500 more calls in the first six months than for the same period in 2019. The team continue to work in a hybrid model of part home and part office due to the IPC restrictions and are awaiting a new telephony system which will allow a more resilient model of service delivery to our patients.

SPA Telephony has been a well-documented challenge for many years and a recent deep dive into the service was commissioned to review incidents and complaints. The review period was over a 15-month period, March 2020 – Jun 2021 where the team received 240,000 calls over that time.
Any incident or cause for complaint are far from what we want to see; however, the proportionality of these issues in comparison to the number of contacts remains very small.

- Incidents - 40 incidents in the period equates to **0.2% of overall contacts**
  - 11 of those incidents relating to suboptimal care is **0.004% of overall contacts**
- Complaints 18 (for SPA) & 87 (for services where SPA was mentioned) = total of 105 equates **to 0.044% of overall contacts**
- Complaints relating to waits specifically – total 81 – a total of **0.03% of overall contacts**

*MSK*

We continue to see an increase in demand, particularly in the west. Some targeted work to address the waiting lists means the position is improving, but, with an increased demand of c20% on 2019/20 volumes for both physiotherapy and specialist physiotherapy in Southampton, it means longer waits and the additional activity is only able to help us maintain rather than improve the backlogs.

| Service | Urgent Wait | Routine Wait |
|---|---|---|
| MSK Physio East | 2 weeks | 10 weeks |
| MSK Physio West | 2 weeks | 16 weeks |
| Specialist Ports | 2 weeks | 2 weeks |
| Specialist Southampton | 2 weeks | 17 weeks |
| Specialist FG&SEH | 2 weeks | 6 weeks |

*Podiatry*

Current waits are shown below:

| 0 to 2 weeks | 2 to 4 weeks | 4 to 6 weeks | 6 to 12 weeks | 12 to 18 weeks | 18 to 26 weeks | 26 to 52 weeks | Over 52 weeks | Total |
|---|---|---|---|---|---|---|---|---|
| 181 | 200 | 207 | 335 | 140 | 46 | 32 | 18 | 1159 |
| **181** | **200** | **207** | **335** | **140** | **46** | **32** | **18** | **1159** |

Our usual referral rate average is 664 per month however we have seen an average of 800 a month for the past 4 months. It is of note that 45% of referrals are for short course low / moderate risk treatment of Nail surgery and Biomechanics which means that at present, our discharge rate is matching our referral rate as we address the backlog of low risk short course treatment and we are not growing the caseload of these patients.

It is important to note that the Podiatry caseload of 8,660 is mainly comprised of patients with diabetes who have high risk feet and who are unlikely to be discharged until they die. This means that there is an increasing pressure where 55% of new referrals add to this growing, long standing caseload.

## Solent East Care Group Chief Operating Officer's Commentary

*Waiting Lists*

The Board will be aware of the recent work completed by the Clinical Directors on waiting lists. This is an issue which rightly continues to demand attention from both clinical risk and operational perspectives. There are a number of inter-related pieces of work in play i.e. business intelligence & data quality; proactive triage and re-triage of patients waiting; conversations with commissioners which will result in improvement trajectories.

*0-19 Service*

The Health Visiting service are currently experiencing issues with the notification of new births from Portsmouth Hospitals University Trust (PHUT). This is causing delays in new birth information being shared with our Health Visiting teams, and subsequently impacting performance against the new birth visit standard which forms part of the Healthy Child Programme. Concerns have been discussed directly with PHUT and identified as being related to a new IT system being used, Badgernet.

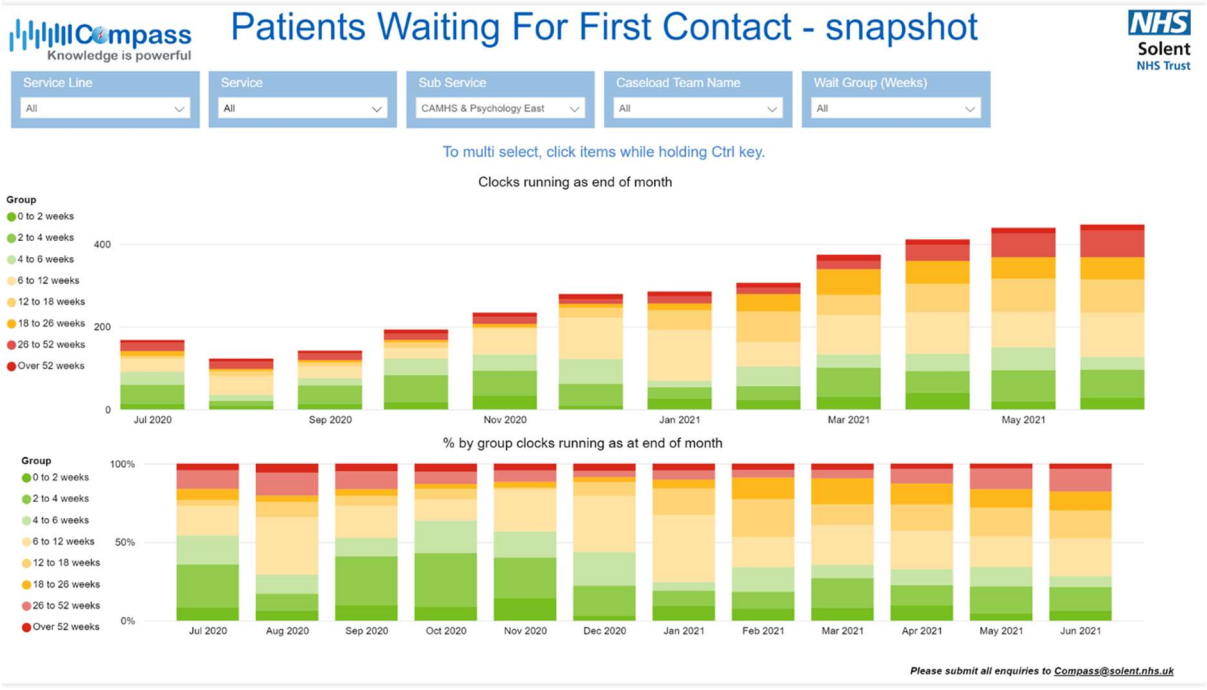
*CAMHS East*

Demand and capacity for all aspects of the CAMHS East service; single point of access, neurodiversity and eating disorders, continues to be a challenge, with referrals still maintaining at 25% higher than pre-COVID. This is further exacerbated by national recruitment challenges. Whilst there has been investment into our CAMHS services locally, there are CAMHS practitioner posts being advertised across the HIOW region and competition to recruit staff is extremely fierce. The situation has been escalated as a HIOW ICS priority.

Waiting lists for various teams within the service are currently as follows:

- 112 children waiting on average 15 weeks for first assessment. There is a plan in place to work through this by October 2021.
- 207 children waiting on average 25 weeks for extended team input. There is a plan in place to work through this by April 2022.
- •Collectively, 322 children waiting on average 41 weeks for both first Neurodiversity assessment and comprehensive Neurodiversity assessment. There is a plan in place to work through this by April 2022.
- Duty Calls are increasingly complex and time consuming and reduce capacity to triage/work through waiting lists.
- Eating Disorder referrals have increased during May/June and national narrative would indicate that this will continue to increase. May referrals equated to approximately 130% of team capacity.

The waiting times snapshot shows the steady increase in patients waiting for their first contact.




*Pulmonary Rehabilitation*

Throughout 2020 patients were given the option to access the Pulmonary Rehabilitation service remotely or be put on a holding waiting list for when face-to-face service provision resumed. Work had begun to plan for the reopening of face-to-face activity; however, the increasing spread of the COVID-19 Delta variant has resulted in this being delayed further due to the increased risk to this specific patient cohort. Referrals for F2F are now on old for all but urgent cases but there are 440

patients on the waiting list (across Portsmouth, SE & North Hampshire)

*Speech & Language Therapy*

As at July 2021 342 patients are waiting for a speech and language therapy assessment, with 14% (n.49) over 18 weeks, these are all priority 3. To improve the wait times an additional fixed term staff member has been recruited (0.81 WTE for 12 months), the team is resuming group work, and implementing a new approach to managing Care Home referrals:

- Advice & guidance at point of triage
- Access to Swallow Toolkit
- Potential for further education to reduce demand

*Bladder & Bowel Nurse Assessment Service*

The Bladder and Bowel Nurse Team is under pressure with increased caseloads, with 175 new patients waiting for assessment, 168 patients waiting for telephone f/up and 421 for F2F f/up. The service are continuing to RAG rate the waiting list and prioritise urgent need. All patients wating for follow ups have been written to and asked to contact the service if their needs have changed. These waiting lists do not impact the delivery of continence products.

*Secondary Care Psychology*

There is a significant waiting list for some therapies provided by the secondary care psychological therapies team. This primarily affects 1:1 sessions at present with waits extending to over a year:

| 1:1 | Time Waiting | No. Waiting |
|---|---|---|
| Trauma (EMDR/CBT) | 1y 36 wks | 59 |
| DBT | 1y 26 wks | 56 |
| CBT Mood | 1y 23 wks | 29 |
| CAT | 1y 16 wks | 11 |
| ACT | 38 wks | 09 |
| CBTp - HI | 35 wks | 10 |
| CBTp EIP | 24 wks | 11 |
| Family Work | 23 wks | 03 |
| CBTp - LI | 00 | 00 |

Waiting lists have increased for several reasons, including sick leave; increased demand, length of therapy; and Band 6 staff stretched so unable to take more cases. Psychological therapists are still delivering most CAMS cases which reduces their therapy caseload.

There is a strategy in place to address of all of this, including:
• Managing patients whilst waiting
• additional staffing needed to reduce waiting times to within 20 weeks national standard

A risk summit with the CCG is scheduled for 3rd August 2021 to discuss the risks associated with these extended waits.

## 1.4 NHS Improvement Oversight Framework

Month: Jun-21

| | Indicator Description | Internal / External Threshold | Threshold | Current Performance | Capability | Variance |
|---|---|---|---|---|---|---|
| **Quality of Care Indicators** | | | | | | |
| Organisational Health | Staff sickness (rolling 12 months) | I | 4.5% | 4.5% | | |
| | Staff turnover (rolling 12 months) | I | 14% | 10.8% | | |
| | Staff Friends & Family Test - % Recommended Employer | I | 80% | * | * | * |
| | Proportion of Temporary Staff (in month) | I | 6% | 4.1% | | |
| Caring | Written Complaints | I | 15 | 20 | | |
| | Staff Friends & Family Test - % Recommended Care | I | 80% | * | * | * |
| | Mixed Sex Accommodation Breaches | E | 0 | 0 | | |
| | Community Friends & Family Test - % positive | E | 95% | 95.3% | | |
| | Mental Health Friends & Family Test - % positive | E | 95% | 86.1% | | |
| Effective | Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS | E | 95% | 80.0% | | |
| | % clients in settled accommodation | I | 59% | 69.1% | | |
| | % clients in employment | E | 5% | 4.0% | | |
| Safe | Occurrence of any Never Event | E | 0 | 0 | | |
| | NHS England/ NHS Improvement Patient Safety Alerts outstanding | E | 0 | 0 | | |
| | VTE Risk Assessment | E | 95% | 97% | | |
| | Clostridium Difficile - variance from plan | E | 0 | 0 | | |
| | Clostridium Difficile - infection rate | E | 0 | 0 | | |
| | Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias | E | 0 | 0 | | |
| | Escherichia coli (E.coli) bacteraemia bloodstream infection | E | 0 | 0 | | |
| | MRSA bacteraemias | E | 0 | 0 | | |
| | Admissions to adult facilities of patients who are under 16 yrs old | E | 0 | 0 | | |

| Operational Performance | | | | | |
|---|---|---|---|---|---|
| Maximum 18 weeks from referral to treatment (RTT) – incomplete pathways | E | 92% | 98.8% | P | |
| Maximum 6-week wait for diagnostic procedures | E | 99% | 75.7% | F | |
| Inappropriate out-of-area placements for adult mental health services - Number of Bed Days | E | 0 | 0 | ? | |
| People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral | E | 50% | 75.0% | ? | |
| Data Quality Maturity Index (DQMI) - MHSDS dataset score** | E | 95% | 90.9% | F | |
| Improving Access to Psychological Therapies (IAPT) | | | | | |
| - Proportion of people completing treatment moving to recovery | E | 50% | 52.1% | ? | |
| - Waiting time to begin treatment - within 6 weeks | E | 75% | 97.0% | P | |
| - Waiting time to begin treatment - within 18 weeks | E | 95% | 100.0% | P | |

| Use of Resources Score | | | | | |
|---|---|---|---|---|---|
| Use of Resources Score | E | 2 | 3 | ? | |

* 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 NHS Improvement Oversight Framework was initially implemented in 2019/20. This was not refreshed during 2020/21 due to the COVID-19 pandemic. In June 2021, NHS England published guidance as to how it will monitor the performance of ICSs going forward (NHS oversight metrics for 2021/22). This has been called the System Oversight Framework, which replaces the Single Oversight Framework (which only impacted on providers). The guidance provides a wide range of measures that ICSs will be benchmarked against, although there are limited specific examples within it and therefore it is presently difficult to establish how we should judge the performance of Solent against the measures. For the next Board meeting, the Performance Team working with relevant teams will propose what metrics could be used and these will go through our internal governance; an example of this is the measure of maximising dental activity and targeting capacity to minimise deterioration in oral health and reduce health inequalities on which Caroline Frolander (CD for our Dental Services) is assessing what specific measure is best.

### Significant negative exceptions on this month's NHS I Oversight Framework (section 1.4):

*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 12 months of significant under performance. The number of patients waiting to receive a diagnostic has increased at the end of June to the highest levels reported (650) in the last 12 months, with an average wait time of 3 weeks. At the end of June, the average wait for patients that received a diagnostic was 5 weeks.

In Health have provided a trajectory that shows they should be able to clear the MRI backlog completely during July as they have the capacity and there is also the potential to add more in August if required. With the additional capacity now built in, patients should consistently be seen within 6 weeks by the end of July.

In Health are unable to increase the ultrasound activity in the same way that they have for MRI. There are currently 104 patients waiting for an appointment and there is no availability until August. We have invested additional monies into the In Health contract to purchase additional capacity, however this is not ongoing. We have submitted a bid for funding that would allow us to access some of the additional capacity from UHS & SHFT, but it will be limited in year 1 as the capital available has been reduced. Bids are still being considered. With the challenges in ultrasound, we expect to achieve the diagnostics target by the end of Q2 2021/22.

*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 remained around 91% until the end of last financial year, when the focus shifted off the DQMI and the national CQUIN scheme ending. Internal workstreams to improve the quality of the information within the MHSDS have taken a pause in recent months due to the emergence of a Hampshire and Isle of Wight group focussing on improving the consistency of MHSDS data collected across providers.

It has been recognised that further work needs to be undertaken as a Trust to instil and embed more sophisticated data assurance culture. Accurate and meaningful data is essential for an organisation not only to retain oversight on patient safety, but also to ensure effective and timely decision making. A business case has been approved to recruit service line data assurance experts to facilitate

improvement in data quality metrics across the Trust. It is envisaged that this team will be managed centrally but work locally within and to an individual service line. The core framework of deliverables and job descriptions for this additional resource are currently being developed. Once the data assurance experts have been recruited, we will begin to see improvements in the DQMI score, with full compliance achieved by the end of Q4 2021/22.

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

NHS England/NHS Improvement Patient Safety Alerts outstanding has achieved the target of zero for 6 consecutive data points.

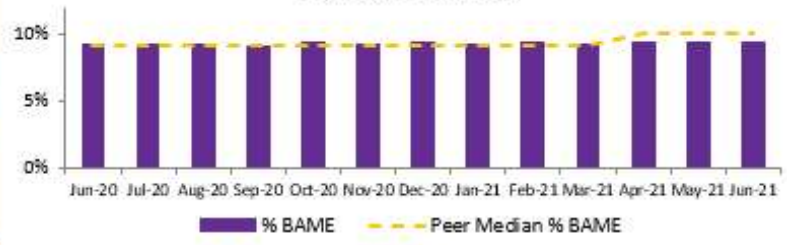
## For Information:

The threshold for sickness absence has been increased to 4.5% from June 2021 as a result of internal analysis and discussion. This has been approved by the Workforce and Organisational Development Committee and has been applied to the report.

