Agenda

Solent NHS Trust In Public Board Meeting

Date: Monday 4th October 2021
Timings: 9:30 – 12:55
Meeting details: Virtual meeting via Zoom

Judgements and decisions made in the context of a Level 3 National Emergency

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Board Requirement
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive**	Chair	To receive
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
			Register of Interests & Declaration of Interests	Chair	To receive
2	09:35	30mins	**Patient Story – Occupational Therapy Service**	Chief Nurse	To receive
3	10:05	30mins	**Staff Story – Infant Feeding (Breastfeeding) Service**	Chief People Officer	To receive
4	10:35	5mins	***Previous minutes, matters arising and action tracker**	Chair	To approve
Quality and safety first					
5	10:40	5mins	**Safety and Quality – contemporary matters including:** • **Board to Floor feedback including 6 monthly Board to Floor update** • **Freedom to Speak Up matters**	Chief Nurse Chief of Staff	Verbal update / To receive
Item to approve					
6	10:45	10mins	**Risk Management Framework** *A 'track-changed' version is available on request*	Chief Nurse	To approve
7	10:55	5min	**Same Sex Accommodation Declaration**	Chief Nurse	To approve

8	11:00	15min	**Organisational Strategy - Final content**	Director of Strategy and Partnerships	To approve
9	11:15	5mins	**A Framework of Quality Assurance for Responsible Officers and Revalidation**	Chief Medical Officer	To approve
Items to receive					
10	11:20	15mins	**Chief Executive's Report**	CEO	To receive
11	11:35	20mins	**Performance Report** *Including:* • *Operations* • *Workforce* • *Quality* • *Financial* • *Research* • *Self-Declaration*	Executive Leads	To receive
-.-	11:55	15mins	- **Refreshment break** -		
12	12:10	10min	**Staff Survey – progress on actions summary presentation**	Chief People Officer	To receive
13	12:20	5mins	**Emergency Planning Resilience Response Annual Report**	COO Southampton	To receive
14	12:25	15mins	**Community Outreach Vaccination presentation** *With Steph Clark and Sarah Malcolm* *Presentation to be provided at the meeting*	COO Southampton	To receive
Reporting Committees and Governance matters					
15	12:40	10mins	**Workforce and OD Committee -** *Exception report from meeting held 23rd September 2021* **Including:** • *WRES Report & action plan (supplementary papers- item 15.2 & 15.3)* • WDES Report & action plan *(supplementary papers- item 15.4 & 15.5)*	Committee chair	To receive
16			**Engagement and Inclusion Committee –** *Exception Report from meeting held 7th September 2021*	Committee chair	To receive

17			**Mental Health Act Scrutiny Committee-** *No meeting held since last. Next meeting- 14th October 2021*	----	----
18			**Audit & Risk Committee –** *Exception report from meeting held 5th August 2021* **Including:** • *Freedom to Speak Up Annual Report (supplementary paper- item 18.2)*	Committee chair	To receive
19			**Quality Assurance Committee-** *Exception report from meeting held 23rd September 2021*	Committee chair	To receive
20			**Governance and Nominations Committee** – *No meeting held since last. Next meeting- 30th November 2021*	----	----
21			**Non-Confidential update from Finance & Infrastructure Committee–** *non confidential verbal update from meeting 27th September 2021*	Committee chair	To receive
22			**Charitable Funds Committee –** *Exception report from meeting held 17th August 2021*	Committee chair	To receive
Any other business					
23	12:50	5mins	**Any other business and reflections** • *lessons learnt and living our values* • *matters for cascade and/or escalation to other board committees*	Chair	-
24	12:55	---	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Chair	-

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

Date of next meeting:

- ***6th December 2021***

Solent NHS Trust

Minutes

Solent NHS Trust In Public Board Meeting

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

Chair:
Catherine Mason, Trust Chair (CM)

Members:
Sue Harriman, Chief Executive Officer (SH)
Andrew Strevens, Chief Finance Officer (AS)
Jackie Ardley, Chief Nurse (JA)
Dan Baylis, Chief Medical Officer (DB)
Suzannah Rosenberg, Chief Operating Officer Portsmouth (SR)
Jas Sohal, Chief People Officer (JS)
Mike Watts, Non-Executive Director (MW)
Thoreya Swage, Non-Executive Director (TS)
Gaurav Kumar, Non-Executive Director (GK)
Calum Mercer, Non-Executive Director (CMe)

Apologies:
Gordon Fowler, Strategic Transformation Director & Director of Estates (GF)
David Noyes, Chief Operating Officer Southampton and County Wide Services (DN)
Stephanie Elsy, Non-Executive Director (SE)

Attendees:
Gordon Muvuti, Director of Strategy & Partnerships (GM)
Rachel Cheal, Chief of Staff & Corporate Affairs (RC)
Sam Stirling, Corporate Affairs Administrator (SS)
Helen Copinger-Symes, Observer (prospective NHS NED)
Mary Anne Stanley, Learning Disability Service User (MAS) *(item 2- Patient Story)*
David Dewar, Learning Disability Service User (DD) *(item 2- Patient Story)*
Ian Chalcroft, Integrated Learning Disability Services Manager (IC) *(item 2- Patient Story)*
Jo Ball, Senior Occupational Therapist (JB) *(item 2- Patient Story)*
Preethy Mary, Staff Nurse (PM) *(item 7- Staff Story)*
Chris Box, Associate Director Estates & Facilities (CB) *(item 8- Green Plan)*
Sadie Bell, Data Protection Officer and Head of Information Governance & Security (SB) *(item 20- IG, GDPR Update and Annual Report)*

Judgements and decisions have been made in the context of a Level 3 National Emergency

1	**Chair's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests**
1.1	CM welcomed all to the meeting, including JS to her first meeting as the substantive Chief People Officer following recent successful appointment. Apologies were received as noted above.
1.2	The meeting was confirmed as quorate. The Board were asked to declare any new interests. There were no further updates to note.
2	**Patient Story – LD**
2.1	*IC, JB, MAS & DD joined the meeting.* MAS and DD explained how they, as service users, assist the Trust. MAS informed of assistance in providing Makaton signing videos to help people understand information about the Covid-19 vaccination as well as assisting with signing for a recent video tour of the Kestrel Centre. DD explained role in assisting with recruitment activities and emphasised the value of service user inclusion for this work.