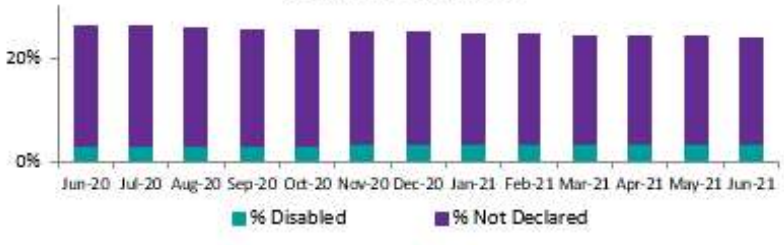
# 2.1 Workforce Integrated Performance Report — Month: Jun-21

## Planning


WRES



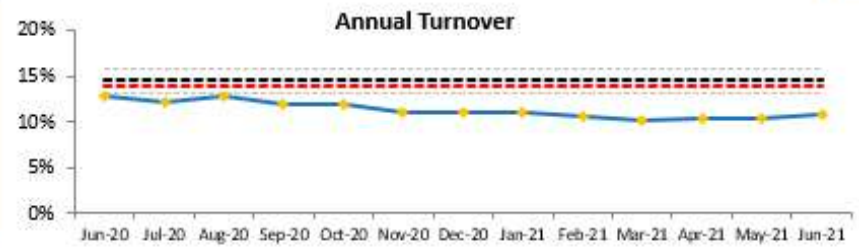

WDES

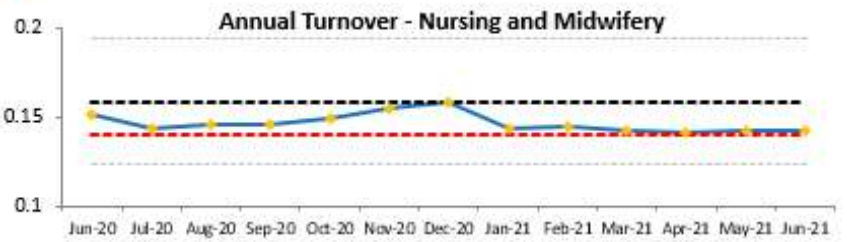



Actual vs. Planned


Stability Index


Turnover





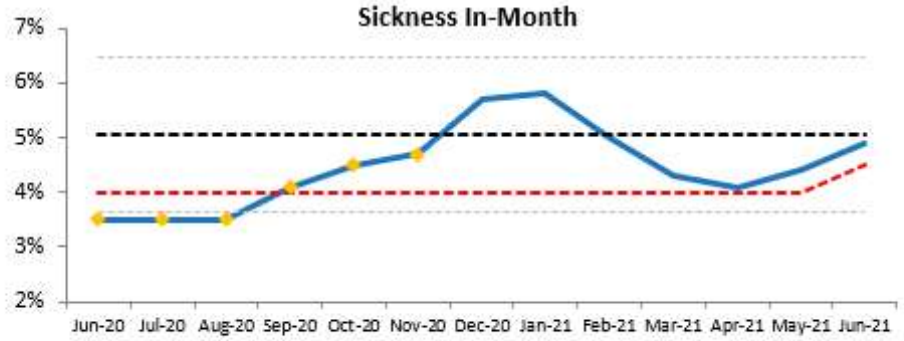
Budgeted Establishment has been updated to reflect M1 - M3 following the workforce plan submissions. Stability Index has decreased this month from 88% in May to 87% in June. Stability Index is a retention metric, a measure of the % of staff in the Trust 12 months ago, who remain at the Trust 12 months on The stability index peer median, based on trusts within the ICS has however increased to 89%, however we continue to record above the Solent mean. During June we can see our in month and annual turnover increasing slightly, however both continue to report below the mean. With turnover of staff increasing we can expect the stability index to continue to decrease if leavers are within their first year of employment with the Trust.

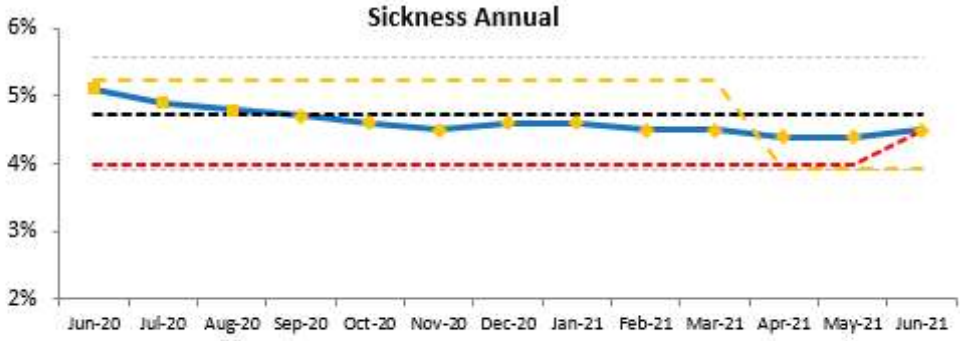
# Deployment

Month: Jun-21

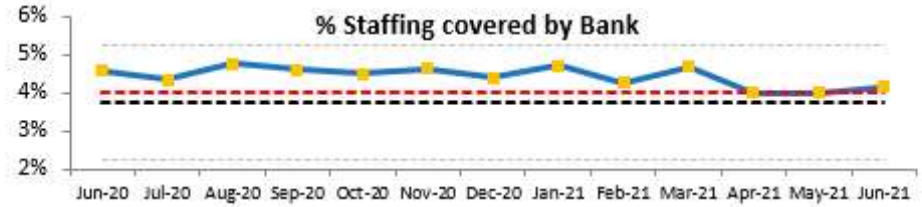
Key: Data | Target | Mean | Upper / Lower Control Limit | 6 Points Above/Below Mean | Rising/ Falling Trend (6 points) | Peer Median

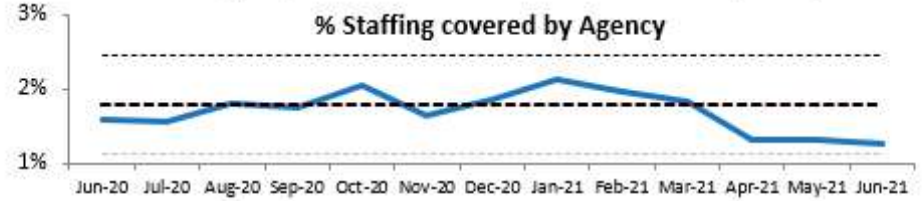
## Sickness




## Bank & Agency





**In Month Cost:** Bank - £316986 Agency - £184967


## Rostering

**Current Position: 1 / 4**

Sickness in-month has increased from 4.4% to 4.9% during June 21. In month sickness has been increasing over the last 2 months but is still below the Solent Mean. 0.4% of in-month sickness relates to Covid-19 absence. This is the same as May. Where Covid 19 sickness is decreasing we are seeing an increase in general sickness across the trust. Annual Sickness has been steadily decreasing from June 2020. This was previously reporting below the peer median, however having updated the peer median Solent are now above the peer median of 3.9% when benchmarked against trusts of the same type at July 2020 (latest data available). We expect to see this figure increasing over the coming months based on in month sickness. The threshold for sickness absence has been increased to 4.5% from June 2021 as a result of internal analysis and discussion.

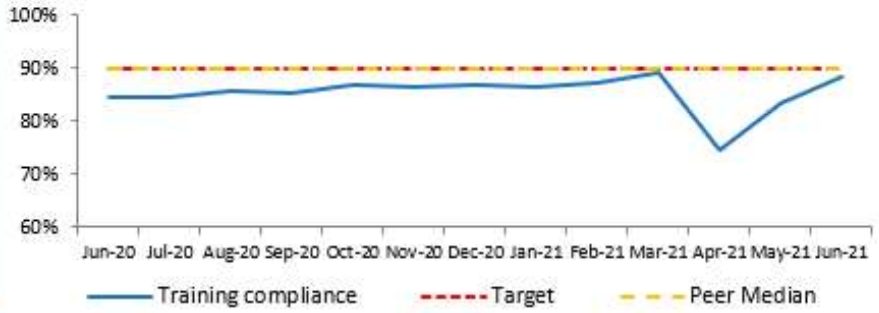
Due to the increased levels of sickness across services we have also seen an increase in bank admin placements and specifically in relation to Portsmouth sites were we have been achieving good levels of cover. Increased 2:1 patient requirements have increased demand from Maples, with overall demand remaining static over the last month. Due to late requests there has been increase in off framework agency usage for Snowdon and Kite wards. For all Southampton clinical areas the request for agency staff has been re-introduced to help drive down agency usage and associated costs.

# Development

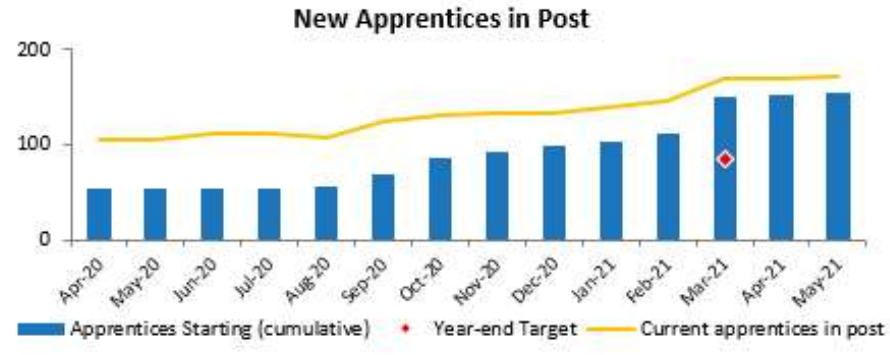
**Month: Jun-21**

## Appraisals


## Stat & Mand Training




## Apprentices




The new LMS platform, My Learning, was launched on 4 May. This will be a significant boost for morale and will significantly strengthen our learning and development infrastructure. The target remains at 90% and an increase in compliance is already visible. Feedback continues to be that the system is clear and easy to use.
Phase 2 of the implementation was the addition of the appraisal functionality. This was launched in June. Design work will commence shortly on Phase 3 with the addition of the Nurse Revalidation module.

## 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 due to the COVID-19 pandemic.*

### Staff Survey

Percentage of Staff who would recommend Solent as an Employer

**76%**

**2020/21**

# Acquisition

## Month: Jun-21

Vacancy Rate

### All Staff


### Nursing & Midwifery (N&M)


### Medical and Dental (M&D)


The Trust vacancy rate has decreased from 5% in May to 4.8% in June. The current vacancy rate of 4.8% equates to 167.4 FTE across the trust. Vacancy rates are highest in Facilities Management and Estates (FME) at 19.2% which equates to 48.9 FTE, contributing to just over 1/4 of the Trust's vacancy rate. FME are reviewing their substantive needs where agency and bank staff are currently covering (Housekeeping teams for Southampton sites). Substantive recruitment will be taking place over the coming weeks and months. Mental Health Services vacancy rate 11.5%, equates to 53.9 FTE and the largest number of WTE vacancies.

We continue to create a pipeline of Mental Health Nurses in collaboration with International Global Learners Programme and general nurses with HHFT. Now the Indian travel pause has been lifted, we are in the process of planning the arrival for a pipeline of 5 Mental Health Nurses to arrive in mid-August, with a further 4 arriving in September. We are continuing to recruit Mental Health Nurses with more interviews being scheduled this month. We are moving forward at pace with our international nursing approach in our Community Nursing localities which is a pilot project working with NHS England and NHS Improvement. Further cohorts of general nurses are being planned for Southampton and Portsmouth Adult Inpatient units; recruitment will commence in August with expected arrival dates of October.

# Leadership and Culture

**Month: Jun-21**

**Learning**

The Learning Management System (LMS) was launched on 4 May 2021 and throughout June enhancements are being made to the eLearning content. Further development will continue through July / Aug with the team now trained in creating e learning content in house.
In June we continued to run the staff induction virtually. The new 'My Learning' site has a tab for 'New Starters' which contains the slide deck and handbook along with useful contact details for Corporate services. New staff are now given a live tour of the learning site as part of the 2-hour welcome session.

**Engagement**

During June, we celebrated the contribution of our volunteers, a valued part of our workforce, during Volunteer's Week. We featured stories from volunteers working at our vaccine centres, as well as long standing volunteer, Robert Page who works at the Royal Hants Hospital. Volunteers were interviewed by local TV and radio channels.
In celebration of Pride month we share the story of Dr Joe Bagley who is the chair of the LGBTQ+ and Allies Staff Resource Group.
We launched our engagement activities to understand how employees would like to work in the future, following the pandemic. This was launched with a film from Sue Harriman, CEO. The engagement activities have been led by the People and OD Team.
Early July saw the 73rd birthday of the NHS and the celebration of the contribution of everyone in Team Solent through the NH Big Tea.

**Leadership**

We are continuing to design a programme of Line Management and Leadership Development interventions which combines a mixture of reference guides, e-learning, short videos and reading suggestions and programmes of learning. We have cohorts booked for our three new leadership programmes; Stepping into Management, Leading with Confidence and Leading Beyond the Team and further dates will be added to the My Learning site.
The Leadership Development area on the My Learning site continues to be developed and added to the 90 minute workshop, 'Managing an Appraisal', has been popular and so far 41 staff have attended. Feedback has included 'I felt energised and have already reflected on the info and ideas'; 'I'm going to focus on people's strengths' and 'the strengths spotting exercise was a really insightful way to look at it'. The 'Making Virtual Meetings Work' session is also still available along with signposting to the training for Health Roster managers and Managers' Self-Service ESR.

**Inclusion**

Hennessy coaching sessions have commenced with the groups having at least two sessions. Initial themes are starting to be identified which will help focus the work of the Diversity and Inclusion team. A second meeting was held with the Leadership Academy to further streamline our approach to the Reciprocal Mentoring programme and a project board is in the process of being established. Focused work on recruitment and retention of BAME staff is continuing at pace in partnership with People and OD. Stonewall's Equality Index submissions opened and will be completed over the next few months by Kate Sonpal with input from the LGBT+ Resource Group and People and OD team. Diversity and Inclusion annual report submitted to WOD.

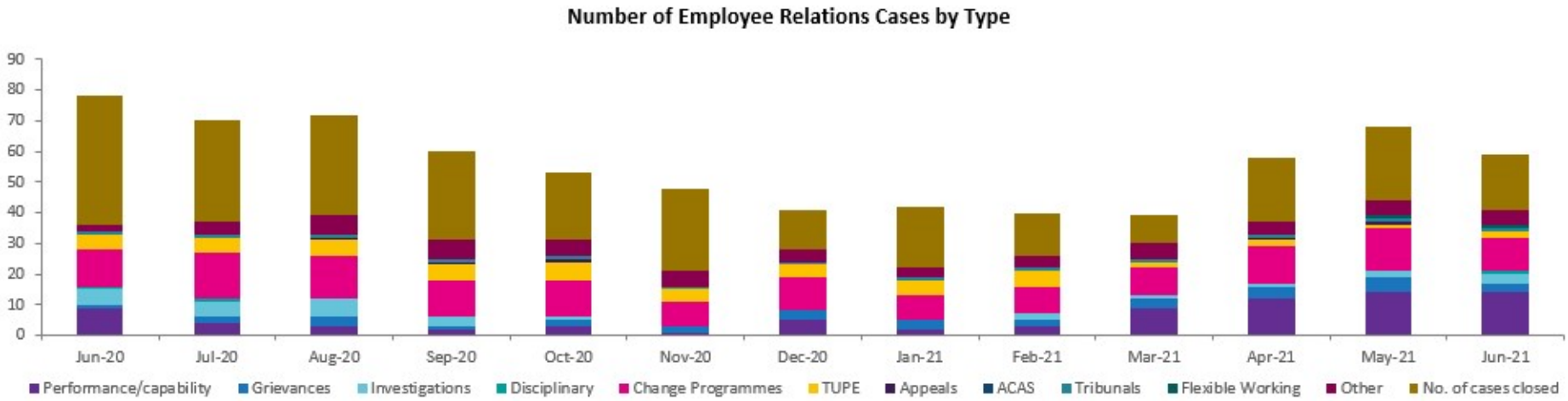
**Wellbeing**

Wellbeing support remains in high demand, Mental health in particular in addition to MSK, Lifestyle and work-life balance. We continue to review our delivery options and resources to respond to the changing needs of people as they work through the different phases of Covid recovery, its impacts and wider wellbeing needs. We are also increasing our self- help support and developing sessional resources to increase access to key needs/themes, group support and therefore protect resource required for individual sessions. Alongside resource design, we are implementing smarter working and efficiencies e.g. through review of the DNA and other admin processes to increase our available resource. Our flexible Wellbeing team continue to work with managers, Wellbeing Champions and MHFA's to understand the nature of the support needed to provide responsive expertise both internally and by sign-posting to external sources. We have experienced a hike in support required around Covid needs due to emerging and changing guidance and are responding to this need. As the HIOW Enhanced Wellbeing programme develops, this will broaden the range of access that people will have and further strengthen our existing wellbeing offers for our people and the sharing of expertise and experience.

# Change and Employee Relations

**Month: Jun-21**

## Employee Relations




There are 142 cases currently being managed as at the end of June compared to 131 May. 10% of the 142 open cases are BAME employees, and of this total 10 cases relate to a variety of Employee Relation (ER) issues, including 3 of which are absence management. The other 4 cases are attributed to long-term COVID support from OH in collaboration with the HR Consultancy team rather than formal action, thus would reduce 10% to 7%. For reference of the total staff in post in the Trust, 9% are BAME. There are 13 change management cases, 2 of which are TUPE and 1 is on hold.

The new values-based Trust Resolution Approach launched in January 2021 aims to successfully resolve workplace conflict and provide a different, positive employee experience. There are 8 live informal resolution cases being managed in the month of June by the Resolution Hub and 2 within HRC team, who are focusing on an early resolution approach to support people to resolve matters earlier and quicker in a safe and supportive environment.

## D&I ESR Data

A message has been added to ESR Portal reminding all individuals to check and ensure their Information is all correct and missing fields are completed where possible. We are now seeing An increase in data held and message will continue to run through July and August.
There will still remain a small number of blank fields that staff wish to not declare, the majority being Disability and Ethic Origin.

**Diversity & Inclusion Fields completed in ESR**

**99%**

**Target - 100%**

# Notes

**Month: Jun-21**

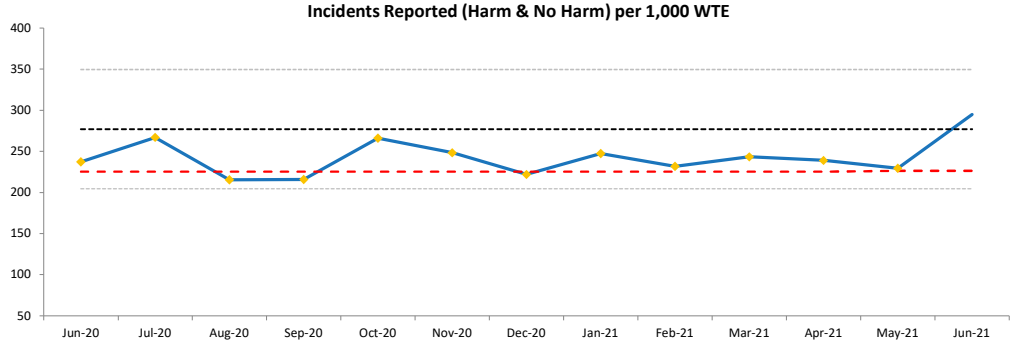
| | Metric | Benchmark |
|---|---|---|
| Benchmarking | Workforce Ethnicity (WRES) - % of staff who are BAME | Peer median based on the trusts within our STP at December 2020 |
| | Stability Index – Staff retention rate | Peer Median based on the trusts within our STP at December 2020 |
| | Turnover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

## 3.1 Quality Performance Dashboard

Month: Jun-21

### Safe

#### Incident Reporting Rates




| YTD | Moderate & Above Incidents | |
|---|---|---|
| 2021-22 | 94 | |
| 2020-21 | 70 | ▲ 34.3% |

| YTD | Serious Incidents (SI) Raised | |
|---|---|---|
| 2021-22 | 5 | |
| 2020-21 | 2 | ▲ 125% |

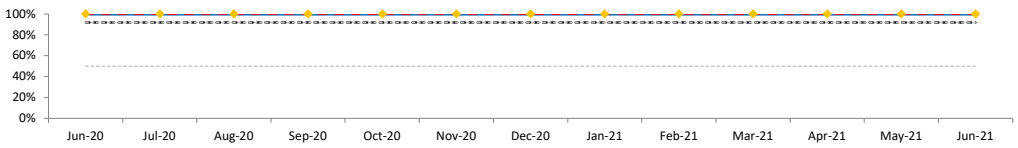
| YTD | Physical/Verbal Assaults to Staff | |
|---|---|---|
| 2021-22 | 148 | |
| 2020-21 | 132 | ▲ 12.1% |

**Narrative**

The figures for this period reflect continued improvements in the culture of incident reporting. Whilst the overall number of moderate & above incidents has increased, this remains proportionate to the overall number. i.e. moderate & above incidents represent approximately 3.5% of all incidents compared with 3.3% in the previous year. In respect of SI's raised, the figures for last year were not representative due to the impact of COVID, so need to be interpreted in that context.

### Effective

#### SI Investigation and Closure



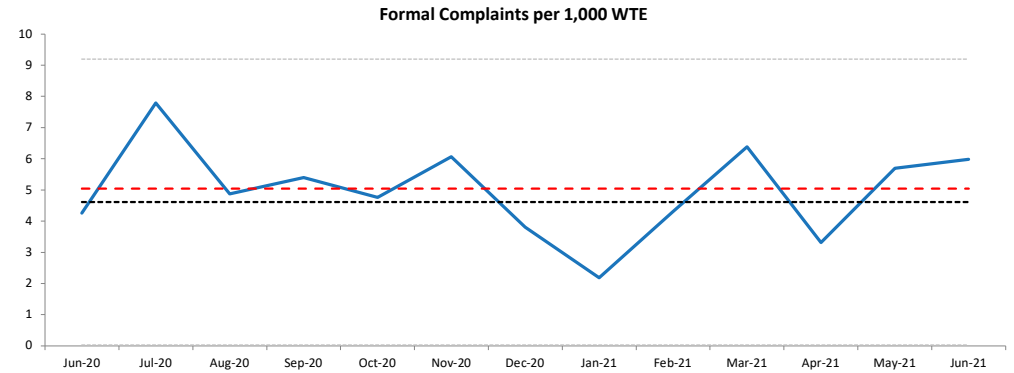

No associated data feed

**Narrative**

All SIs have continue to be submitted within agreed timescales.

### Experience

#### Formal Complaint Rate




| YTD | Complaints Received | |
|---|---|---|
| 2021-22 | 50 | |
| 2020-21 | 18 | ▲ 177.8% |

**Complaints Closed to Timescale**

| Target | Actual | |
|---|---|---|
| 80% | 100% | ● |

| YTD | Unsolicited Plaudits | |
|---|---|---|
| 2021-22 | 208 | |
| 2020-21 | 231 | ▼ 11.1% |

**Narrative**

The 50 complaints received in 2021/22 compared to 2020/21 can be attributed to the fact that the complaints process didn't properly resume until June 2020 and we were advised to only deal with serious complaints during the first lockdown. The lower figure of 18 indicates the smaller amount of complaints that met this criteria. The dip in complaints in April 2021 could be attributed to the higher level of SC and advice and signposting contacts we received during this period compared to last year. In effect, if more people are getting their concerns addressed earlier we will see a dip in complaints. Encouraging to note that we are still closing 100% of complaints to timescale. However, there's still work to be done with services to remind them to record plaudits in a timely manner. We will continue to remind services in our complaints training sessions.

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

## 3.2 Chief Nurse Commentary (May – June 2021)

## Current Events to Note

- **IPC Update: Asymptomatic Staff Testing**
  From July 2021, all NHS Staff will move to a new system where they can order their own LFD testing kits from www.gov.uk/order-coronavirus-rapid-lateral-flow-tests. The testing kits will enable colleagues to carry out regular testing for Covid-19 at home.
  This transition will make the best possible use of LFDs available and notification of this change has been communicated vis staff communications including Manager's matters and a FAQs document is available to support this.
- **Infant Feeding Training**
  A series of training sessions have now been developed by the Infant Feeding Team. These were extremely well received. The training sessions have been recorded and will be available for staff to view shortly. These are being provided as part of our work to deliver better outcomes for children through the Unicef Baby Friendly Initiative.
- The inpatient mental health wards have had their annual Mental Health Act visit from CQC on 20th July. The outcome will be reviewed when report received and relevant actions will be agreed.
- Sarah Balchin, Associate Director – Engagement and Experience, has been invited to showcase the Trusts approach to engagement and inclusion at the Beryl Institutes forthcoming 'New existence' webinar. This is a testament to the excellent work Sarah has led on behalf of the Trust and demonstrates the commitment to ensuring the strengths of the community influence our development as teams and as an organisation.

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### Professional Leadership & Clinical Standards

The Chief Nurse Directorate have recently welcomed the Clinical Workforce Team to the Chief Nurse Directorate, now sitting within the Deputy Chief Nurse portfolio. Key news and progress updates will be included within the Chief Nurse commentary going forward.

### Preceptorship

**Current programme**

18 Newly qualified clinical registrants started on the May cohort with a total of 60 currently on programme. Sessions have continued to be delivered virtually but the team are looking forward to facilitating a face-to-face element in the near future. Preceptees particularly benefit from peer support opportunities that can be difficult to replicate online.
Individuals have been provided with additional pastoral care and links with occupational health, recognising the higher than usual stress levels associated with a recovery phase.

**Programme plans**

Our current programme is under routine review. We will be improving monthly session content, involving more members of the wider Solent team, nurturing a stronger sense of belonging and launching our 'Solent Newly Qualified Network'

This will become increasingly important as newly qualified registrants make choices around their first post based on the quality of preceptorship (NHS England and Improvement). We are sharing our work in regional and national forums.

## Preceptorship Plus

**Pilot Programme Launch**

I5 early clinical careers registrants have started our first pilot cohort focusing on leadership and management, blended learning, and peer support as proposed. The aim of the programme is to improve our newly qualified (NQ) retention performance through enhanced early careers support, progression preparedness, embodying key aspects of the NHS people plan. 7 of the pilot cohort are international recruits and the remainder are those who expressed an interest having completed our preceptorship programme. The professions represented on the programme are physios, occupational therapist, LD nursing and community nursing registrants and international nurses from our inpatient areas. Further opportunities will be available from October 2021 with the programme complementing the L+D leadership offer.

## 50+ Workforce Retention: Later Careers and Retiring well

Overall, 35% of our nursing registrants are aged 50yrs and over with 18% 55yrs +. However, some services e.g. community nursing, have higher percentages and will need appropriate, timely support.

Focus Groups have been held and provided a wealth of insight into how we might best offer interventions that are tailored to our people. Several themes are emerging to inform future planning. Plans are in place for further targeted listening initiatives, including a survey for specific service lines and stakeholder engagement. Workforce data has driven an initial priority to Nursing and Midwifery, whilst respectfully attending to the views of AHPs and non-clinical staff to inform future developments. Further details will be available shorty.

## Manual Handling Training

From March 2021, the provision of face to face classroom-based Level 2 Manual Handling training has resumed within COVID secure conditions and guidelines. This has been a welcomed and positive move towards delivery of practical training in order to effectively meet the needs of service lines and support clinical staff within the safe and effective provision of manual handling procedures, promoting patient and staff care, health and wellbeing.

Alongside the formal training provision, trainers regularly complete ward ‘walkabouts’ to provide inpatient support and problem solving advise to promote a proactive approach to risk management, incident management and prevention of falls.

## Service Achievements to note:

- Coordination and provision of manual handling level 2 training incorporating PCC Integrated Occupational Therapy team facilitating partnership working and an inclusive shared learning approach.
- Formulation of a Paediatric forum group identifying the need to implement a specialist manual handling training program focused on the paediatric patient and service lines’
- Working in collaboration with Practice Educators in the provision of the newly qualified and international nurse’s recruitment initiative.

Frequent non - attendance of assigned staff to manual handling training without prior notification is an ongoing concern impacting adversely on efficiency of training delivery. Tracking and monitoring systems have been identified and systems implemented to flag up staff who failed to attend without prior arrangement have been activated within the new LMS and this will support managers in following up with individual members of their teams.

## Community Engagement and Experience

### Alongside Communities – the Solent approach to engagement and inclusion.

In May, positive progress of implementation of the plan to support our ambitions described in Alongside Communities was reported to the Engagement and Inclusion Committee. Key areas to note are:

- Solent Super Connect Event was held in response to our community asking us to help them get to know more about local groups and the support and services they offer. People from our community and partner health and social care organisations joined us.

| FEEDBACK FROM PARTICIPANTS |
|---|
| "Powerful and fabulous conversations" |
| "Honouring, valuing peoples' experience" |
| "So many people with the same heart" |
| "Gave me a pep up" |
| "I now feel really hopeful" |
| "The best event of its' kind" |

- Our approach to ***Caring for Carers*** has been created in partnership with our carer community and partners from health and social care. Two key priorities have been identified; the early identification and support of family carers who look after people who use our services, and support for family carers who work with Solent to remain in work. We are working with Portsmouth Hospitals on early dentification and our People and OD Team for carers who are members of team Solent.

- ***The People Participation Framework*** is being developed with the Academy, service lines, communications and engagement team and community partners. It will provide guidance for the governance of people participation in the Trust, ensuring we keep people who participate safe, and the organisation. A community conversation with partners in May resulted in nearly 60 more people guiding the development of the documents, and whilst introducing a little delay in the finalising added exceptional value to getting it right.

- The voice of the community in the ***review and development of policies and guidelines*** will be ensured by the recent introduction of a community engagement representative on the policy group and the development of a community panel.

- A ***Quality Account (QA) development user group*** has been formed to inform and guide the production of a more accessible and community friendly QA publication for 2022.

**Experience of Care**

The ***Experience of Care – making a difference group*** has service user, community partner and Solent team members. It oversees the delivery of the experience of care improvement workstreams, including:

- The ***Story Telling Programme***, codesigned and delivered with Touch Network CIC, has started with 23 participants from service line and corporate teams. The aim is to increase our ability to gather and use stories to drive improvement.
- The implementation of the ***Quality Checkers programme*** has started with services users (currently people with a learning disability) visiting and feeding back to services about their experiences.

**Complaints and PALS**

We have been chosen to participate in the national pilot of the newly published ***NHS Complaints Standards*** (to which we and community partners contributed).

The ***Complaints and PALS Team*** have moved to join the community engagement and experience team, to further improve the integration of feedback enabling us to better understand the experience of care of people who use our services.

## Quality, Risk and Patient Safety Arm

**Patient Safety Strategy Update**

The implementation of the Patient Safety Strategy is in the planning phase. During this phase the Patient Safety Specialist has engaged with the Community Engagement and Experience Managers and the Head of People Participation to build the foundations for the inclusion of Patient Safety Partners.
The Head of Learning and Development has been briefed on the Patient Safety Syllabus level 1 essential training requirements for all staff due to be released in August/September 2021. The training will be available via the 'My learning' system.
The Quality Insight, Intelligence and Systems Solutions Team are involved in national and local systems discussions about the implementation of the Learn from Patient Safety Events Service and are prepared to 'test' the new reports.
Solent have representatives working with the Patient Safety Collaborative on three of the pertinent five improvement programmes set out in the Strategy.

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## May – June 2021 Performance

### Incident Updates

As outlined in previous reports, there was a significant reduction in the total number of incidents reported from March 2020 onwards. This was a consequence of the emerging COVID-19 pandemic. Now, with COVID-19 having a less acute impact on services, the number of incidents being reported has increased by 16.7% compared with the same period in 2019. This indicates the continued emphasis Solent puts on Incident Reporting as part of efforts to promote a 'Safety Culture'.

In May-June in each of the past three years, four High-Risk Incidents were declared, with the learning distributed across the Trust in the form of Learning Posters.

The number of Incidents classed as Moderate continues to increase, with the majority resulting from Category 3 or above Pressure Ulcers. Work is ongoing to ensure that oversight of Pressure Ulcers in Solent is effective, and learning is reviewed and acted on across the Trust. The table below provides a summary:

| Year Reporting (March – April only) | Total Incidents reported | +/- versus previous year | Number of incidents classed as Moderate | +/- versus previous year | Number of Pressure Ulcers | Pressure Ulcers as % of moderate incidents |
|---|---|---|---|---|---|---|
| **2019** | 1541 | - | 35 | - | 25 | 71.4% |
| **2020** | 1461 | -5.2% | 47 | +34.3% | 44 | 93.6% |
| **2021** | 1799 | +23.1% | 64 | +38.3 | 64 | 100% |

### Serious Incident (SI) Update

In May-June 2021, we declared one Serious Incident investigation. This compares to eleven in May-June 2019 and two in May-June 2020.

High levels of scrutiny continue to happen in respect of incidents which have the potential to require a Serious Incident Investigation. The number of IRMs held remains constant with 41 incidents reviewed in both Q4 of 2020/21 and Q1 of 2021/22.

Two SI Reports submitted in May 2021 were subsequently de-escalated to High- Risk Incident Investigations with the agreement of the relevant commissioners.

The single Serious Incident investigation which commenced in May-June 2021 (summarised in the table below) will be shared and discussed at the Learning from Incidents and Deaths Panels in August, with outcomes to be determined following investigations. The themes and identified learning will also be reported in the quarterly Patient Safety Reports.

| Service Line | Cause Code | Description |
|---|---|---|
| **Adult Mental Health Service** | Unexpected Death | A patient of the Older Persons Mental Health Team, with a family history of suicide, took their own life. |

## Complaints Update

**Review of Approach to Raising Concern within Solent**

The team have been working to review how we can strengthen the presentation of information related to when our patients raise a concern. The purpose being to enhance our understanding of their experience of raising a concern, the themes of their concerns and what actions were taken to address these concerns.