2.2	IC commented on the value of service user support to ensure considerations of alternative views and appropriate inclusion.
2.3	MAS shared recent experiences at Queen Alexandra Hospital and how care could have been improved. JA confirmed that the Trust were making contact to discuss the experience further and ensure the story was shared appropriately.
2.4	JB commented on challenges in relation to ensuring understanding of issues, such as sensory problems. JB informed of guidance developed with service users regarding areas of importance when delivering care and agreed to circulate to the Board.
2.5	CM thanked MAS and DD for attending and commented on useful insight into how services were received and could be improved. SH agreed and emphasised the value of input and the difference made to the people the Trust cares for. SH thanked MAS and DD for attending and explaining their work and experiences to the Board.
2.6	DB further reiterated the importance of raising awareness of challenges in order to work closely with all organisations providing care and improve overall experiences. The Board formally thanked MAS, DD, JB & IC for their attendance. *MAS, DD, JB & IC left the meeting.*
3	**Reflections and progress made following Patient Stories- 12-month review**
3.1	JA provided an overview of the report and explained the purpose of ensuring impact made following stories presented to the Board.
3.2	MW suggested usefulness of an action plan following outcomes of Patient Stories. CMe commented on complexities of reviewing themes and suggested use of a range of sources. JA agreed and highlighted review of complaints and responses, as well as consideration via the Experience of Care Group.
3.3	SH emphasised vast opportunities to learn and reflect as a Trust. SH suggested usefulness of an overarching view of current areas with patient and service user input and how linked to patient stories and actions/outcomes. The role of the Patient Safety Strategy was discussed. **The Board noted the report.**
4	**Minutes of the meeting held 7th June 2021, matters arising and action tracker**
4.1	The minutes of the last meeting were agreed as an accurate record.
4.2	The following action was agreed as closed: AC003746
Quality and safety first	
5	**Safety and Quality first & feedback from Board to Floor Visits**
5.1	JA provided positive staff feedback following improved Board to Floor process. MW commented on the importance of clear protocol to ensure Covid-19 safety. JA agreed and highlighted effective use of Personal Protective Equipment (PPE) and best practice of lateral flow testing.
6	**Freedom to Speak Up - Any matters to raise to the Board**

6.1	There were no contemporary updates to raise.
7	**Staff Story - International Nurses**
7.1	PM joined the meeting and explained background and qualifications leading to successful appointment to the Trust in March 2021. PM shared welcoming and supportive transition and commented on differences working in this country, particularly in relation to paperwork.
7.2	SR reflected on recent discussions with PM whilst on call and highlighted professionalism and clear ability to lead wards, despite only being in the Trust/country a few short months.
7.3	CM asked if there were any improvements to be made to the process. PM emphasised supportive and effective process in place. **The Board noted the Staff Story**. *CB joined the meeting.*
Items to approve	
8	**Green Plan**
8.1	CB provided an overview of work undertaken since November 2020 to develop the plan, in collaboration with services and key staff across the Trust. CB explained the key areas of focus, including Net Zero considerations. The Board were briefed on challenging target and action plans and CB emphasised the importance of clear monitoring of progress.
8.2	The role of the Board was shared, including requirement for an executive Net Zero lead and relevant executive sponsors. CB informed of obligation to review progress with the Board and submit to the Integrated Care System (ICS) in January 2022, to establish a consolidated plan by April 2022.
8.3	CB commented on alignment to Trust values and commended the level of engagement across the Trust.
8.4	RC queried the requirement for a Non-Executive Director Sustainability & Net Zero Lead, and it was confirmed that GF had been recommended as the accountable lead from an entire Board perspective. SH suggested further considerations required to embed across all Committees and Sub-Committees. RC agreed to work with CB outside of the meeting to draft key prompts/logos for meeting agendas to ensure consideration at all levels. RC also commented on the importance of links to use of technology and inclusion of the patient voice. **Action- RC to review.**
8.5	CMe queried further emphasis on the importance of prevention/early intervention of the management of medicines and associated impact on sustainability. The Board agreed and discussed alignment to other priorities.
8.6	MW asked about further work to integrate across all levels of the Trust. CB commented on progress with the Communication Engagement Plan and assured of dedicated Comms support in developing a detailed framework (to be available by the end of August). The Board were informed of intention to oversee the plan at the Sustainability Working Group, to support and underpin key actions and leads. Considerations regarding information sharing, guidance and ensuring awareness was emphasised.

8.7	GK commented on links to the Solent Strategy. SH agreed and shared the importance of ensuring inclusion within an overarching strategy.
8.8	**It was agreed to schedule 6 monthly progress updates and an annual report (via Finance & Infrastructure Committee) going forward.** **The Board approved the Green Plan**. *CB left the meeting.*
Items to receive	
9	**Chief Executive's Report**
9.1	<u>NHS Premises Assurance Model</u> SH explained the model and its purpose. The Board were informed of adjusted governance due to the extraordinary year and reported improvements to recent assessment, with a range of 'good' and 'outstanding' areas. SH confirmed that this was being raised for information and agreed to provide the full report to Board when available.
9.2	<u>Covid Update</u> Pressures across all service areas were shared and SH commented on the impact on the vaccination in terms of mortality rates. Ongoing adherence to national guidance was emphasised and constraints regarding service access highlighted. Challenging operational environment was emphasised and SH commented on collaborative decision making relating to operation pressures and managing demand, with focus on early intervention/prevention.
9.3	<u>Appointments/Board Portfolios</u> SH formally welcomed JS as the substantive Chief People Officer, following recent successful appointment. SH informed of NHSE/I requirements for a Board-Level net zero lead to ensure accountability of the *Delivering a net zero National Health Service strategy*. It was proposed that GF undertake the designated exec lead role as part of the environmental and sustainability agenda. **The Board formally agreed the recommendation.** It was also proposed that GF assume the role of designated exec lead for violence prevention and reduction, as part of the security agenda within the Transformation and Estates portfolio. **The Board formally agreed the recommendation.**
9.4	The Board were briefed on rapid developments in relation to the Organisational Strategy and proposed timelines/phases.
9.5	SH referenced signing of the Armed Forces Covenant and continued commitment to the Armed Forces Community.
9.6	An update regarding the ICS Design Framework was provided and SH informed of formal Hampshire and Isle of Wight Chairperson appointment. It was confirmed that news of the CEO appointment would be circulated in due course.
9.7	SH commented on recent comprehensive and well led CQC inspections undertaken at the Isle of Wight and early indication of significant improvements (full report awaited).

9.8	MW asked about potential challenges regarding behaviour towards staff. JA confirmed triangulation of incidents and ongoing discussions to support staff. DB commented on staff fatigue and extreme pressures being experienced. SH emphasised the importance of Board level consideration of staff wellbeing and using qualitative data from the recent Pulse Surveys to inform actions. **The Board approved the recommendations and noted the report.**
10	**Performance Report**
10.1	<u>Operational- Southampton</u> • Regarding the Covid Dashboard, SH commented on the need to consider meaningful key metrics going forward and considerations of a new process was confirmed. • Extensive discussions were held regarding waiting lists and mitigations in place. Potential system activity effecting waiting lists was highlighted and the Board were assured of monitoring. • SH reported that the Electoral Recovery Fund had increased to a 95% target baseline and shared challenges. THE Board were assured that there was no financial impact expected. • SH reported challenges in relation to increased call demand within the Single Point of Access (SPA) service. Current hybrid working was explained and SH informed of new telephony system being introduced to allow a more resilient model of service delivery. **It was agreed to provide a post-meeting note to assure the Board of solution timelines. Action- DN/AS.** • TS asked about potential data regarding the number of SPA service abandoned calls. SH commented on challenges due to remote working. • MW queried appropriate review of waiting list data to understand system and demand and emphasised the importance of consideration of Board monitoring/reporting. Discussions regarding monitoring were held and usefulness of a separate agenda item was suggested. • RC commented on the fragility of sub-scale services and queried the most appropriate governance route to ensure effective monitoring/oversight. **It was agreed to consider further outside of the meeting. Action- DN/SR.**
10.2	<u>Operational- Portsmouth</u> • The Board were briefed on extensive work in relation to waiting lists, including discussions with the CCG, review of data and harm/impact. • The importance of providing improvement trajectories was emphasised, in order to help the Board to understand that the Trust can tolerate risks associated with waiting lists.
10.3	<u>Workforce</u> • JS briefed the Board on monitoring of vacancy rates and potential issues. • It was noted that the Trust had achieved Statutory and Mandatory training compliance, as a result of the Learning Management System. • JS commented on exercise taking place to ensure effective recording of appraisals. • A change in Employee Relations was shared and JS briefed on the new people partnering model. • Close monitoring of Covid related absences was highlighted. It was confirmed that Annual Leave was currently the highest level of absence.

10.4	Quality • JA informed the Board that AA had been shortlisted for the national Nurse of the Year award. • Close monitoring of Infection Prevention and Control across inpatient wards was confirmed and JA commented on review of risk assessments and pressures. The Board were briefed on risk-based approach being undertaken. • CM asked about pressure ulcer benchmarking due to increase reported. JA informed of deep dive undertaken to review trends and assured of close monitoring via QIR.
10.5	Finance AS reported that the Trust was on track to deliver financial plans for the 2nd half of the year. It was confirmed that a full update would be shared at Confidential Board.
10.6	The Board noted the Self-Declaration and Research Updates.
10.7	**The Performance Report was noted.**
11	**Safe Staffing- 6 monthly Report**
11.1	JA presented the report and current position within the inpatient wards/units directly provided by the Trust. JA informed of considerations of the role of the ICS and focus on international recruitment. Positive work with service lines and review of Safe Staffing Meetings going forward was shared.
11.2	**The Board noted the Safe Staffing 6 Monthly Report and supported the priorities outlined.**
Reporting Committees and Governance matters – Exception Reports	
12	**Workforce and OD Committee-** *Exception report from meeting held 15th July 2021*
12.1	• MW informed of discussions held in relation to BAF scoring and risk mitigations in place. • Review of the Diversity and Inclusion Annual Report was confirmed, and improvements requested prior to formal Board approval. • MW shared key highlights and usefulness of the Internal Labour Market Map Analysis 2020-2021 Report. • Discussions and agreements taken regarding the Single Oversight Framework were reported.
12.2	Employee Relations Assurance Report CM queried potential incremental interventions required, following reports of 5 red cases for FM and Estates. Significant work was emphasised, including use of an independent investigator in one case. It was confirmed that a leadership deep dive was underway and proactive monitoring via the Committee was assured. **The Workforce and OD Committee Exception Report was noted.**
13	**Engagement and Inclusion Committee-** *Exception Report from meeting held 8th June 2021*
13.1	**The Board noted the Engagement and Inclusion Committee Exception Report.**
14	**Mental Health Act Scrutiny Committee-** *Exception report from meeting held 22nd July 2021*

14.1	• TS reported increase in referrals, particularly within CAMHS. • Further discussions required regarding Associate Hospital Manager (AHM) visits were highlighted. DB informed of action taken to review the role of AHMs and confirmed that this would be shared when complete. • CM commented on the improvement in regularity of training and suggested valuable opportunities for the Board. **The Board noted the Mental Health Act Scrutiny Committee Exception Report.**
15	**Audit & Risk Committee**
15.1	*No meeting held since last meeting. Next meeting- 5th August 2021*
16	**Quality Assurance Committee-** *Exception report from meeting held 22nd July 2021*
16.1	• The Board were briefed on the Wheelchair Services Deep Dive and subsequent assurance provided. • TS commended the annual reports presented to the Committee and confirmed that these had been circulated to the Board for information. **The Quality Assurance Committee Exception Report was noted.**
17	**Governance and Nominations Committee**– *Exception report from meeting held 4th June 2021*
17.1	**The Board noted the Governance and Nominations Committee Exception Report.**
18	**Non-Confidential update from Finance & Infrastructure Committee-** *verbal update from meeting 27th July 2021*
18.1	It was confirmed that there were no updates to provide In Public.
19	**Charitable Funds Committee**
19.1	*No meeting held since last meeting. Next meeting- 5th August 2021*
Items to receive	
20	**Information Governance (IG), GDPR Update and Annual Report**
20.1	The Board were informed of areas of non-compliance and SB provided an overview of action plans and mitigations in place. SB emphasised large amount of work in relation to IG training and confirmed 75% compliance.
20.2	It was noted that compliance remains high for Subject Access Requests (SAR) and Freedom of Information Requests (FOI). SB briefed the Board on proactive FOI work being undertaken to consider trends, such as agency spend.
20.3	Consistency of incident management was reported and ongoing engagement with services to understand potential challenges and actions required was confirmed.
20.4	SB explained review of potential gaps in relation to information management and security assurance, which would be reported via the Digital Information Group.

20.5	CM expressed concern in relation to the high score risks detailed within appendix A. SB explained mitigations in place and factors effecting impact and likelihood scores. AS emphasised the importance of continuing need to balance risks.
20.6	In relation to cyber security, GK asked if the Trust received regular reports from CGI regarding security standards and queried any issues/actions highlighted. SB informed of local patching reports received and monitoring via the IG Security Group. SB provided further assurance regarding terms of future contract provision and agreed to provide information regarding timeframes via the appropriate governance route. AS suggested usefulness of input from GK in this area and agreed to discuss outside of the meeting
20.7	**The Board noted the Information Governance (IG), GDPR Update and Annual Report.** *SB left the meeting.*
Any other business	
21	**Reflections**
21.1	CM reflected on potential future meetings to be held in person. There were no further items of reflection to note.
22	**Any other business & future agenda items**
22.1	Thanked HCS for attending to observe the meeting. No other business was discussed and the meeting was closed.
23	**Close**

Action Tracker

Overall Status	Source Of Action	Minute Ref	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
On Target	Board meeting - In Public	7	AC003946	BOD1- Green Plan	RC agreed to work with CB outside of the meeting to draft key prompts/logos for meeting agendas to ensure consideration at all levels. RC also commented on the importance of links to use of technology and inclusion of the patient voice. **Action- RC to review.**	Rachel Cheal	**September 2021-** Complete: Logos co-developed for implementation from early September' **2nd Aug 2021**- In progress – RC made contact with Estates Team (re: Green agenda prompts) and Community Engagement team (re: patient voice prompts) regarding logo and key question prompts.
On Target	Board meeting - In Public	9	AC003947	BOD1- Performance Report	SH reported challenges in relation to increased call demand within the Single Point of Access (SPA) service. Current hybrid working was explained and SH informed of new telephony system being introduced to allow a more resilient model of service delivery. **It was agreed that SH provide a post-meeting note to assure the Board of solution timelines. Action- DN/AS.**	David Noyes, Andrew Strevens	**Post meeting note (August 2021)-** The SPA service are reviewing a package, which is believed is suitable for their requirements. Once they have confirmed this, it should take circa 6 weeks to implement.
On Target	Board meeting - In Public	9	AC003948	BOD 1- Performance Report (subscale services)	RC commented on the fragility of sub-scale services and queried the most appropriate governance route to ensure effective monitoring/oversight. **It was agreed to consider further outside of the meeting. Action- DN/SR.**	David Noyes, Suzannah Rosenberg	**September 2021**- Debbie James has completed a desk top review [audit with conclusions] which is being discussed with Operations Directors. The output from this will be brought to Executive Directors' Meeting [and CEG] end of September for discussion and agreement on next steps.