The key areas of data presentation we are working to develop include:

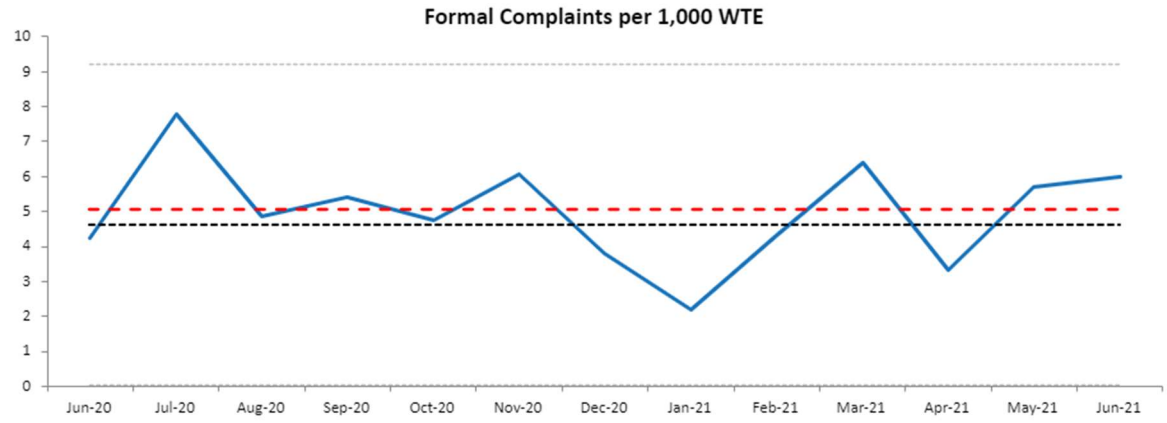
1. **SPC Charts**
   To further refine and present data in this form with supporting narrative around variations and plans to reduce the scope of variation, moving towards benchmarking as and when we establish a comparable cohort.
2. **Themes from complaints:**
   a. all themes (classification methods to be reviewed) moving towards repeated themes.
   b. Specific actions taken in response to feedback of concern, outcome and a full circle back to did this make a difference by comparing with repeated themes.
3. **Experience of raising a concern**:
   Understanding of how our patients can raise a concern, ease of access to our process, experience whilst going through the process, issues of keeping connected, outcome of process (random sample selection of people who raised a concern, using conversation based structure gather, analyse and report feedback to then inform actions).
4. **Numerical KPI**:
   No of early conversations offered as a % of number of concerns received, no of people dissatisfied with the response asking us to take further action.

In May and June 2021, the Trust received in total, 39 formal complaints, including 2 MP Enquiries, which is an increase of 8 from the previous two months. In addition, we also registered 7 Professional Feedbacks.

The most notable increase is in Child & Family services and this was noted at a recent Learning from Experience Panel, where the Head of Quality & Professions made the panel aware of the difficulties

the service and staff have, and still are facing, as an impact of the Covid-19 pandemic.

The SPC chart below shows the complaints data per 1,00 WTE and demonstrates that the levels are within the expected ranges with no statistically significant deviations. Year to date there have been 50 complaints received and although more than 50% higher than the same period in 2020/21 it is noted that this was wave 1 of the pandemic where many services had ceased operating business as usual and the complaints process reverted to normal business in June 2021. However, when compared with 2019/20, whilst there is a slight increase, they remain in line with what would be expected.




There are no notable changes to the themes from the complaints received with the exception of complaints relating to staff attitude, there have been 0 complaints during May and June with this as a theme. The team continue to work hard to manage complaints within timescales and during this reporting period have achieved 100%.

There are currently 0 cases which have been referred to the Parliamentary Health Service Ombudsman (PHSO). Whilst we have been contacted and asked to supply information to them for a preliminary investigation, we have not received any form of formal notification that they will be looking into any complaints responded to by the Trust. The team has continued to achieve the 100% acknowledgement of new complaints being received within 3 working days during May and June.

During May and June, we have also escalated the number of contacts being received by the team regarding access to Sexual Health appointments, and the length of time that patients are spending on the telephone, trying to get through via the Single Point of Access (SPA) to make an appointment. For both months, the team have continued to receive a high number of patients contacting us for help and to escalate their concerns. The service are working to address the issues which includes a more flexible approach to how the service is delivered being implemented in July 2021 and the introduction of a new telephony system in the coming months.
To note - the Complaints relating to waits specifically – 13 (attributable to SPA) 68 (not attributed to SPA) = **total 81 – a total of 0.05% of overall contacts across the service line.** The improvements needed are being worked through the service lines.

The team have successfully delivered 2 virtual Complaint Training Sessions with good attendance from services and feedback has been very positive. Further initiatives are being developed to support learning across the organisation.

Since our last report, we are pleased to be able to confirm that the new Complaints and Feedback policy has been ratified by the Clinical Executive Group (CEG), and that it more closely reads through

the lens of the service user. A new Standard Operating Procedure (SOP) has been developed which describes the nature of what were previously described as 'vexatious' complaints as, Habitual Unacceptable Persistent (HUP). This helps to remove the stigma from the person, and instead focuses on the kind of complaint the person is raising.

## Friends and Family Test (FFT)

Over the past few months, the number of FFT responses have fluctuated and analysis of the FFT from November 2020 to June 2021 shows that the measure of Community Friends and Family Test - % positive response reported through the Single Oversight Framework (SOF) has been consistently below the target threshold of 95% from November 20 – March 21. The range has been between 94.5-95.3% so not statistically significant. This varies across service lines and it is noted that Mental Health FFT has remained above target from February until May but has dropped significantly below the target to 86% in June 21. This may be due to the delay from the point of completion / submitting paper feedback and uploading the survey onto the system therefore once included the data will be amended.

The table below shows the data for May and June combined and split by month with no significant changes although noting performance against the 95% target of respondents rating their experience as "Very Good" or "Good", being slightly below at 94.3%. The numbers reporting their experience as ''Poor'' or ''Very Poor'' remains well within the 5% target running at 2.5% on average.

| | Number of responses | Good |
|---|---|---|
| **May & June 2021** | 1983 | 1870 (94.3%) |
| **May 2021** | 1182 | 1118 (94.6%) |
| **June 2021** | 801 | 752 (93.9%) |

**Themes for FFT responses**

The themes of the feedback remain consistent in comparison to 2020/21 but a notable increase in the numbers raising concern about waiting times as well as an increase in concerns about emotional and physical support available. This is reflective of the impact of the Covid-19 pandemic and the backlog of work as services return to business as usual with some restrictions remaining.

Some improvements have been made to make it easier for people to provide feedback and this has included the introduction of SMS feedback as well as continuing to work with our system provider to explore alternative methods of capturing feedback, including use of QR codes, which will support more timely uploading of feedback.

## 1. 4.1 Chief Finance Officer Commentary

### Month 3 Results

The Trust is reporting an in month adjusted deficit of £85k, £363k favourable to plan. Year to date the Trust is reporting an adjusted deficit of £654k, £688k favourable to plan. Please note that the internal plan excluded £1.0m of HDP income; including HDP income reduces the plan deficit for the first half of the year to £1.5m.

The in-month favourable variance is due to recruitment delays in specific services, reduction in Covid-19 expenditure and recognising HDP income to match costs incurred to date, partially offset by recognising sexual health underperformance with Local Authorities. There is a risk that the £305k HDP income recognised in month will not be received in full as this is not yet agreed by the ICS.

### Covid-19 Expenditure

The Trust continues to incur additional expenditure because of Covid-19. The reported in-month costs were £382k compared to an expenditure budget in the plan of £501k. Year to date costs are £1,093k compared to an expenditure budget of £1,503k

The Trust will continue to receive a block funding allocation for Covid-19, initially covering April to September 2021.

### Covid-19 Vaccination Centres Expenditure

The Trust incurred expenditure in month totalling £1,177k (£1,889k year to date) in the operation of four vaccination hubs in Southampton, Portsmouth, Basingstoke and the Isle of Wight. The operating costs are fully funded. The values for months 1 and 2 were significantly impacted by the release of accruals from the year end.

### Capital

The Trust's CDEL for 2021-22 is £11.4m, consists of £4.7m of internally generated funding and £6.7m PDC funding.
The PDC funding is for the Western Community Bed Optimisation project and the business case is with NHSE/I for approval. Notification has been received from NHSE/I that no business cases will be approved until after the spending review in September and so spend on the project will be minimal until the business case is approved.

In month expenditure was £275k (£403k year to date) and spend will increase as projects progress through the approval process.

### Cash

The cash balance was £33m at 30 June 2021, £2.4m higher than the previous month. The increase is a result of increased commissioner receipts in respect of SDF investments and a number of overdue Local Authority invoices being paid.

The forecast cash balance at the end of the financial year is £23.5m.

Current block income arrangements are guaranteed for the first half of 2021-22. National guidance has confirmed block payments will continue for the second half of 2021-22 and the cashflow forecast assumes minimal impact to funding levels and the receipt of cash.

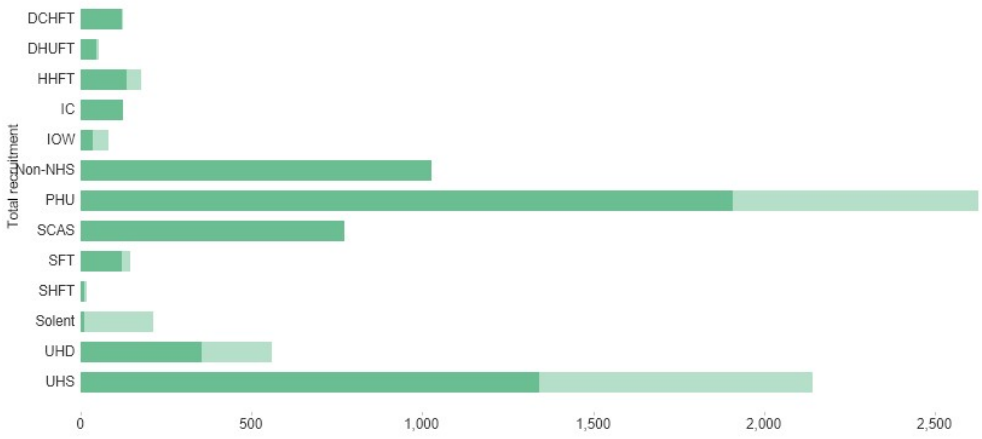
## Aged Debt

The Trust's total debt was £3.1m at the end of June, a decrease of £3.8m on May, primarily due to receipts from Local Authorities. 91+ days overdue debt at the end of month was £0.6m, a decrease of £0.3m, being the result of 3 invoices that were 91+ days overdue being paid.

## 5.1 Research and Improvement Commentary

### Research

Performance targets are still suspended in light of the reset and recovery from the pandemic. A programme of work is now in place to re-start non COVID related research, whilst continuing to support the Urgent Public Health studies and the vaccine trials.

| | |
|---|---|
| **Current Activity** | ▪ Ongoing follow up for COVID studies, including vaccine trials.<br>▪ Approximately 80% of research staff resource still required to run COVID studies limiting the scope for additional work currently.<br>▪ Pipeline of 12 additional trials to open over next 4-8 weeks.<br>▪ Almost 300 new participants to trials since April 2021<br>▪ Comparative participant recruitment across Wessex (note vaccine trial participants mapped only to PHU and UHS)<br>  |
| **Case study: PREVENAR** | ▪ Paediatric post pneumococcal conjugate vaccine study – (PREVENAR) – ongoing surveillance study to monitor effectiveness of childhood vaccines<br>▪ Inform carriage rates and efficacy of vaccines<br>▪ Has contributed to changes to the vaccine components (in partnership with UHS and Pfizer) over the past 5 years. Extending until 2024.<br>▪ 286 children recruited this year. Solent highest recruiting Trust to this programme of research, and only community organisation participating. |

# 6.1 NHS Provider Licence – Self Certification 2021/22 – May 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. The Executive Team Portfolios were reviewed in Q1 2021/22.

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.

The Trust ended the financial year 2020/21 with a small surplus.

For the 2021/22 H1 plan, the Trust submitted a £1.5m deficit plan; the deficit arising from the additional workforce (c160 WTEs) recruited in Q4 2020/21. The mechanism of moving financial resource within the ICS is to be established, including the upside in the elective recovery fund.

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. The Executive Team Portfolios were reviewed in Q1 2021/22.

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.

On an annual basis the Chair and CEO are required to formally sign this declaration on behalf of the Board, which will then be published on our website.

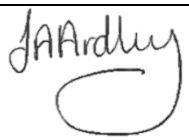
Item 11.1

# Board and Committee Cover Sheet

| | | | | |
|---|---|---|---|---|
| Item No. | 11.1 | | | |
| Presentation to | Trust In Public Board | | | |
| Title of Paper | Safe Staffing Report | | | |
| Purpose of the Paper | To provide a 6-monthly update on the nurse staffing position within the inpatient wards/units directly provided by the Trust. | | | |
| Author(s) | Angela Anderson, Associate Nurse Director, Chief Nurse Directorate | | Executive Sponsor | Jackie Ardley, Chief Nurse |
| Date of Paper | 12/07/21 | | Committees/Groups previously presented | Quality Assurance Committee |
| Action Required | For decision? | N | For assurance? | Y |
| Recommendation | The Board is asked to note the contents of this report (as presented to the Quality Assurance Committee) and support the priorities outlined within for the following 6 months, detailed below:<br>• Continuing to support the international recruitment programme of work – ongoing targeted recruitment, alongside facilitating and supporting the recently recruited postholders. Targeted work in focused on Community Nursing services and the opportunity for international recruitment.<br>• We have trialled the Mental Health Optimal Staffing Tool (MHOST) across Solent Mental Health services. Following this we are in the process evaluating the findings from a recent audit to determine how this may impact on workforce planning and to inform full implementation.<br>• The Perfect Ward pilot was introduced across in-patient areas in January 2021, enabling mechanisms to strengthen quality assurance. Plans in place to review implementation and agree future audit plan.<br>• To achieve sustained improvement on key aspects of roster management with oversight of targeted support ongoing following a push during the previous reporting period, with notable improvements as a result.<br>• To work with workforce colleagues and services to strengthen the onboarding of all new staff, taking the learning from the recent international recruitment programme.<br>• A dedicated safe staffing dashboard is now being developed and plans are in place to share this with key leads to gain feedback. Following this, the structure and format of the safe staffing meetings will be reviewed working with the HQPs across the Service Lines. This work cannot be progressed at pace whilst we work to inform the development of the safe staffing dashboard. | | | |

## For presentation to Board and its Committees: - To be completed by Exec Sponsor

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Level of Assurance *(tick one)* | Significant | | Sufficient | X | Limited | | None | |

| | |
|---|---|
| Assurance Level | Concerning the overall level of assurance Trust In Public Board are asked to consider whether this paper provides:<br><br>Significant, sufficient, limited or no assurance<br><br>And, whether any additional reporting/ oversight is required by a Board Committee(s) |
| Executive Sponsor Signature |  |

**Safe Staffing Report, 01 December 2020 – 31 May 2021**

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.

## 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 a series of 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 key expectations are set out below:

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

This report covers the period December 2020 – May 2021, with in-patient data published via an upload to Unify each month and this now includes Care Hours Per Patient Day (CHPPD) data.

Monthly safe staffing meetings continue to be held with the Chief Nurse and/or their delegated lead and in this reporting period we have refocussed these meetings to maximise the opportunity for sustained improvement and sharing of learning. A summary of themes from each meeting had previously been submitted to the Chief Operating officers for discussion at the performance review meetings. As we return to business as usual, we will re-introduce this approach to ensure discussions at performance review meetings are closely linked with the staff staffing discussions. Service lines will continue to 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: to include improvements in last 6 months**
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 December 20 – May 21, 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 redeployed staff and the impact upon staff wellbeing
- Impact on service capacity to deliver within limited resources and expertise
- As with Wave 1, within Wave 2 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). Lessons were learnt from Wave 1 to improve the experience of the redeployees and processes such as the management of rosters were improved.
- Throughout Wave 2 there continued to be concern regarding further waves requiring additional bed capacity and how in future this could be facilitated. A review of "shelved" space in Southampton was undertaken to reduce the reliance on outpatient areas being utilised. This would enable the staffing model to replicate our existing in-patient areas, accepting that an increase may be required to reflect an increased complexity / acuity.

Services reported focussed efforts on the return to business as usual during March – April 2021 during which time bank and agency usage was manageable.