Board and Committees

Item No.	6.1	Presentation to	Trust In Public Board		
Title of paper	Risk Management Framework Review				
Purpose of the paper	To approve changes to Risk Management Framework				
Committees/Groups previous presented and outputs	Quality Improvement and Risk Group (QIR) Quality Assurance Committee				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Action required	For decision	X	For assurance		
Summary of Recommendations and actions required by the author	The Board is asked to: • Approve changes to the Risk Management Framework				
To be completed by Exec Sponsor - Level of assurance this report provides :					
Significant		Sufficient	X	Limited	None
Exec Sponsor name:	Jackie Munro, Chief Nurse	Exec Sponsor signature:	JAMunro		

Key messages /findings

The Trust Risk Management Framework has been subject to its 3-yearly review.

Changes were approved in principle at Executive Officers Group meeting on 4th August 2021.

Key changes:

Previously – there has been some inconsistency in the review of Corporate Services risks.

Proposed – risks will need to be reviewed at the appropriate Group meetings as per the diagram in Appendix 1 of the Framework.

Previously – the Trust whole risk picture was presented to Trust Management Team, and then Clinical Executive Group (CEG).

Proposed – in line with the redesign of QIR, QIR will now be the Group which reviews the whole Trust risk picture, with CEG receiving risks assigned to the Clinical risk groups only.

In addition, there is new risk scoring guidance in Appendix 2 of the Framework.

Next steps – sign off by October Board

Item 6.2

Solent NHS Trust

Risk Management Framework

Version 0.7.3
17th August 2021

CONTENTS

1. Introduction

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

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

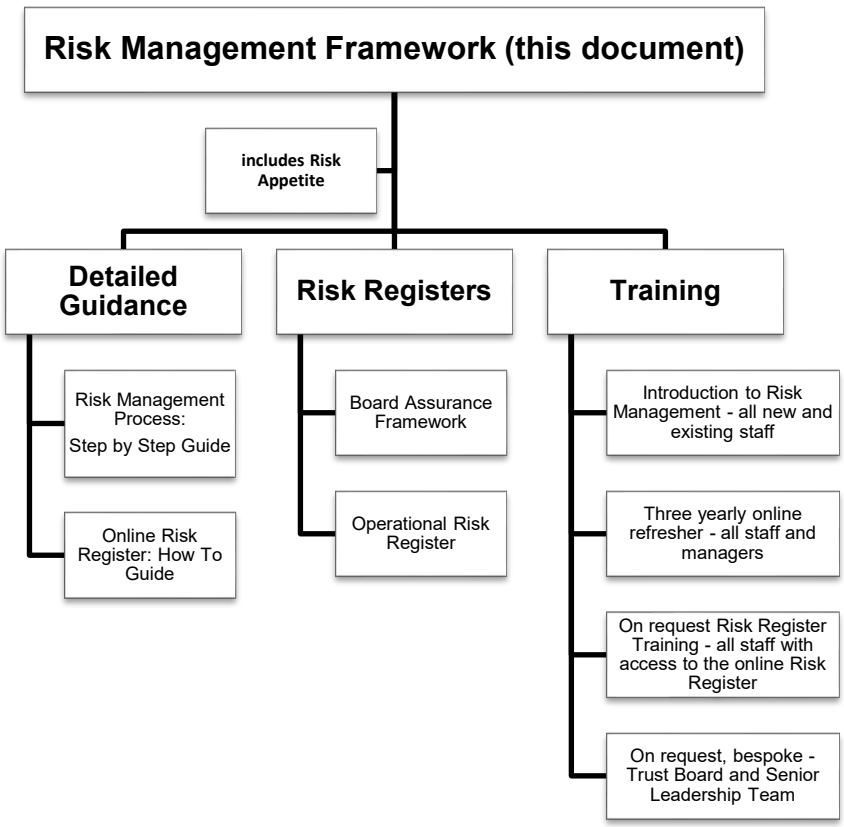
The delivery of healthcare will always involve a degree of risk however a positive risk management culture empowers staff to make sound judgement and decisions concerning the management of risk and risk taking.

2. Aim and Purpose

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

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

Framework components:



3. Scope

This Framework is Trust wide and applies to all permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

4. Risk Management Terms & Definitions

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

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

5. Risk Appetite and Tolerance

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

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

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

It is reasonable to tolerate a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including nothing, is even greater. Priority should be given to mitigating patient and staff safety risks.

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

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

Risks will have controls and mitigations in place.

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

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

Once risks have been successfully controlled and/ or mitigated they should be changed from Open to Accepted or Closed.

6. Roles and Responsibilities

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

6.1 Trust Board

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

6.2 Board Committees

Within the scope of their terms of reference, the Committees of the Trust Board are responsible for assuring the application of the Board's risk appetite and tolerance, and assuring risks to the successful delivery of the strategic objectives are managed as appropriate. This will be facilitated via the Board Assurance Framework. See Appendix 1 for details of the governance structure..

- The Quality, Improvement and Risk Group (QIR) seeks assurance that plans are being executed to mitigate risks to the target/ tolerable level. Specifically, QIR will:
    - Review individual risks on the Risk Register scoring 15 or higher to ensure scores and mitigation plans are appropriate and being delivered
    - Determine if risks should be controlled or tolerated
    - Escalate risks that score 15 or higher to the appropriate Board Committee if it is decided to request permission to tolerate
    - Ensure the sharing and triangulation of corporate service and clinical service risks.
    - Escalate risks appropriately to the Trust Board via the Quality Assurance Committee.
    - Request other Trust Groups to address risks as appropriate.

- The *Audit & Corporate Risk Committee*[1] will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives including effective use of the Board Assurance Framework.

[1] Audit & Corporate Risk Committee Terms of Reference – May 2017

6.3 Operational Management Groups

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

- Quality Improvement and Risk Group
- Clinical Executive Group
- People Group
- Digital Information Group
- IOW Partnership Group
- Estates, Facilities and Sustainability Group
- Health and Safety Group
- Performance Review Meetings (PRMs)

Their Terms of Reference will include:

- Reviewing operational risks, with a focus on those scoring >=12, and identifying top three risks at PRMs
- Receiving assurance from risk owners that risks are being appropriately managed and mitigated
- Escalating risks as appropriate to the appropriate Committee
- Escalating requests to tolerate risks scoring 15 or above to the relevant Committee

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

6.4 Service Line Meetings

Service Line committee meetings will review risks on that Service Line's Risk Register; they will receive assurance that action plans are in place and risks are being appropriately managed and mitigated and will identify for raising at QIR, those risks which required additional oversight, monitoring and/or support.

6.5 Executive Directors

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

The Chief Operating Officers are responsible for ensuring Service Line Risk Registers are reviewed in Performance Review meetings and for escalating risks through the governance structures as appropriate.

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

6.6 Non-Executive Directors

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

6.7 Chief Executive

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

6.8 Chief Nurse

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

6.9 The Quality & Governance Team

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

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

6.10 Deputy CEO

The Deputy CEO is the designated Executive Director responsible for internal financial control and sound financial governance.

6.11 Chief of Staff and Corporate Affairs

The Chief of Staff and Corporate Affairs is responsible for ensuring the Board Assurance Framework (BAF) is developed, reviewed and reported to the Trust Board, with oversight by the relevant Committees and its effectiveness reviewed by the Audit & Corporate Risk Committee. The Chief of Staff and the Quality & Governance Team will ensure the BAF is aligned to the Risk Register and the most significant operational risks from the Risk Register are reported to the Board and its Committees.

6.12 Service Line Leadership and Corporate Directorates

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

6.13 Managers

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

- The identification of risks and for implementing and monitoring any identified risk management control or assurance measures within their designated area and scope of responsibility

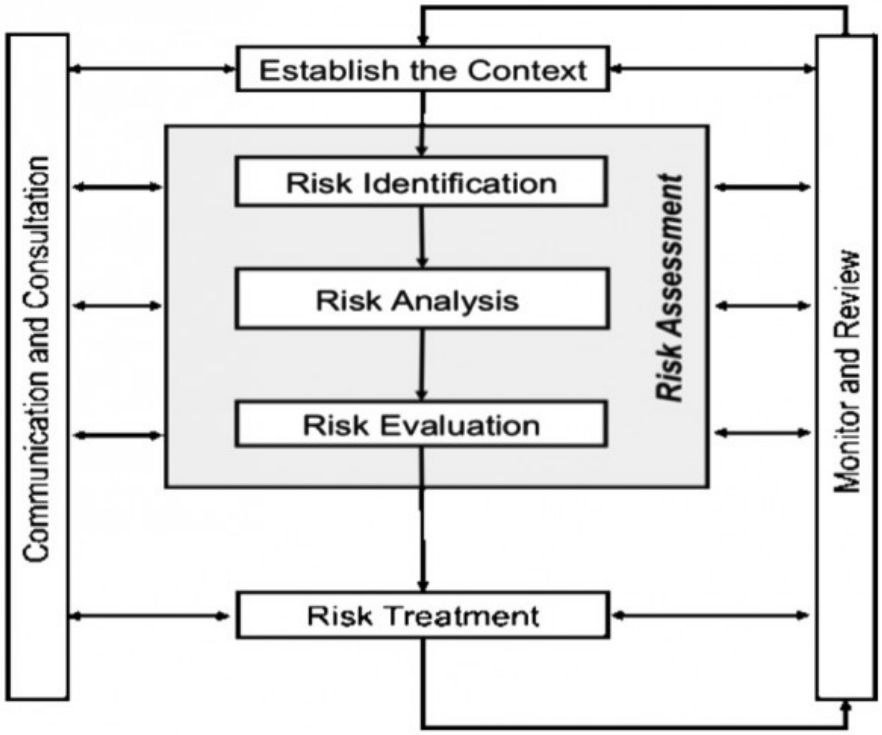
- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility and that all staff are aware of the significant and potential risks within their work environment and of their personal responsibilities
- Addressing risks as they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

6.14 All Staff

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

7. Risk Management Process

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



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

The key roles involved in the risk management process are:

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

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

7.1 Establish the Context

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

7.2. Communicate & Consult

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

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

7.3 Identify Risks

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

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

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

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

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

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

7.4 Assess & Analyse Risks

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

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

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

Likelihood x Consequence = Total Risk Score

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

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

The Trust uses a bespoke, internally developed scoring matrix based on the guidance published by the National Patient Safety Agency (January 2008).

See Appendix 2 for the current scoring guidance.

Risk Approval

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

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

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

7.5 Risk Register

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

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

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

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

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

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

7.6 Manage & Act

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

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

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

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

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

7.7 Monitor & Review

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

All risks should be reviewed as appropriate.

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

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

Service Lines and Corporate Directorates will be responsible for providing assurance to the appropriate governance Group reviews have been completed and onward assurance is provided to the appropriate Committee.

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

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

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

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

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

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

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

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

8. Risk Analysis and Surveillance

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

Analysis and surveillance should support the identification and communication of:

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

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

9. Risk Management Reporting & Risk Profiling

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

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

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

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

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

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

	•	
	•	•
	•	•
	•	•
	•	
		•

*Annual Governance Statement

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

10. Training

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

- Staff will complete the e-learning *"Introduction to Risk Management"* training within one month of commencing employment with the Trust
- Existing staff will undertake the *"Introduction to Risk Management*" e-learning when this Framework is launched and every three years thereafter
- The Trust target for permanent staff completion of the triannual e-learning is 90%.
- Managers responsible for assessing and managing risks can complete face-to-face Risk Register training on request
- Additional bespoke training will be provided to Board members (e.g. Non-Executive Directors on appointment) and the Senior Leadership Team as required through Leadership and Board Development Programmes

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

11. Resources

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

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

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

12. Communication and implementation

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

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

13. Monitoring implementation

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

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

14. Review

This Framework will be reviewed every 3 years.