During this reporting period the position in relation to reliance on temporary staffing in some service areas, particularly across mental Health services, remained a concern and continued to be monitored and strategies planned to reduce reliance on bank and agency solutions. Mental Health was identified as the initial focus of Solent's international recruitment program resulting in 8wte registered nurses having been recruited alongside a further 5wte trained staff via the standard recruitment process (further details below).
There continue to be challenges with effective roster management across all teams. During the reporting period the safe staffing meetings continued to utilise the previous reporting periods agenda focussing upon 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. An initial audit was undertaken in March 2021 and plan to re-audit in July 2021 and then quarterly. The March audit results were hampered as each MH inpatient ward had several beds closed / empty and so affected the overall % of wte per bed.

A continuing 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

Working with the Service Lines, we continue to progress the pivotal work of the International Recruitment programme. We now have a total of 7 Mental Health Nurses within the UK all completing their supernummary period. With the recruiting temporary restrictions lifted with regards to India, we are re-engaging with our international mental health nurses and have provisional arrival dates in August and September. We expect to complete all our mental health international recruitment by January 2022.

Working with Southern Health, we have recently received national funding to support the introduction of a dedicated post across Mental Health Services to develop a localised in-house Objective Structured Clinical Examination, (OSCE), training programme to support Mental Health international recruitment going forward. The postholder is due to commence in late June 2021, with an opportunity to work in partnership with our colleagues across the wider system once a robust process is in place.

On our community in-patient wards, we have welcomed and provided a comprehensive induction to our first group of general nurses and will be welcoming our 2nd group in June 2021. A further cohort will be arriving prior to October 2021.

Solent has joined a national pilot (6 sites) to develop international recruitment within community nursing services. This is an exciting opportunity to develop a sustainable community nurse programme, and the pilot will be supported by the NHSE/I International Recruitment Team and the Queens Nurse Institute (QNI). We aim to recruit to our community services piloting our programme within Q3/ Q4.

If all international recruits are successful in achieving NMC registration we anticipate having placed a total of 60 Solent International Recruits within the Trust during 2021/22.

## 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. To achieve this the ward level data is reviewed monthly and the team 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 a continued impact on staffing provision across all services because 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. 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 throughout this period included:

- Introduction of International Recruits into service, across Mental Health and Physical Health wards. Staffing resource required to support induction of international recruits in line with programme of induction over 3-month period (including supernummary time).
- 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 transition of redeployees back into substantive roles and ensuring continuation of service across all in-patient areas.
- 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 continuing to work closely together to share resources and support.

The staffing numbers across all in-patient areas has shown an improvement in comparison to the previous period. This is in part due to the introduction of international recruits and operationalising implementation of workforce plans within service. However, it should be noted that these improvements in staffing numbers require a significant period of induction meaning that temporary staffing numbers will continue during this transition period. Further to this, staffing numbers continue to fluctuate meaning that our efforts are also focussed on developing a long-term strategy to staffing recruitment.

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

- Additional focus on recruitment of bank staff (registered and unregistered)
- Continued liaison with the IPC team to support actions taken
- International Recruitment with continued focus targeted towards prioritised areas
- Ongoing development of a proposed “Safer Care Nursing Tool” to strengthen monitoring of acuity and dependency

As we return to business as usual, all our in-patient areas have worked to close the additional bed capacity operationalised in wave 1 and return to previously commissioned bed capacity levels. A structured approach to modelling the staffing requirements was completed, leading to a planned approach to the return of redeployees into their substantive services, linking this transition closely to the closure of additional bed capacity. The in-Patient areas have implemented this transition successfully with no reported adverse impact.

Services have provided feedback at staffing meetings a positive position in relation to staffing numbers during the last 2 months of this reporting period and services are managing within their existing capacity, noting continued need for temporary staff as induction periods for recruitment programmes are concluded.

## 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. The table below summarises the incident reporting for in-patient wards in relation to key indicators which are considered when looking at safe staffing during this reporting period.

The review of incident data shows a further reduction in the number of incidents in comparison to the previous period where 666 incidents were reported. The most notable increase is in the reports of pressure ulcers and a small increase in slips, trips and falls. This reporting period has seen a reduction in the numbers of reported medication errors with the most notable reduction within the Orchards Acute – Hawthorn ward. There has also been a reduction in reported physical assaults from

162 to 113, a further reduction from the previous reporting period, with the most significant reduction in The Limes which reported 34 incidents in comparison to 72 in the previous reporting period. Despite an overall reduction in reported physical assaults, the Orchards Maples Ward and Hawthorn Ward have both seen an increase in reported incidents related to physical assaults.

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 in May 2021 which outlined the concerns were not related to safe staffing numbers, a number of actions were identified including:

- 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

Building on the work outlined within the previous reporting period, the number of medication error incidents reported during December – May has continued to decrease across the Mental Health wards with Hawthorn ward reporting a significant reduction of 36 incidents (compared to 83 in the previous period) and 25 incidents within the Maples (compared to 35 in the previous period). This pivotal work continues across the Mental Health wards.

**Table 1**: Incident Reporting

| Ward/Cause Group | Assault Non-Physical | Assault – Physical | HR and Staff | Medication Errors | Pressure Ulcers | Slips, Trips and Falls | Total |
|---|---|---|---|---|---|---|---|
| **Fanshawe Ward (RSH)** | 3 | 2 | 6 | 8 | 35 | 16 | **70** |
| **Jubilee House Continuing Care (JUBH)** | 1 | 0 | 1 | 14 | 12 | 6 | **34** |
| **Lower Brambles Ward (RSH)** | 1 | 0 | 3 | 13 | 7 | 24 | **48** |
| **Snowdon Ward (WCH)** | 1 | 1 | 2 | 17 | 2 | 11 | **34** |
| **Spinnaker Ward (SMH)** | 2 | 0 | 0 | 19 | 32 | 20 | **73** |
| **Kite Unit (WCH)** | 3 | 5 | 9 | 6 | 0 | 8 | **31** |
| **The Limes (LIMES)** | 7 | 34 | 1 | 37 | 2 | 53 | **134** |
| **The Orchards Acute – Hawthorn (OCSJ)** | 14 | 19 | 0 | 36 | 0 | 6 | **75** |
| **The Orchards PICU – Maples (OCSJ)** | 24 | 52 | 1 | 25 | 0 | 3 | **105** |
| **TOTAL** | **56** | **113** | **23** | **175** | **90** | **147** | **604** |
| **Variance from last 6-month period** | **-1** | **-49** | **n/a** | **-69** | **+30** | **+4** | **-62** |

During the reporting period there has been a significant decrease in the number of formal complaints received, 11 compared to 19 in the previous reporting period. The area which has received the most complaints is The Orchards Acute - Maples, with 3 formal complaints alongside 1 service concern. The number of service concerns has seen an increase from 8 to 12 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 and/or care provided.

***Table 2*** *below summaries the complaints and services concerns received and the themes by in-patient ward for December 2020 – May 2021:*

| Service Area | Total Complaints | Total Service Concerns | Themes |
|---|---|---|---|
| Snowdon Ward (WCH) | 1 | 0 | The theme of the complaint related to the attitude of a staff member and lack of communication. |
| The Kite Unit (WCH) | 1 | 0 | The theme of the complaint related to clinical treatment provided to the patient, and the family not feeling listened to. |
| Spinnaker Ward (SMH) | 1 | 1 | The theme of the complaint related to communication issues where the family were not advised the patient had been discharged from the ward, resulting them having a fall at home, and then having to go back into hospital after catching Sepsis from their wound.<br><br>The service concern theme related to the communication difficulties a family encountered when trying to liaise with the patient whilst they were on the ward. |
| Jubilee House – Inpatient Therapies | 1 | 2 | The theme of the complaint related to clinical treatment provided to a patient when removing a catheter. The complaint was closed by PALS, and escalated to an SI, following further clinical discussions at an IRM.<br><br>The themes to the service concerns both related to clinical treatment received, and some items which went missing when the patient stayed on the ward. One was originally logged as a formal complaint; however, deescalated to a service concern as the ward manager resolved this directly with the patient. |
| The Limes (LIMES)<br><br>MHS Brooker (SJH-LIMES) | 2 | 4 | The themes of the formal complaints both related to general procedures whilst on the ward; one complaint was regarding missing items from a deceased patient, and the other about the patient's beard being shaved off without consent to remove it.<br><br>The service concerns related again to the general procedures when a patient was left outside their property following their discharge from the ward, communication issues around when a patient would receive a covid vaccination, when family members |

| | | | |
|---|---|---|---|
| | | | would be allowed on the ward to visit, and a person who received written communication about a patient staying on the ward which was sent to them in error. |
| The Orchards, Hawthorns Ward, St James Hospital | 2 | 4 | Both formal complaints related to the attitude of staff.<br><br>The service concern themes related to communication issues, clinical treatment, and general procedures when a patient was able to withdraw £250 and go shopping. |
| The Orchards, Maples Ward, St James Hospital | 3 | 1 | The formal complaint themes related to communication, clinical treatment and staff attitude. One complaint was unable to be responded to with clinical information, as the patient declined to give their consent to respond to the complaint that had been raised on their behalf by a friend.<br><br>The service concern them related to the attitude of staff. |
| **TOTAL** | **11** | **12** | |

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 mainly been on or above plan for staffing. Considering the themes of the complaints however, it is possible that this reflects/links to the dependency levels on the wards and therefore the pressure experienced by staff during these periods.

## Community Teams

The community teams across Southampton and Portsmouth continue to review the national and local information available to support safe caseload management and to identify safe staffing levels with no nationally recognised tools available at present. During the reporting period, it is acknowledged within all community teams that the acuity and dependency of the patient cohort (whether adult, paediatric or mental health) has increased leading to an impact on service capacity. In response, all teams are undertaking robust triage of referrals to ensure the service have sufficient capacity and referrals are matched to required skill sets, liaising with service commissioners to ensure awareness of increasing complexity and exploration of how these should be managed going forward.

There is national drive to develop a community nursing safer care nursing tool, however due to the national impact of Covid on Community Nursing Services, this had been placed on hold pending the outcome of the pandemic. The programme has now re-commenced and whilst Solent Community Nursing Teams remain engaged due to the increase in demand/complexity of the current caseload alongside the number of in-service projects, a decision has been made to withdraw from the data collection phase of the tool development with plans to re-engage at the “testing” phase.

The aim of the national international recruitment programme for community nursing is to design and develop a robust programme to recruit international nurses to work within the community. The programme will in part look to address the circular vacancies within community services and provide a medium to long term solution. The programme is currently under development to include:

- Marketing strategy acknowledging minimal transferrable community models internationally
- Support to drive in UK and options to access vehicles
- Transferrable IT skills / experience to enable staff to work remotely / autonomously
- Clinical skill programme to support transition to community nursing
- Pastoral and cultural support

Specialist Dental services have returned to business as usual with some areas of service yet to reach pre-Covid levels. The service continues to work within IPC and national guidance regarding fallow time, which has impacted upon their capacity however this is under continual review. The service has also noted a sustained increase in the number of DNAs and are working with commissioners to review and address the impact on capacity. Specialist Dentistry have worked to successfully recruit a high level of clinicians within service (dental nurses and dental officers).

Sexual Health continue to return to business as usual and redeployees from Wave 2 have returned to service. Following discussion with Service leads, SHS safe staffing meetings will move to a quarterly schedule as will Specialist Dentistry.

## Bank and Agency Usage

Overall demand for bank and agency has increased in the last 6-month period by 25% with nearly 20,000 requests in total (a continuing trend from the previous periods). Bank cover has achieved a 65% cover of all requests (an increase from 62% in the previous period), whilst agency cover has remained static which is attributed to the national shortage of Registered Nurse within the NHS. This is specifically relevant to our specialist services including Mental Health nurse and Childrens Nurses.

We are now starting to see increasingly successful recruitment activities for trained substantive staff leading to the number of requests starting to reduce since April 2021. The international recruitment programme which is currently underway will also assist in addressing our nursing numbers as this new group of staff are transitioned into services following training and induction onto our ward areas.

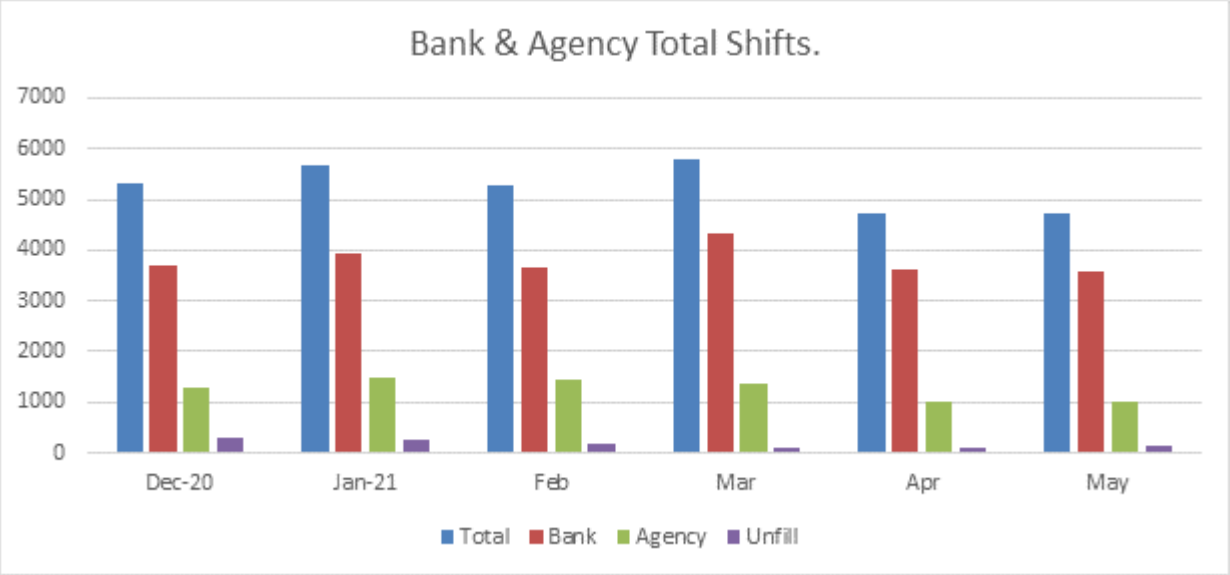
The focus for the next 6 months will be to further reduce our agency usage in services and eradicate the use of non-framework agencies as the initial impact of Service Lines substantive recruitment workstreams are realised.

<u>The below table highlights level of Bank & Agency requests for clinical areas for December 20 – May 2021</u>

| Clinical Dec 20 - May 2021 | Req | Bank | % | Agency | % | Unfilled | % |
|---|---|---|---|---|---|---|---|
| MHS SERVICES | 7193 | 3118 | 43% | 3477 | 48% | 598 | 9% |
| PORTSMOUTH ADULT SVS | 3360 | 2294 | 68% | 488 | 14% | 578 | 18% |
| PORTSMOUTH CHILDREN SVS | 881 | 881 | 100% | | | | |
| SOUTHAMPTON ADULT SVS | 4757 | 2998 | 63.00% | 1439 | 30.00% | 52 | 7% |
| PRIMARY CARE | 573 | 573 | 100% | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| SOUTHAMPTON CHILDREN SVS | 2030 | 2030 | 100% | | | | |
| SPEC DENTAL SERVICES | 98 | 98 | 100% | | | | |
| SEXUAL HEALTH SERVICES | 472 | 472 | 100% | | | | |
| **TOTALS** | **19364** | **12464** | **65.00%** | **5404** | **28.00%** | **1228** | **7%** |

The below table highlights level of Bank and Agency shifts down to Service Level.




## 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. Concern remains regarding the ongoing challenges in both recruiting and retaining staff, although Solent have been successful with the initial response from international recruitment and at the same time some areas are experiencing positive responses to recent job adverts which may in part be due to the positive coverage of the NHS during the pandemic.

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. Staff induction and retention will be a focus of work for the clinical standards and professional leadership team in the coming months.

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.

Targeted work in focused on Community Nursing services and the opportunity for international recruitment.

- We have trialled the Mental Health Optimal Staffing Tool (MHOST) across Solent Mental Health services. Following this we are in the process evaluating the findings from a recent audit to determine how this may impact on workforce planning and to inform full implementation.

- The Perfect Ward pilot was introduced across in-patient areas in January 2021, enabling mechanisms to strengthen quality assurance. Plans in place to review implementation and agree future audit plan.

- To achieve sustained improvement on key aspects of roster management with oversight of targeted support ongoing following a push during the previous reporting period, with notable improvements as a result.

- To work with workforce colleagues and services to strengthen the onboarding of all new staff, taking the learning from the recent international recruitment programme.

- A dedicated safe staffing dashboard is now being developed and plans are in place to share this with key leads to gain feedback. Following this, the structure and format of the safe staffing meetings will be reviewed working with the HQPs across the Service Lines. This work cannot be progressed at pace whilst we work to inform the development of the safe staffing dashboard.