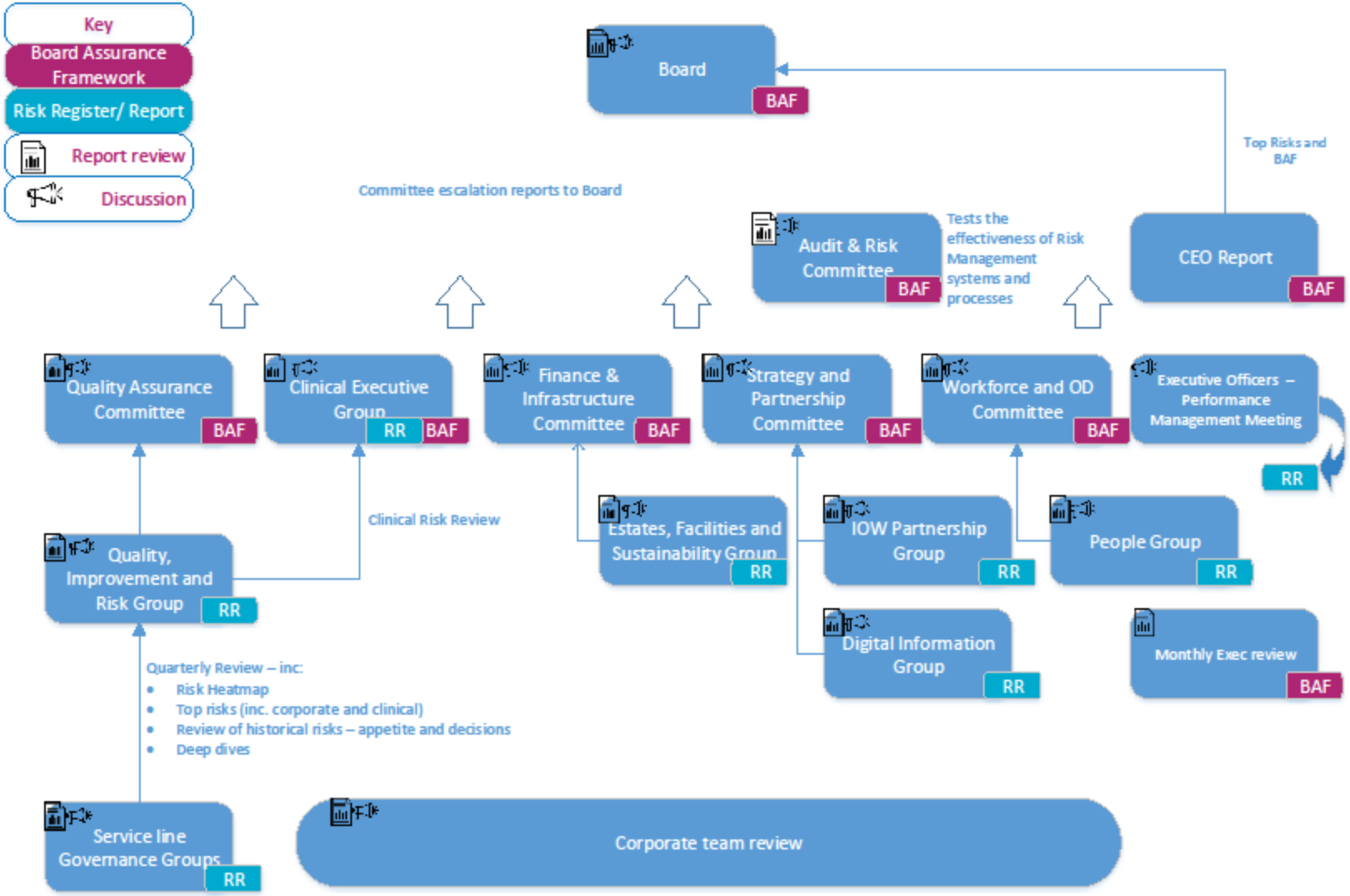
Version Control

Date	Version	Detail	Author/Contributors
27-11-2017	DRAFT v1	New Risk Management Framework to replace Risk Management Strategy & Policy (RK02) June 2015	Julie Jones, Project Manager
06-12-2017	DRAFT v2	Comments incorporated from Rachel Cheal, Company Secretary	Julie Jones, Project Manager
08-01-2018	DRAFT v3	Updated following development of draft Risk Management Process	Julie Jones, Project Manager
15-01-2018	DRAFT v4	Addition of Risk Appetite Statement & Governance Structure	Julie Jones, Project Manager
25-01-2018	FINAL v5	Revisions following feedback from members of the Trust Management Team, Quality Improvement & Risk Group, Quality & Governance Team, Chair of Audit & Corporate Risk Committee and Chair of Assurance Committee	Julie Jones, Project Manager
05-03-2018	FINAL V5.1	Amendments following feedback from Risk Process Workshop held on 28 January 2018	Julie Jones, Project Manager
17-05-2018	FINAL v5.2	Governance Structure chart updated to include People & OD Committee	Julie Jones, Project Manager
19-06-2018	FINAL v5.4	Training requirements updated in agreement with Ceri Connor, Associate Director of People	Julie Jones, Project Manager
07-01-2020	FINAL V5.5	Updated risk appetite, roles and responsibilities and training. Updated governance diagram.	Ben Heaton, Head of Risk & Litigation
29/09/2020	FINAL v6.1	Updated risk appetite in light of Covid. Roles and responsibilities updated to reflect new EOG. Updated governance diagram.	Ben Heaton, Head of Risk & Litigation
17/08/2021	V0.7	Full review of Risk Management Framework. Changes to governance structures and responsibilities of Groups.	Ben Heaton, Head of Risk & Litigation

Approvals

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

Appendix 1: Trust Risk Management Governance Structure



Appendix 2: Trust Risk Scoring Guidance

Risks, Issues and Incidents

Risks are those uncertain events that may have an impact on the successful delivery of your objectives. It is a simple calculation of the likelihood of the event occurring, multiplied by the consequence if it were to occur.

Issues are current situations that are suboptimal, and which in turn can lead to one or more related risks. Issues are already happening; risks have not happened but could.

Incidents have happened in the past.

The house could catch fire (risk), the house is on fire (issue), the house burnt down yesterday (incident).

Top Tip – always identify your objective first, then think about the events that *could* happen to stop you achieving it.

Issues Causing Risks, Issues Affecting Risks

As already stated, issues can give rise to one or more risks, or may influence the likelihood or consequence scores of a risk.

An example of an issue could be a broken lift. This gives rise to a number of risks such as health and safety for moving of heavy goods up the stairs, or access risks for staff, visitors or patients with mobility issues.

An example of an issue affecting the likelihood of a risk could be a risk associated with staffing – if there are inadequate numbers of competent staff on ward duty to fulfil the safe staffing requirement, then there may be a business disruption resulting in avoidable harm to patients.

If there is a shortage of substantive staff for a shift. this is mitigated with agency staff. However, this increase in the use of agency staff (issue) rather than substantive staff may increase the likelihood score of the risk, or even give rise to an entirely new financial risk.

Likelihood

Table 1 provides definitions of descriptors that can be used to score the likelihood of a risk being realised by assessing frequency.

Table 1 Likelihood scores (broad descriptors of frequency)

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

It is possible to use more quantitative descriptions for frequency by considering how often the adverse consequence being assessed will be realised. For example, when assessing the risk of a fatal medication incident on a ward, the likelihood of a medication incident could be assessed as expected to occur weekly or even daily. However, in reality, a *fatal* medication incident should not be expected to occur for years, and it should be graded as rare. A simple set of time-framed definitions for frequency is shown below in table 2.

Table 2 Likelihood scores (time-framed descriptors of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely/ UNUSUAL**	**Possible/ ANTICIPATED**	**Likely**	**Almost certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Specific 'probability' scores have been developed for projects and business objectives which match the Trust CPMO methodology (see table 3, below).

Table 3 Likelihood scores (probability descriptors)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely/ UNUSUAL**	**Possible/ ANTICIPATED**	**Likely**	**Almost certain**
Probability Will it happen or not?	Less than 20% chance of happening	20%-39% chance of happening	40%- 59% chance of happening	60%- 79% chance. Difficult to prevent, or outside of direct influence.	80% + chance of happening, Strong evidence to back this up

Avoiding Catastrophisation

As already discussed for Table 2 above, a certain amount of care is required when applying a likelihood score to an incident. A simple example is that of patient falls whilst mobilising. Following a serious fall, the severity of the incident could well be scored as 4. It may be that a particular trust may experience patient falls (whilst the patient is mobilising) on a weekly basis (using table 2 above, this gives a likelihood score of 4).