**Board Recommendation**

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

**Appendix 1**

| | Dec-20 | | | | Jan-21 | | | | Feb-21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | Day | | Night | | Day | | Night | |
| | Fill Rate | | Fill Rate | | Fill Rate | | Fill Rate | | Fill Rate | | Fill Rate | |
| | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthorn | 102.4% | 165.1% | 109.7% | 151.6% | 108.1% | 185.5% | 127.4% | 162.4% | 111.6% | 165.5% | 105.4% | 167.9% |
| AMH Orchards - Maples | 98.4% | 169.0% | 174.2% | 161.3% | 103.8% | 202.4% | 158.1% | 194.4% | 101.2% | 198.2% | 158.9% | 173.2% |
| The Limes | 101.6% | 97.3% | 101.1% | 99.2% | 104.8% | 109.1% | 102.2% | 118.5% | 95.2% | 107.4% | 97.6% | 128.6% |
| Jubilee House | 80.0% | 75.8% | 75.8% | 71.0% | 118.7% | 146.8% | 95.2% | 153.2% | 112.9% | 153.6% | 110.7% | 150.0% |
| Spinnaker | 105.8% | 101.9% | 98.4% | 96.8% | 133.5% | 105.8% | 133.9% | 130.6% | 112.9% | 78.6% | 108.9% | 132.1% |
| Lower Brambles | 98.7% | 97.3% | 98.4% | 100.0% | 96.8% | 112.9% | 98.4% | 96.8% | 96.4% | 95.2% | 98.2% | 100.0% |
| Fanshawe | 99.4% | 99.5% | 98.4% | 98.4% | 91.0% | 99.5% | 100.0% | 127.4% | 85.7% | 97.0% | 100.0% | 100.0% |
| Snowdon Ward | 101.6% | 143.2% | 96.8% | 101.6% | 108.1% | 132.3% | 98.4% | 103.2% | 112.5% | 94.3% | 98.2% | 100.0% |
| Kite | 104.8% | 119.0% | 103.2% | 191.9% | 105.6% | 120.6% | 106.5% | 193.5% | 102.7% | 122.3% | 100.0% | 191.1% |

| | Mar-21 | | | | Apr-21 | | | | May-21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | Day | | Night | | Day | | Night | |
| | Fill Rate | | Fill Rate | | Fill Rate | | Fill Rate | | Fill Rate | | Fill Rate | |
| | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthorn | 110.5% | 146.2% | 117.7% | 123.7% | 129.8% | 181.4% | 126.9% | 150.0% | 108.1% | 198.4% | 103.2% | 171.0% |
| AMH Orchards - Maples | 98.9% | 213.7% | 153.2% | 214.5% | 168.3% | 126.7% | 192.3% | 130.2% | 149.2% | 101.8% | 156.5% | 103.7% |
| The Limes | 96.8% | 111.3% | 103.2% | 116.1% | 117.3% | 125.6% | 114.1% | 123.1% | 107.5% | 114.8% | 108.6% | 122.6% |
| Jubilee House | 97.4% | 162.1% | 114.5% | 127.4% | 104.6% | 203.8% | 128.8% | 128.8% | 98.1% | 150.0% | 108.1% | 117.7% |
| Spinnaker | 101.9% | 89.0% | 100.0% | 98.4% | 127.7% | 112.3% | 113.5% | 107.7% | 108.4% | 100.0% | 98.4% | 87.1% |
| Lower Brambles | 96.8% | 98.4% | 100.0% | 98.4% | 115.4% | 114.7% | 115.4% | 115.4% | 98.1% | 103.8% | 98.4% | 100.0% |
| Fanshawe | 102.6% | 96.2% | 100.0% | 100.0% | 115.4% | 123.1% | 115.4% | 134.6% | 104.5% | 101.1% | 100.0% | 111.3% |
| Snowdon Ward | 100.8% | 136.8% | 100.0% | 100.0% | 126.9% | 176.9% | 115.4% | 115.4% | 105.6% | 137.4% | 100.0% | 100.0% |
| Kite | 104.8% | 113.7% | 100.0% | 162.9% | 122.1% | 124.0% | 115.4% | 184.6% | 114.5% | 93.1% | 100.0% | 154.8% |

Item 12

NHS Solent NHS Trust

# Board and Committee Cover Sheet

| | |
|---|---|
| Item No. | 12 |

| | | | |
|---|---|---|---|
| Presentation to | Trust Board | | |
| Title of Paper | Information Governance Annual Report | | |
| Purpose of the Paper | It is a requirement of the Data Protection Regulations that the Trust has oversight of and take accountability for Information Governance (IG). | | |
| Author(s) | Sadie Bell, Data Protection Officer | Executive Sponsor | Andrew Strevens, Deputy Chief Executive and Chief Finance Officer-SIRO |
| Date of Paper | 12 July 2021 | Committees/Groups previously presented | N/A |
| Summary of key issues/messages | This report should be considered as "read" prior to the meeting and covers;<br>• The Trust's DPO is to produce an Information & Security Strategy for 2021/22<br>• Data Security and Protection Toolkit: discussions around areas of non-compliance, gaps and action plans are taking place between the SIRO, DPO and Head of ICT Operations<br>• Information Request: SAR and FOI compliance remains high.<br>• Incidents: an in-depth, high level review was completed in 2020, however actions were delayed due to covid. A revised deep dive is to be undertaken and a revised action plan produced.<br>• Information Governance working with services: The IG Team are working with services to streamline information governance practices and ensuring a greater level of compliance with Data Protection Requirements.<br>• The IG Team have identified several areas that it would like to concentrate on over the next six months, to improve compliance, learning and collaborative working | | |

| | | | | |
|---|---|---|---|---|
| Action Required | For decision? | N | For assurance? | Y |
| Recommendation | The Board is asked to:<br>• Consider the contents of the briefing, which is aimed at providing 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 In Public Board is asked to consider whether this paper provides:<br>Significant, **sufficient**, limited or no assurance<br><br>And, whether any additional reporting/ oversight is required by a Board Committee(s) | | | | | | | |
| Executive Sponsor Signature |  | | | | | | | |

## 1. Purpose

**1.1** The purpose of this report is to provide the Trust with a summary of the Trust's current Information Governance Compliance with Law, National Requirements and Mandatory NHS Requirements.

**1.2** Solent NHS Trust believes that it is essential to the delivery of the highest quality of health care for all relevant information to be accurate, complete, timely and secure. As such, it is the responsibility of all staff and contractors working on our behalf to ensure and promote a high quality of reliable information to underpin decision making.

**1.3** Information Governance promotes good practice requirements and guidance to ensure information is handled by organisations and staff legally, securely, efficiently, and effectively to deliver the highest care standards. Information Governance also plays a key role as the foundation for all governance areas, supporting integrated governance within Solent NHS Trust.

**1.4** This report covers Solent NHS Trust's Information Governance's Activity;

- Data Protection and Security Toolkit
- Compliance with legal requests for information
- Information Governance Incidents
- Information Management, Information Security Assurance and Cyber Security

**1.5** Key information to note, as of 17 May 2021, the Trust appointed a new Senior Information Risk Owner (SIRO), Andrew Strevens, Deputy Chief Executive Officer and Chief Finance Officer. The Trust's Data Protection Officer (DPO) has met with the new SIRO, to discuss the Trust's current Information Risk's and workstreams, current compliance, gaps, and risk assessments.

## 2. Data Protection and Security Toolkit

**2.1** The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool, mandated by the Department of Health and provided by NHS Digital, which enables Health and Social Care organisations to measure their performance against Data Security and Information Governance standards and legislation.

The ten Data Security Standards were a result of the NDG review and therefore the focus of the new Toolkit, which is then split into three categories:

- **Leadership Obligation 1 – People:** *Ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles*.
- **Leadership Obligation 2 – Process:** *Ensure the organisation proactively prevent data security breaches and responds appropriately to incidents or near misses*
- **Leadership Obligation 3 – Technology:** *Ensure technology is secure and up to date*

**2.2** **2020/21 Toolkit:** The publication of this year's Toolkit was delayed until 1 December 2020, with an initial baseline assessment published on 26 February 2021 and final submission now due end of June 2021.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Organisations are mandated to meet all mandatory requirements, in order to be classified as Compliant & Assurance Met.

The number of assertions required to be met has increased from 40 to 42, with a total of 110 mandatory requirements, under these assertions. The Trust's submission, at the end of June 2021, identified that the Trust had not fully meet all requirements mandated by the 2020/21 DSPT. The Trust was compliant with 93 of the requirements (84.5% compliant), with regards to this year's submission.

The Head of Information Governance & Security and DPO, alongside the Head of ICT Operations, have provided the new SIRO, with a briefing paper on current compliance, gaps, and planned proposals / actions (a summary of this is available in Appendix A). The Head of Information Governance & Security and DPO and Head of ICT Service Delivery are currently in the process of producing a clear action plan, to present and discuss with the SIRO in July 2021, aimed at addressing the Trust's non-compliance. Once signed off by the SIRO, the action plan will then be shared with NHS Digital. The Head of Information Governance & Security is regular contact with NHS Digital.

**2.3 Implications of non-compliance:** The following are all implications of the Trust being non-compliant

- The Trust's DSPT compliance (or non-compliance) is publicly published by both NHS Digital and Solent NHS Trust (in our Annual Report).
- NHS Digital will require a full action plan, to demonstrate how compliance will be met, in the next submission; it is important to note, that a number of these outstanding assertions, may not be met in 2021/22 either (refer to Appendix A).
- DSPT compliance is a standard question when bidding for any procurement contracts and non-compliance could cause Solent NHS Trust to mis-out on procurement / service opportunities.
- The DSPT requirements are built around standard Information Security Standards and Cyber Essentials, which are required to safeguard data and organisational infrastructure. Non-compliance could mean that the Trust is vulnerable to Cyber / Security incidents (refer to Appendix A, for assessments on individual risks).

It is important to note that the Trust was non-compliant with the 2019/20 DSPT.

**2.4 Proposals:** The Trust has recently had a thorough DSPT assessment undertaken by PwC, funded by NHS Digital (this audit is different to the Trust's internal audit, also undertaken by PwC). It is recommended and scheduled for the Head of Information Governance & Security and Head of ICT Service Delivery, thoroughly review this report and devise an action plan to ensure that all in-house areas of compliance, recommendations and actions are implemented within 2021/22. The action plan must provide detailed actions, gaps and resources required to meet full compliance. This should be the Trust primary focus, as it is within the Trust's control. Specific attention and actions should be given to areas of non-compliance, over areas where improvements could be made.

The Trust, led by the Head of ICT Service Delivery (as these relate to ICT operations), should undertake an assessment of all non-compliance areas, within the control / remit of the Trust's contracted outsourced ICT Provider and where actions can be implemented, without any disproportionated financial cost, ensure that mechanisms are in place to implement these.

Where there is a disproportionated financial cost, the Head of ICT Service Delivery, supported by the Head of Information Governance & Security, should outline mitigations that can be implemented to safeguard the Trust's data and infrastructure and ensure that these are implemented. In addition, any areas of non-compliance for 2021/22, within the control / remit of the Trust's contracted outsourced ICT Provider, should be placed on a priority list of implementations, upon the completion and mobilisation of the current ICT procurement exercise within 2022/23. These actions should be implemented ASAP, as the Trust would have been non-compliant for two financial years.

***A full breakdown of the Trust's compliance and risk assessment on non-compliant requirements can be found in Appendix A.***

## 3. Summary of Information Governance's Legal Requirements Compliance

**3.1** An overarching review of the Trust's Information Governance Legal Requirements (Freedom of Information Requests (FOI) and Subject Access Requests (SARS)) to date, shows that there continues to be a high number of requests being received by the Trust, compared to previous years. Compliance rates have however not been impacted by this; SARs have been above the mandate of 95% compliance rate since September 2020 and FOI's have been in the high 90% (plus) compliance rate since October 2020 (due to

the number of requests received in this particular area being around 25 per month, even one breach can cause compliance to dip below 95%).

This huge achievement has been as a result of the re-implementation of monitoring processes, by the interim IG Officer (Records Lead) and the return of the IG Teams Senior Leadership roles, who collectively, as a team, have also identified efficiencies and changes in the process being undertaken to meet this requirement. Some of the efficiencies are identified below;

- Revision of processes
- Closer working relationships with services to ensure compliance and lessen the burden on services, whilst providing a high-quality information service, to our service users.
- New Covid-19 Business Continuity Plans have improved efficiencies in turnaround, whilst reducing impact on clinical and corporate services. Considerations into maintaining current processes is currently being undertaken.
- The launch of a revised Publication Scheme – making information available.
    - Uploading of released FOI's and revision of FAQ on public website; the aim is to reduce the number of FOI requests services are required to answer, by redirect to already published information
    - Proactive publication of information, of highly requested and potentially requested information; this will enhance the Trusts open and transparent culture, by sharing information and reduce impact on services to respond to such requests.

***A full breakdown of the Trust's current Information Requests compliance can be found in Appendix B.***

## 4. Information Governance Incidents/Security

### 4.1 *IG Incident Summary*

In November 2020, the Head of Information Governance & Security and Data Protection Officer, undertook a deep-dive review into the Trust's Information Governance (IG) Incidents; review with regards to both how IG incidents are reported, recorded and validated within the Trust, as well as an assessment of the root causes of these incidents. Three out of four of the review process elements were completed, with the final staged planned to be completed January – March 2021.

**Outstanding elements:** Greater insight into the human elements of IG Incidents and what we can do to reduce "Human Error"; through training, awareness, assessment of service demands that may impact on these incidents, system changes, technology advancements, etc… This will be achieved by using the data as a baseline assessment and then the IG Team working with services to assess what may need to change and ensuring the right changes are made, that will benefit service compliance.

Unfortunately, this has been delayed due to covid-19 response work and focus is to recommence and form part of the Information Governance Teams plans for 2021/22.

**What Next?**

- It is recommended and planned, that a revised deep dive and subsequent action plan is undertaken in Q3 of 2021/22. The Information Governance Manager's position is currently vacant, but it is hope will be appointed to shortly; they will be tasked with this requirement, as one of their main focuses, once appointed.
- IG Team is to ensure that best practice / reminders of processes, for all incidents reported with a Root Cause of Process (Failure to follow, Lack of and Unaware of) are cascaded to staff as "IG Learning"
- Working with key services, to establish what the Human Elements are of IG Incidents relating to PID Sent to Wrong Person / Address and PID in Wrong Record / Record Error are. The IG Team will work with Services Lines, with the highest number of reported incidents in this field. It is important to note however, this is not stated that these Service Lines are the cause of the incidents, but rather they have identified the issue through reporting and therefore best suited to work with to establish what more we can learning from these incidents.

- Monthly incident data reports are reviewed and assessed by the IG Team (this has already commenced). It is hoped that this early assessment will allow for issues and themes to be caught early and therefore reduce the number of future incidents.

**5. Information Management / Information Security Assurance / Cyber Security**

The DPO has undertaken a gap analysis of the Trust's current Information Management / Information Security Assurance / Cyber Security working practices and compliance. This has been presented to the SIRO, for revision and consideration, to determine Trust prioritises. Once a decision has been made with regards to the proposals and the direction the Trust is going to take, with regards to its Information Management and & Security Assurance, as part of the Trust's wider Digital Journey, the Trust's DPO will, alongside discussions with the SIRO, produce an Information Management & Security Strategy, outlining the Trust's direction of travel and priorities for 2021/22 and 2022/23.

**6. Information Governance Working with Services**

The Information Governance Team, over the next several months will be working with services to streamline Information Governance Practices and ensure a greater level of compliance with Data Protection requirements. This will include among other things,

- The sharing of information with key working partners – improving upon current arrangements
    - An overarching Information Sharing Agreement with Southern Health NHS Foundation Trust has already been established, providing for safer, easier, and legal information sharing practices can be implemented. This is to be duplicated with other working partners.
- The revision and implementation of technological advises / working practices
- The Data Protection Compliance of ICT Security
- Working with services to expand upon their Data Protection Compliance statements, and individual services Privacy Notices

**7. Top Three Security Risks (Taken from the last monthly SIRO Report: July 2021)**

1. **Information Management:** This is becoming an increase risk and demand on the Trust to address, as a result of;
    - Increased number of incidents around access controls
    - Cyber Essential Plus requiring increased assurance
    - DSPT requiring increased assurance
    - Advances in computer technology
    - Legacy processes / practices

    Refer to section 5 of this report, for more information.

2. **Cyber Security (Cyber Essentials Plus):** The mandatory requirement of compliance with Cyber Essential requirements, has been placed on hold at present by NHS Digital; however, this work will still need to be completed. This work should be incorporated into the Trust's Information & Security Strategy.

3. **DSPT – ICT/CGI Requirement (assurance required):** The increase in assertions and requirements, has result in attentional work needing to be undertaken by both IG and ICT (internal Solent and CGI). Current compliance and risks are outlined in Section 2 and Appendix A of this report.

**8. Summary**

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

The Information Governance Team have worked extremely hard, pulling together to rebuild and reimplement IG Practices within the team and across the Trust, increasing compliance and create a learning culture, both within the Team and across the Trust.

The IG Team have identified several areas that it would like to concentrate on over the next six months to improve compliance, learning and collaborative working and include (but not exclusive to);

- Improvements in FOI Practices, including the revision of the Trust's Publication Scheme, the continual development of an FOI FAQ and the introduction of a new FOI System
- Improvements in SAR Practices, including the introduction of a new SAR System, education on SAR and Records Management Practices across the Trust, improved communication links with requestors
- Implementation of the IG Training Strategy for 2021/22: Revision of training materials and resources, in line with the Trust's new Learning & Development training system and vision. Creating an increased learning culture.
- Implementation of the IG Communication Strategy for 2021/22: Designed at improving communication and learning with staff, patients, and the wider communication. Increasing and enhancing the Trusts Open and Transparent culture.
- Incident Management Plan; revision of incident root causes and working with services to identify improvements in working practice. This will also include embedding an IG culture from service level up.
- Information Sharing: identify more efficient and service / patient beneficial information sharing arrangements, to make information sharing across organisation more efficient, whilst meeting our legal obligations
- Refresh / revision of IG Legal Compliance factors, such as Data Protection Impact Assessments, Data Processing Agreements, Privacy Notices, etc… to ensure that the Trust remains compliant with its legal obligations.
- Implementation of an Information Management & Security Strategy

## Appendix A: DSPT Compliance and Risk Assessment on Outstanding Requirements

| Assertion Number | Assertion Description | Action | Action Owner | If not, reasoning behind | If not, what is the risk? | If not, what mitigations are in place? | What actions are required? * Full action plan and details to be established |
|---|---|---|---|---|---|---|---|
| 4.1.2 – Partially Compliant | Does the organisation understand who has access to personal and confidential data through your systems, including any systems which do not support individual logins? Each system may use its own user list(s) or use federated access. There may be systems where technically or operationally it is not possible to have individual logins but there are alternative methods of maintaining user lists. Where this occurs, it is understood, and risk assessed by the organisation. | a) Recommend Trust raise a change to obtain a list of staff members that have access to personal / confidential data | Sadie Bell | Not in scope of any current work stream | Significate - Users may have unrestricted access to PID they do not need access too.<br><br>This includes shared mailboxes, shared drives, clinical applications<br><br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16** | Policies and internal process are in place, but these are largely unmanaged and unmonitored | Head of Information Governance & Security is producing a GAP analysis for the SIRO, with regards to resource requirements to implement adequate Information Management and Information Security Assurance controls – this requirement is one of the main aspects covered by this report. |
| 4.5.1 – Non-Compliant | Do you have a password policy giving staff advice on managing their passwords? Password policy must cover<br>(a) How to avoid choosing obvious passwords (such as those based on easily-discoverable information).<br>(b) Not to choose common passwords (use of technical means, such as using a password blacklist, is recommended).<br>(c) No password reuse.<br>(d) Where and how they may record passwords to store and retrieve them securely.<br>(e) If password management software is allowed, and if so, which.<br>(f) Which passwords they really must memorise and not record anywhere | a) Implementation of 13 Digit Password | CGI / Dawn Day | This requirement is currently being implemented, but the rollout will not be completed by the end of June. Rollout to be completed by end of July 2021 | Until this action is complete, the Trust's email system and network accounts are left vulnerable to cyber-attacks. A large number of accounts have now implemented the 13 digit-password.<br><br>**Likelihood: 3**<br>**Severity: 5**<br>**Risk: 15** | Access to our accounts is being closed monitored, and access outside of the UK has been blocked with regards to email accounts. | Continue with current rollout. |

| Assertion Number | Assertion Description | Action | Action Owner | If not, reasoning behind | If not, what is the risk? | If not, what mitigations are in place? | What actions are required? * Full action plan and details to be established |
|---|---|---|---|---|---|---|---|
| 4.5.3 – Partially Compliant | Multifactor authentication is used [wherever technically feasible]. Multifactor authentication can include hardware-based certificates. This applies to end user devices. [Where it is not possible to apply multifactor authentication, this should be considered in your response to 9.6.10] | a) MFA to be implemented in O365 environment<br>b) MFA to be implemented in Power BI environment<br><br>Agreed Solent to raise a Service Request for quick wins and CCR for full solution.<br><br>MFA is currently used for Remote access, access via smartcards to some clinical applications and Azure Global Administrator roles. | CGI / Dawn Day | Impact of Covid support on Resource availability. | Moderate – Weak passwords without MFA could lead to data breaches due to being easier to hack.<br><br>***Prior to 13-digit password being implemented***<br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16**<br><br>***After 13-digit password is implemented***<br>**Likelihood: 2**<br>**Severity: 4**<br>**Risk: 8** | There is a plan to implement MFA on external Office 365 access | Solent ICT to place CCR for two factor authentications to be implemented on emails (already in place for VPN). This is to be actioned within 2021/22 |
| 7.1.2 – Partially Compliant | Do you have well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise? This may include the preservation of manual processes for essential services. | a) To have BCPs and DRPs in place for main and critical systems<br>b) To write BCP testing reports | Dawn Day | There are currently no plans to implement this | Significate | There is a CGI BCP<br><br>There is a Solent IT BCP however there is a lack of understanding if this has been formally approved.<br><br>There is currently no Disaster Recovery plan. | We are unable to implement a Disaster Recovery Plan with CGI, as this is outside of the contract and therefore cannot be achieved until 2022/23<br><br>Solent ICT to ensure that our internal BCP is in place and it covers what the Trust would do, if a cyber incident or similar where to occur; inclusive of identifying critical systems and priorities or reinstating BAU. |
| 7.2.1 – Non-Compliant | Explain how your data security incident response and management plan has been tested to ensure all parties understand their roles and responsibilities as part of the plan. Exercise scenarios should be based | Security Incident response and management plan to be written and tested | CGI / Dawn Day / Sadie Bell | No plan is currently in place, to test | Significate – there is no documented plan in place and therefore this has not been tested. The Trust has not formally assessed its security risks or have clearly | Limited mitigations in place | Head of Information Governance & Security is producing a GAP analysis for the SIRO, with regards to resource requirements to implement adequate Information Management and Information Security Assurance |

| Assertion Number | Assertion Description | Action | Action Owner | If not, reasoning behind | If not, what is the risk? | If not, what mitigations are in place? | What actions are required? * Full action plan and details to be established |
|---|---|---|---|---|---|---|---|
| | on incidents experienced by your and other organisations or are composed using threat intelligence.<br>This should be since 1st April 2020 with active board and business representation. | | | | documented response plans in place.<br><br>**Likelihood: 4**<br>**Severity: 5**<br>**Risk: 20** | | controls – this requirement is one of the main aspects covered by this report. Head of ICT Services is to jointly collaborate with this. |
| 7.2.4 – Non-Compliant | From the business continuity exercise, explain what issues and actions were documented, with names of those responsible for the actions listed against each item. Each action should have an owner and timescale. | To test BCP | Dawn Day / Sadie Bell | No plan is currently in place, to test | Significate – there is no documented plan in place and therefore this has not been tested. The Trust has not formally assessed its security risks or have clearly documented response plans in place.<br><br>**Likelihood: 4**<br>**Severity: 5**<br>**Risk: 20** | Limited mitigations in place | Head of Information Governance & Security is producing a GAP analysis for the SIRO, with regards to resource requirements to implement adequate Information Management and Information Security Assurance controls – this requirement is one of the main aspects covered by this report. Head of ICT Services is to jointly collaborate with this. |
| 8.1.3 – Partially Compliant | Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted and signed off by the SIRO. | a) Assess out of data software | Dawn Day | Current report provided by CGI, has made this task difficult to complete | Significate – The trust could be running software or firmware that is vulnerable to exploit.<br><br>There is no mechanism in place by the IT supplier to define or manage this. The expectation is for Solent IT to manage software with limited access and resource available.<br><br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16** | Limited mitigations are in place | Solent ICT: An action is already in progress to identify all software installed and define its suitability for patching and support.<br><br>A review is then needed to understand software requirement and how vital this is to the trust. |
| 8.2.1 – Partially Compliant | List any unsupported software prioritised according to business risk, with remediation plan against each item. Unsupported software is software which is no longer receiving | a) Report to come to Information Security Committee | Dawn Day | Current report provided by CGI, has made this task difficult to | Significate – The trust could be running software or firmware that is vulnerable to exploit.<br><br>There is no mechanism in place | Limited mitigations are in place | Solent ICT: An action is already in progress to identify all software installed and define its suitability for patching and support. |

| Assertion Number | Assertion Description | Action | Action Owner | If not, reasoning behind | If not, what is the risk? | If not, what mitigations are in place? | What actions are required? * Full action plan and details to be established |
|---|---|---|---|---|---|---|---|
| | security updates e.g. Windows XP, Java, or Windows Server 2008. Unsupported software is less secure and so poses a larger risk to your organisation. The unsupported software list will comprise of the results of the software survey where the software is not supported/updated. | | | complete | by the IT supplier to define or manage this. The expectation is for Solent IT to manage software with limited access and resource available.<br><br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16** | | A review is then needed to understand software requirement and how vital this is to the trust. |
| 8.2.2 – Partially Compliant | The SIRO confirms that the risks of using unsupported systems are being managed. The SIRO has been briefed on the unsupported systems and has made a conscious decision to accept and manage the associated risks. If no unsupported systems, please tick and state "No unsupported systems" as a comment. | a) To provide SIROs statement and authorisation<br>b) Report to be produced following ICT & Cyber Security Committee | Dawn Day | As report has not been produced, SIRO has been unable to confirm acceptance of risks | Significate – The assessment has not been completed and therefore the SIRO is unable to assess the level of risk.<br><br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16** | Limited mitigations are in place | Solent ICT: An action is already in progress to identify all software installed and define its suitability for patching and support.<br><br>A review is then needed to understand software requirement and how vital this is to the trust. |
| 8.3.4 – Non-Compliant | Where a security patch has been classed as critical or high-risk vulnerability it is applied within 14 days, or the risk has been assessed, documented, accepted and signed off by the SIRO with an auditor agreeing a robust risk management process has been applied. | a) CCR Required for patching to be implemented within 14days<br>b) CCR Implemented<br><br>CCR577 raised and to be agreed with Solent<br><br>The CCR would only cover the Windows desktops and servers in support, it does not cover all infrastructure | Dawn Day / CGI | In discussion with CGI, however costings provided by CGI mean that financially this is not considered viable at this time | Significate – The trust could be running software or firmware that is vulnerable to exploit.<br><br>Solent do not have a full list of software and hardware used in the provision of IT services to make a full assessment of risk.<br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16** | Limited mitigations are in place | Currently the Trust and CGI cannot fully scope what software or hardware needs to be included in this requirement.<br><br>Recommended that the Trust and CGI priorities the full understanding of its software and hardware within Q2 of 2021/22 and assess the financial implications and security risks in Q3 & Q4 of 2021/22, to assess if compliance can be met in the next financial year. Alternatively, this will ensure that the Trust is in a position to fully implement in 2022/23, under new contract arrangements. |

| Assertion Number | Assertion Description | Action | Action Owner | If not, reasoning behind | If not, what is the risk? | If not, what mitigations are in place? | What actions are required? * Full action plan and details to be established |
|---|---|---|---|---|---|---|---|
| 8.4.2 – Partially Compliant | All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support. | a) Azure Patching Requirement Process and evidence of patching required<br>b) CCR Implemented<br><br>MD – CCR577 raised and to be agreed with Solent<br><br>MT – This is not meet, the BI servers are patched monthly, but a large proportion of the estate is not patched regular | Dawn Day / CGI | In discussion with CGI, however costings provided by CGI mean that financially this is not considered viable at this time | Significate – The trust could be running software or firmware that is vulnerable to exploit.<br><br>Solent do not have a full list of software and hardware used in the provision of IT services to make a full assessment of risk.<br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16** | Limited mitigations are in place | Currently the Trust and CGI cannot fully scope what software or hardware needs to be included in this requirement.<br><br>Recommended that the Trust and CGI priorities the full understanding of its software and hardware within Q2 of 2021/22 and assess the financial implications and security risks in Q3 & Q4 of 2021/22, to assess if compliance can be met in the next financial year. Alternatively, this will ensure that the Trust is in a position to fully implement in 2022/23, under new contract arrangements. |
| 9.3.6 – Non-Compliant | The organisation is protecting its data in transit (including email) using well-configured TLS v1.2 or better. | a) Findings in pen test are being remediated<br><br>Remediation to be completed by 23/04/21 | CGI | There is no evidence that shows this has been fully completed. To be reviewed as part of the 2021 Pen Test, currently being undertaken. | Moderate – Data in transit could be intercepted creating a data breach<br><br>The above is required for the organisation's internal email system to be classified as encrypted and secure.<br><br>***Prior to 13-digit password being implemented***<br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16**<br><br>***After 13-digit password is implemented***<br>**Likelihood: 2**<br>**Severity: 4**<br>**Risk: 8** | NHSMail is used for confidential PID externally but does not protect against internal communications of this nature.<br><br>The absence of other mitigators such as 13-digit password and two factor authentication, increases the current risk.<br><br>13-digit password is due to finalise by the end of June | Further investigation / testing is required to identify any areas systems that are no encrypting data in transit. |

| Assertion Number | Assertion Description | Action | Action Owner | If not, reasoning behind | If not, what is the risk? | If not, what mitigations are in place? | What actions are required? * Full action plan and details to be established |
|---|---|---|---|---|---|---|---|
| 9.6.9 – Non-Compliant | All remote access is authenticated. Strong (ideally multifactor) authentication is required to remotely access personal, confidential information. This includes both web applications and remote access to corporate networks. | b) To be implemented in O365 environment<br>c) To be implemented in Power BI environment<br><br>All remote access is authenticated but not with MFA in all instances currently | CGI | Power BI currently does not have Multi-Factor Authentication (MFA).<br><br>Impact of Covid support on Resource availability. | Moderate – Weak passwords without MFA could lead to data breaches.<br><br>***Prior to 13-digit password being implemented***<br>**Likelihood: 3**<br>**Severity: 4**<br>**Risk: 12**<br><br>***After 13-digit password is implemented***<br>**Likelihood: 2**<br>**Severity: 4**<br>**Risk: 8** | The absence of other mitigators such as 13-digit password and two factor authentication, increases the current risk.<br><br>13-digit password is due to finalise by the end of June | Solent ICT to raise CCR request for MFA.<br><br>13-digit passwords are being rolled out. |
| 9.6.10– Partially Compliant | You have a plan for protecting devices that are natively unable to connect to the Internet, and the risk has been assessed, documented, accepted and signed off by the SIRO. | a) Plan to be produced<br>b) Risks to be assessed<br>c) SIRO to sign off<br>d) Action to be implemented and monitored | Sadie Bell / Dawn Day | Not in scope of any work stream | Moderate – Devices could be vulnerable to compromise and lead to a security incident.<br><br>**Likelihood: 4**<br>**Severity: 4**<br>**Risk: 16** | There is currently no understanding of this and further investigation would be required. | An investigation / analysis of the Trust's current situation, implications and risks, is to be undertaken, jointly between CGI, Solent ICT and IG (Security Assurance) |

## Appendix B: Information Request Compliance Breakdown

### *Subject Access Requests:*

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. requests received | 40 | 62 | 85 | 58 | 59 | 100 | 104 | 83 | 71 | 114 | 90 | 92 |
| No. requests responded to within 21 days (best practice) | 19 | 37 | 73 | 53 | 49 | 86 | 88 | 74 | 59 | 103 | 83 | 74 |
| No. requests responded to within mandated timescale (one calendar month) | 10 | 17 | 11 | 4 | 4 | 11 | 13 | 6 | 8 | 11 | 6 | 8 |
| No. requests responded to within covid-19 extended deadline timescale (40 days) | 5 | 5 | 1 | - | - | - | - | - | - | - | - | |
| No. requests responded to within covid-19 extended deadline timescale (50 days) | 2 | 1 | - | 1 | - | - | - | - | - | - | - | |
| No. requests responded to within covid-19 extended deadline timescale (60 days) | 4 | 2 | - | - | - | - | - | - | - | - | - | |
| No. breaches within (covid extended deadline) | 0 | 0 | 0 | 0 | - | - | - | - | - | - | - | - |
| No. breaches within (legal deadline) *as of 01/08/2020 | - | - | - | - | 6 | 3 | 3 | 3 | 4 | - | 1 | 1 |
| % Compliance – Legal Requirement (30 days) | 72.5% | 87.1% | 98.8% | 98.3% | 89.8% | 97.0% | 97.1% | 96.4% | 94.3% | 100.0% | 98.8% | 98.8% |
| % Compliance – including Covid-19 extended timeframe | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | - |
| **Not Due** | - | - | - | - | - | - | - | - | - | - | - | 9 |