So there is a danger that the incident might be given an overall score of 16 (4 × 4) which could make the incident risk a 'red' incident (see the model risk matrix). This would not accurately reflect the overall seriousness of the incident or the magnitude of the underlying risk.

A more detailed analysis might show that although falls do occur weekly, more serious injuries (consequence score 4) only occur once or twice a year. In the main most of the other falls have relatively minor outcomes (consequence score 2).

The score of 16 is a conflation of the highest likelihood of any fall occurring, matched with the worst case, but most unlikely consequence.

The risk should be scored either according to the severity of the actual outcome that is, C = 4 but L = 1 because major consequence outcomes are unlikely, or according to the most likely or typical outcome for that type of incident (C = 2, L = 4 because it is minor incidents occurring weekly).

This means there might need to be two risks on the register, or if just one is to be added, it should be the highest scoring one.

Model matrix

Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Health & Safety Impact on the safety of patients, staff or public (physical/ psychological harm)	• Minimal injury requiring no/ minimal intervention or treatment. • No time off work • No injury incidents	• Minor injury or illness, requiring intervention. • Fall that results in only bruising, and/ or swelling. • Requiring time off work for <3 days • Increase in length of hospital stay by 1–3 days. • Injuries that will heal within a month. • Category 2/3/4, unstageable and suspected deep tissue injury • Expected Deaths • Recoverable missed medication dose • Wrong medication that does not require treatment or intervention	• Moderate injury requiring professional intervention. • Operable fractured neck of femur. • Requiring time off work for 4–14 days • Increase in length of hospital stay by 4–15 days. • RIDDOR/ agency reportable incident • Category 3/4 Pressure Injuries in Solent care. • An event which impacts on a small number of patients and/ or staff • Recoverable wrong medication that requires treatment or intervention	• Major injury leading to long- term but recoverable incapacity/ disability. • Fractured neck of femur reducing life expectancy. • Never events • Requiring time off work for • >14 days • Increase in length of hospital stay by >15 days. • Mismanagement of patient care with long-term effects e.g., missed diagnosis of fracture. • An event which impacts on a large number of patients and/ or staff	• Trust caused harm directly causing death of one or more people. • Trust caused permanent life changing injuries or health effects e.g., brain injury, spinal injury, paralysis, asbestosis etc. • Gross failure of patient safety • Prosecution of the Trust e.g., by the HSE • Charges of Gross Negligence Manslaughter and/ or Corporate Manslaughter

Information Governance	• There is absolute certainty that no adverse effect can arise from the breach	• Potentially some minor adverse effect or any incident involving vulnerable groups even if no adverse effect occurred. • A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be the cancellation of a procedure but does not involve any additional suffering. It may also include possible inconvenience to those who need the data to do their job.	• Potentially some adverse effect • An adverse effect may be release of confidential information into the public domain leading to embarrassment or it prevents someone from doing their job such as a cancelled procedure that has the potential of prolonging suffering but does not lead to a decline in health.	• Potentially Pain and suffering/ financial loss • There has been reported suffering and decline in health arising from the breach or there has been some financial detriment occurred. Loss of bank details leading to loss of funds. There is a loss of employment.	• Breach directly causes a death/ catastrophic event.
Quality Includes demand outstripping supply with planned level staffing.	• Peripheral element of treatment or service sub- optimal • Critical structured judgement tool.	• Overall treatment or service suboptimal • Single failure to meet internal policies and SOPs. • Increasing waiting times, but still within guidelines • Minor level harm (see Safety domain) • Critical HIRI Report	• Treatment or service has significantly reduced effectiveness • Repeated failure to meet internal policies and SOPs. • Increasing waiting times • Non-compliance with nationally recognised guidance, recommendations, best practice, and KPIs • Waiters managed using a risk-based approach to clinical need, triage and ongoing review. • Moderate level harm (see Safety domain) • Critical SI Report	• Non-compliance with national standards with significant risk to patients if unresolved • Institutional culture of multiple and long-term failures to meet internal policies and SOPs. • Increasing waiting times • Breakdown in the ability to manage waiters using a risk-based approach. • Major level harm (see Safety domain) • Critical SI Theme Report indicating ineffective learning. • Coroner PFD report	• Demonstrable Trust wide culture of inability to learn. • Totally unacceptable level or quality of treatment/ service • Gross failure of patient safety as investigation findings were not enacted. • Out of control, gross failure to meet national standards. • Board resignations and removal of senior leadership of the Trust • Regulators suspend license to operate

	1	2	3	4	5
Complaints	• Informal complaint/ inquiry	• Service Concern, or complaint regarding manner & attitude of staff, short appointment delays, parking issues etc • Repeat unfounded concerns raised by patients and/ or their families with service. • Patient can't get through to service / book appointments. • Late or cancelled appointment • Manner & Attitude of member of staff – clinical or admin • Breakdown in communication / not setting expectations for patient or person who has complained. • Not being called back or contacted by service when requested or expected. • Local resolution	• Service concern or complaint regarding clinical treatment, e.g., delays to wound dressing, preventable distress or pain, failure to deliver service resulting in significant harm. • Lost property resulting in payment being made to person who has complained / patient or being reported to the Police. • Disagreement over diagnosis/referrals needs – possible escalation to Legal Team or patient contacting Solicitor. • Something went wrong with clinical treatment i.e., diagnosis problems, treatment unsuitable/ unreceived (i.e.. dressing not changed resulting in wound deterioration) • Ongoing missed appointments/clinical issues not treated or addressed leading to pain/further problems with patient. • Medication issues • Injury or death, as a result of problems with clinical treatment or lack of (loss of limb) • Harassment or unsuitable comms to or from staff • Complex cases involving multi-agency – CQC, local Trusts, PHSO cases • Harm/change has come to a patient due to lack of following procedures. • Local resolution (with potential to go to independent review) • Ombudsman inquiry • Unsubstantiated complaint to professional governing body e.g., GMC	• Multiple Service concerns or complaints regarding clinical treatment in the same service, e.g., delays to wound dressing, preventable distress or pain, failure to deliver service resulting in significant harm. • Critical ombudsman findings • Threats of violence to staff • Upheld GMC complaint	• Failure of complaints process, in conjunction with other domains e.g., quality or health & safety resulting in catastrophic impact as outlined in the other domains.