**Please note:** As of the 1st August 2020, extended deadlines were removed.

### *Freedom of Information Requests:*

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. Requests | 16 | 16 | 17 | 22 | 24 | 32 | 45 | 25 | 18 | 42 | 28 | 24 |
| No. Responded within 20 working days | 7 | 9 | 7 | 19 | 23 | 27 | 42 | 23 | 17 | 38 | 26 | 22 |
| No. Responded within 30 working days | 2 | 3 | 8 | 3 | 1 | - | - | - | - | - | - | - |
| No. Responded within 40 working days | 3 | 3 | 2 | - | - | - | - | - | - | - | - | - |
| No. Responded within 50 working days | 3 | - | - | - | - | - | - | - | - | - | - | - |
| No. Responded within 60 working days | 1 | 1 | - | - | - | - | - | - | - | - | - | - |
| No. Breaches | - | - | - | - | - | 5 | 3 | 2 | 1 | 4 | 2 | 1 |
| % Compliance – Legal Requirement (21 days) | 43.8% | 56.3% | 41.2% | 86.4% | 95.8% | 84.4% | 93.3% | 92.0% | 94.4% | 90.5% | 92.9% | 95.7% |
| % Compliance – including Covid-19 extended timeframe | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | - |
| No. Not Due | - | - | - | - | - | - | - | - | - | - | - | 1 |

**Please note:** As of the 1st August 2020, extended deadlines were removed.

# Board and Committee Cover Sheet

Item 13

NHS Solent NHS Trust

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|---|---|---|---|---|---|---|
| Item No. | 13 | | | | | |
| 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 15 July 2021 | | | | | |
| Author(s) | Adele Campbell, PA to Chief People Officer | | Executive Sponsor | Jas Sohal, Chief People Officer | | |
| Date of Paper | 15 July 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 | ○ The regular **Workforce & Sustainability Report** was received, and key areas highlighted including:<br>- Statutory and Mandatory training compliance is now at 90% - the new LMS has assisted with reaching our target from a Trust-wide perspective.<br>- International recruitment drive has had a positive impact; reducing agency spend to 1.5% - a significant improvement.<br>○ The **Employee Relations Assurance Report** was received, and key areas noted including:<br>- Employees with long-Covid continue to receive full pay; NHS guidance expected to alter soon regarding this.<br>- 5 red cases discussed in FM and Estates; confirmed work is in progress to improve and reduce cases in the future.<br>- The new People Directorate structure was referred to, confirming the People Team will be aligned more closely to service lines in the future, enabling line manager coaching, preventing the need for intervention.<br>- It was agreed the ROAG Group and discussions within children's services would be sited at WOD in the future.<br>○ The **Workforce Risk Appraisal** was received, and key areas noted including:<br>- Safe Staffing meetings are continuing, and any concerns are escalated to Executive level. Looking to amend how we deliver services and waiting lists are under regular review to ensure safe staffing levels.<br>- Specialist posts are difficult to recruit; new post types are being implemented to ensure essential skill sets are not depleted.<br>- Agreed risk score moderation is required; to be considered within the Performance Committee.<br>○ The **Board Assurance Framework** report was received, and key areas noted including:<br>- WOD considered the risks to ensure they were appropriately captured, and risk scores agreed.<br>- Agreed a raw score of 20, residual score of 12 and a target score of 10; to be achieved within the next 18 to 24 months. For noting, scores are based on the current workforce requirement, not future workforce requirement.<br>○ **Escalation reports** were received for the **People and Organisational Development Group** and the **Doctors and Dentist Negotiation Committee.** No meetings held to report for Joint Consultative Negotiating Committee and Wellbeing Oversight meeting.<br>○ **Solent's Diversity and Inclusion Annual Report** was received, and key areas noted including:<br>- Report timings are to be amended to ensure these are aligned for the WRES/WDES reporting<br>- D&I Team applauded on excellent work undertaken during the pandemic and the continued D&I data reporting.<br>- Agreed for report to be further refined prior to publication to include deep dive into the staff survey discrimination elements, Gordon Muvuti/Jas Sohal becoming part of the Executive Team, and greater visuals to enable clearer interpretation of data. | | | | | |

| | |
|---|---|
| | ○ An **Occupational Health and Wellbeing Update** was received; WOD provided with an update on activity over the last year, assurance on the current status and advised regular updates would be shared with the committee. Occupational Health and Wellbeing Team commended on their fantastic work and thanked for their ongoing support.<br>○ The **Agency Spend Review** report was received and discussed.<br>- An increase in agency spend was highlighted, however this included both Covid and vaccination costs. Data further broken down to conclude agency spend is highest in FM, Mental Health and Adult Services<br>- National funding received to reduce Health Care Support Worker vacancies<br>- Recruitment plans in place to reduce vacancies in FM.<br>- Work undertaken by the team was acknowledged and commended, particularly during the pandemic.<br>○ The **Internal Labour Market Map Analysis 2020-2021 Report** was received, and key areas noted including:<br>- Proposal in place to increase internal advertising from 4% to 20% and ideally advertise all roles internally in the first instance.<br>- Exit interviews are carried out externally; looking to increase internal conversations (e.g., career, etc.) to enable early intervention on those employees that could result in a flight risk.<br>- Board to Floor feedback provided relating to lack of communication from 'home' teams during redeployment. This concern was raised previously after wave one and acted upon for wave two with a buddying system and more robust redeployment process.<br>- Excellent feedback from committee on data provided in the ILM report.<br>○ The **Workforce Planning** Report was received, and an overview was provided of the process required in order to meet the deadline. A plan is being created to achieve a fully integrated planning framework; enabling greater visibility of what the forecasted requirements will be.<br>○ Chair's approval was noted in relation to minor amends made to the **WOD Terms of Reference**.<br>○ **Single Oversight Framework (S.O.F)** raised and the following was discussed/agreed:<br>- Trust-wide annual sickness target currently stands at 4%. A review has been undertaken and the proposal made, that as Covid sickness is included, the target should increase to 4.5% (this is consistent with the Model Hospital for our peer organisations)<br>- Annual sickness is increasing due to vaccination workforce being included in the figures (including temporary workforce). The committee agreed a fairer approach would be to reflect on Solent, excluding these staff members.<br>- The committee considered the targets/approach – both were agreed. |
| Action Required | For decision? N / For assurance? Y |
| Summary of Recommendations | The Board is asked to:<br>• 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:<br>Significant, sufficient, limited or no assurance<br>And, whether any additional reporting/ oversight is required by a Board Committee(s) | | | | | | | |
| Executive Sponsor Signature |  | | | | | | | |

Item 14

NHS Solent NHS Trust

# Board Cover Sheet

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|---|---|---|---|---|---|---|
| Item No. | 14 | | | | | |
| Presentation to | Trust Board | | | | | |
| Title of Paper | Engagement and Inclusion Committee June 2021 – summary report | | | | | |
| Purpose of the Paper | To provide a summary of the Engagement and Inclusion Committee meeting | | | | | |
| Author(s) | Sarah Balchin, Associate Director Community Engagement and Experience | | Executive Sponsor | Jackie Ardley, Chief Nurse | | |
| Date of Paper | 23 July 2021 | | Committees/Groups previously presented | NA | | |
| Statement on impact on inequalities | Positive impact (inc. details below) | x | Negative Impact (inc. details below) | | No impact (neutral) | |
| Positive / negative inequalities | The Engagement and Inclusion Committee received an update of the delivery of Alongside communities – the Solent approach to engagement and inclusion, with progress made as required. | | | | | |
| Summary of key messages / findings | 1. The delivery of the plan to support implementation of Alongside Communities – the Solent approach to engagement and inclusion is on track.<br>2. A comprehensive review of the collection of demographic data has been completed: systems capabilities identified, assessment of local practice of demographic data recording including referral data completed, recommendations for improvement made and agreed, implementation commenced.<br>3. The Anti-discrimination Task Force continues to work with the colleagues from the police force and security specialists, with a E learning tool being developed to support people in practice.<br>4. The COVD hesitancy project, developed in partnership with Our Version Media CIC, has received very positive feedback from members of our local community. | | | | | |
| Action Required | For decision? | | (Y/N) No | For assurance? | (Y/N) N | |
| Summary of Recommendations | • To Board is asked to note the summary from the Engagement and Inclusion Committee June 2021 | | | | | |

# For presentation to Board and its Committees:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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:<br>Significant, sufficient, limited or no assurance<br>And, whether any additional reporting/ oversight is required by a Board Committee(s) | | | | | | | |
| Signature | JAArdley | | | | | | | |

Item 15

Solent NHS Trust

# Board and Committee Cover Sheet

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|---|---|
| Item No. | 15 |

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|---|---|---|---|---|
| Presentation to | In Public Board | | | |
| Title of Paper | Mental Health Act Scrutiny Committee Exception Report | | | |
| Purpose of the Paper | To summarise the business transacted at the Mental Health Act Scrutiny Committee held on 23rd July 2021. | | | |
| Author(s) | Sam Stirling, Corporate Affairs Administrator | Executive/Non-Executive Sponsors | Thoreya Swage, Non-Executive Director (Committee Chair)<br>Dan Baylis, Chief Medical Officer | |
| Date of Paper | July 2021 | Committees/Groups previously presented | -.- | |
| Action Required | For decision? | N | For assurance? | Y |
| Recommendation | The Board is asked:<br>• To note the report from the Committee | | | |

# For presentation to Board and its Committees:

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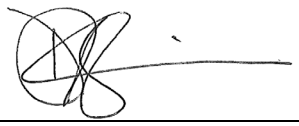
|---|---|---|---|---|---|---|---|---|
| Level of Assurance *(tick one)* | Sigificant | | Sufficient | X | Limited | | None | |
| Assurance Level | Concerning the overall level of assurance the In Public Board is asked to consider whether this paper provides:<br><br>Significant, sufficient, limited or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

## Summary of business transacted:

- The Mental Health Act and Mental Capacity Act Lead took comments on the **Mental Health Act Report**.
    - The Committee were informed of an increase in referrals and ongoing pressures across services.
    - The Committee were briefed on the appropriateness of S2, S3 and S52 cases. It was also confirmed that there were no S4 cases to report.
    - Uses of S62s were explained and monitoring of late SOAD requests was highlighted.
    - Comments from the Committee were taken and relevant assurance provided.
- Standard scrutiny of the **Restraint and Seclusion Assurance Report** took place. The Committee reviewed and considered episodes of seclusion, to ensure cases were appropriate and lawful. High acuity was explained and a brief update in relation to ethnicity data was provided. Questions and comments were taken from the Committee.
- The Mental Health Act and Mental Capacity Act Lead provided an **Associate Hospital Managers (AHM) Update.** Extensive discussions were held regarding approach to AHM ward visits and agreed for further considerations outside of the meeting.
- The **Committee Mid-Year Review** was noted.
- There were no open **Internal Audit Recommendations** to report in relation to Mental Health.
- There were no new risks to report in relation to the **Board Assurance Framework (BAF).**
- The Committee noted Chairs action taken to approve minor amendments to the **Committee Terms of Reference**.

## Decisions made at the meeting:

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

## Recommendations (not previously mentioned):

There are no specific recommendations to note.

## Other risks to highlight (not previously mentioned):

There are no risks to highlight.

Item 17.1

# Board and Committee Cover Sheet

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|---|---|
| Item No. | 17.1 |

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|---|---|---|---|---|
| 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 22nd July 2021. | | | |
| Author(s) | Sam Stirling, Corporate Affairs Administrator | Non-Executive /Executive Sponsor | Thoreya Swage, Non-Executive Director (Committee Chair)<br>Jackie Ardley, Chief Nurse | |
| Date of Paper | July 2021 | Committees/Groups previously presented | -.- | |
| Action Required | For decision? | N | For assurance? | Y |
| Recommendation | The Board is asked:<br>• To note the report from the Committee | | | |

## For presentation to Board and its Committees: - To be completed by Exec Sponsor

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|---|---|---|---|---|---|---|---|---|
| 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:<br>Significant, sufficient, limited or no assurance<br>And, whether any additional reporting/ oversight is required by a Board Committee(s) | | | | | | | |
| Signature |  | | | | | | | |

## Summary of business transacted:

- There were no **Freedom to Speak Up Concerns** to report.
- **Urgent Matters of Safety-** The Committee were briefed on challenges in relation to increased operational pressures, including waiting lists, workforce and changes to national Covid guidance.
- There were no **Partnership governance arrangements** to report.
- The Committee received a **Wheelchair Services Deep Dive**. Key assurance in relation to recent challenges, escalation processes and next steps were provided. Comments from the Committee were taken and relevant assurance provided.

- The Committee **noted** the following annual reports presented *(and agreed to circulate all reports separately to the Board for information)*:
    - **Experience of Care Annual Report**- The Associate Director of Community Engagement attended to present the report and shared significant progress against priorities, despite the pandemic. The Committee agreed the recommendations for the 2021-2022 priorities, as recommended by the July Quality Improvement and Risk Group (QIR).
    - **Infection Prevention and Control (IPC) Annual Report** *(supplementary paper- item 17.2)* - The Head of IPC shared the report and informed of Covid-19 outbreaks and clear learning. Ongoing support to staff was emphasised and the Committee formally commended and thanked the team for their continued efforts.
    - **Safeguarding Annual Report** *(supplementary paper- item 17.3)* - The Head of Safeguarding reported significant implementation of safeguarding activity. A decrease in Level 3 Safeguarding Training compliance due to changes in reporting was noted. Assurance of ongoing support was provided.
    - **Academy of Research and Improvement Annual Report**- The Associate Director of Research and Improvement explained high level of work and positive culture across the Trust. Commitment of services and effective engagement with partners was emphasised.
    - **DSPT Assessment - End of year summary and future DSPT plans**- The Head of Information Governance and Data Protection Officer summarised the Trusts current position in terms of compliance with law, national requirements and mandatory NHS requirements. Comments from the Committee were discussed.

- Highlights from the **Safe Staffing 6-month report** were presented. The Committee noted the report and recommended for Board approval *(included as item 11 of the In Public Board papers).*
- **Exception Report from the QIR Group and Chief Operating Officers**- Key updates were provided from the Southampton and Portsmouth Care Group and exceptions arising from the QIR Group.
- **Ethics and Caldicott Panel Exception Report-** A verbal update on panel activity was noted.
- The Committee reviewed the **BAF consideration and oversight of risks Report** and scoring of risks aligned for Committee oversight.
- An update on activity from the recent **Mental Health Act Scrutiny Committee** was provided.
- The Committee received a verbal update on **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)** and noted update in relation to the **CQC Strategy Update.**
- The Committee noted Chairs action taken to approve minor amendments to the **Committee Terms of Reference.**

## Decisions made at the meeting:

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

## Recommendations (not previously mentioned):

There are no specific recommendations to note.

## Other risks to highlight (not previously mentioned):

There are no risks to highlight.

# Board and Committee Cover Sheet

Item 18

NHS Solent NHS Trust

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|---|---|---|---|---|---|---|
| Item No. | 18 | | | | | |
| Presentation to | In-Public Board meeting | | | | | |
| Title of Paper | Governance and Nominations Committee Exception Report | | | | | |
| Purpose of the Paper | To summarise the business transacted at the last Governance and Nominations Committee held on 4 June 2021 | | | | | |
| Author(s) | Jayne Jenney, Corporate Support Manager and Assistant Company Secretary | | Executive Sponsor | Catherine Mason, Chair | | |
| Date of Paper | 4 June 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 | The Committee:<br>o Received clarification with regards to **Associate Hospital Manager service visits** by way of an action update. It was agreed to consider the purpose of visits further.<br>o Composition changes for key committees was shared following the recent review of executive portfolios.<br>o Received an update on the **CPO recruitment process** that is to be supported by NHSI&E<br>o Received proposed changes to the scope of the **Strategic Partnership Committee** and were approved. The proposed governance structure was also shared. It was noted that Terms of Reference are to be reviewed.<br>o Noted the **NED Tenure report** as presented<br>o Approved the **Committee Annual Report** | | | | | |
| Action Required | For decision? | N | For assurance? | Y | | |
| Summary of Recommendations | The Board is asked to:<br>• Note the exception report | | | | | |

## For presentation to Board and its Committees: - To be completed by Exec Sponsor

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|---|---|---|---|---|---|---|---|---|
| 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:<br>Significant, sufficient, limited or no assurance<br>And, whether any additional reporting/ oversight is required by a Board Committee(s) | | | | | | | |
| Executive Sponsor Signature |  | | | | | | | |