Human resources/ organisational development/ staffing/ competence Below planned level full time staffing.	• Easily manageable using business as usual solutions. • Unusual and short-term below planned full time staffing level that temporarily reduces service quality (an hour here and there) • Negligible level of harm (see Safety domain)	• Manageable using business as usual solutions. • Intermittent and low below planned full time staffing level that reduces service quality. • Using agency and bank to maintain safe staffing. • Increasing waiting lists • Minor level harm (see Safety domain)	• Becoming unmanageable using business as usual solutions • Regular below planned full time staffing level that reduces the service quality. • Late service due to lack of planned full-time staff • Significant increase in waiting times. • Moderate level harm (see Safety domain) • Low staff morale • High sickness rates • Staff openly discussing a desire to leave. • Poor staff attendance for mandatory/ key training	• Unmanageable using business as usual solutions. • Failure to deliver parts of service due to lack of staff/ competencies. • Unsafe staffing level or competence • Major level harm (see Safety domain) • Loss of staff • Very low staff morale • Remaining staff actively seeking to leave. • No attendance for mandatory/ key training	• Service closure due to lack of planned full-time staff and/ or competencies
Statutory duty/ inspections/ audit	• No or minimal impact or breech of guidance/ statutory duty	• Breech of statutory legislation • Threat of reduced performance rating if unresolved	• Single breech in statutory duty • Challenging external recommendations/ improvement notice • Low performance rating - Failure to meet performance metrics e.g., model hospital (not just CQC)	• Enforcement action • Multiple breeches in statutory duty • Critical regulator report submitted to Board. • Reduced CQC inspection rating to requires improvement or inadequate. • Trust subject to special measures	• Prosecution • Complete systems change required. • Zero performance rating • Severely critical report • Regulators suspend licence to operate

	1	2	3	4	5
Adverse publicity/ reputation	• Rumours • Potential for public concern	• Local media coverage e.g., article in Daily Echo or Portsmouth News • Local social media • Short-term reduction in public confidence • Statement requested from Trust from local media. • Elements of public expectation not being met	• Critical local media coverage e.g., article in Daily Echo or Portsmouth News • Critical local social media • Long-term reduction in public confidence • Statement requested from CEO or CMO from local media. • Local press/ families attending public Board meeting requesting answers to questions.	• National media coverage with <3 days service well below reasonable public expectation. • Multiple statement requests from CEO or CMO from national media • Critical national social media • Regulator involvement • National press/ families attending public Board meeting demanding answers to questions. • Local demonstrations outside Trust properties	• National media coverage with >3 days service • Well below reasonable public expectation. • Minister/ MP concerned (questions in the House) • Viral on social media • Total loss of public confidence • Multiple statement requests from CEO or CMO from national media • Highly critical national social media • Demands for regulator investigation. • Large, nationally attended demonstrations outside Trust properties
Business objectives/ projects	• will have little effect on Programme / Project milestones, timescales, or achievement of overall goals or benefits. • No additional cost	• It may delay delivery or quality of one or more deliverables but not delay the overall Project or affect achievement of overall goals or benefits. • No additional cost	• A Project milestone is delayed which could extend timescales, but it is unlikely to materially affect successful delivery of the programme / project objectives and benefits. • Additional costs by up to 5%	• It will delay the achievement of a number of Programme / project milestones or a major milestone which could significantly extend timescales or costs. Successful delivery of the Programme / Project benefits could also be materially impacted. • Additional costs from 5+% to 10%	• Programme/ Project objectives no longer achievable or major reduction of benefits due to significant time, cost or quality issues. • Additional costs over 10%
Finance including claims Claims are insured.	• Small loss – less than £100k • Risk of claim remote	• Loss of up to £100k • Claim less than £10,000	• Loss of £100k to £250k • Claim(s) between £10,000 and £100,000 • Purchasers failing to pay on time	• Loss of £250k to £500k • Claim(s) between £100,000 and £1 million • Loss of contract / payment by results	• Loss of >£500k • Claim(s) >£1 million
Service/ business interruption	• Loss/interruption of >1 hour	• Loss/ interruption of >8 hours	• Loss/ interruption of >1 day	• Loss/ interruption of >1 week	• Permanent loss of service or facility
Environmental impact	• Minimal or no impact on the environment	• Minor impact on environment	• Moderate impact on environment	• Major impact on environment	• Catastrophic impact on environment

END

Item No.	7			Presentation to	Trust In Public Board		
Title of paper	**Solent NHS Trust Self Declaration on Same Sex Accommodation – September 2021**						
Purpose of the paper	To present to the Board the annual statement of compliance against the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest or reflects their personal choice.						
Committees /Groups previous presented and outputs	n/a						
Statement on impact on inequalities	Positive impact (inc. details below)	X		Negative Impact (inc. details below)		No impact (neutral)	
Positive / negative inequalities	Solent is committed to providing accommodation that complies with the delivering same sex accommodation standards and considers these to be a key factor in maximising patient privacy, dignity and respect.						
Action required	For decision	X		For assurance	X		
Summary of Recommendations and actions required by the author	The Board are asked to: • Review the declaration within and approve the outlined declaration for assurance.						
To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	**Jackie Munro, Chief Nurse**			Exec Sponsor signature:			

Solent NHS Trust Self Declaration on Same Sex Accommodation – September 2021

Solent NHS Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest or reflects their personal choice.

Delivering single sex accommodation simply means providing an environment where men and women do not share sleeping accommodation and bathroom and toilet facilities.

Solent is committed to providing accommodation that complies with the delivering same sex accommodation standards and considers these to be a key factor in maximising patient privacy, dignity and respect.

- ✓ There are no exemptions from the need to provide high standards of privacy and dignity
- ✓ Men and women should not have to sleep in the same room, unless sharing can be justified by the need for treatment or by patient choice. Decisions should be based on the needs of each individual not the constraints of the environment, nor the convenience of staff.
- ✓ Men and women should not have to share toilet and washing facilities with the opposite sex, unless they need specialised equipment such as hoists or specialist baths.

- ✓ Men and women should not have to walk through the bedrooms/ bed bays or bathroom/ toilets of the opposite sex to reach their own sleeping, washing, toilet facilities.

What does this mean for our patients?

Patients who are admitted to any of Solent NHS Trusts' wards can expect the following:

The room where you sleep will only have patients of the same sex as you

Transgender patients/service users should be accommodated in the same ward areas as your chosen gender

All toilet and bathroom facilities will just be for people of the same sex as you and if it is not en-suite will be close to your bed area

In all our wards there will be both male and female patients but patients of the opposite gender will not share your sleeping area. However, you may have to cross a ward corridor to reach your bathroom, but you will not have to walk through the opposite-sex area.

Any breach of same sex sleeping accommodation will be reported as an incident and highlighted to the Trust Board. Breaches will also be reported to the CQC in line with regulation.

What do I do if I think I am in mixed sex accommodation?

If you have any concerns about your accommodation being "mixed sex" during your admission, please ask to speak to the nurse in charge on your ward or alternatively contact our Patient Advise and Liaison Service (PALS) on **0800 013 2319**.

Board and Committees

Item No.	8.1			Presentation to	Trust In Public Board
Date of paper	27 September 2021			Author	Debbie James, Associate Commercial Director
Title of paper	Organisational strategy refresh				
Purpose of the paper	The aim of this paper is to update the Trust Board on the proposed revised vision and strategy for Solent NHS Trust				
Committees /Groups previous presented and outputs	Presented to Executive Team and now to Trust Board for approval				
Statement on impact on inequalities	Positive impact (inc. details below)	x	Negative Impact (inc. details below)		No impact (neutral)	
Positive / negative inequalities	Our refreshed vision reflects the core belief that everyone deserves equitable access to high-quality health and care services which support their health and independence, no matter who they are or where they live. Delivery of this strategy will help Solent continue to improve the services we deliver, support the health, wellbeing and future of our workforce and ensure we use precious NHS resources wisely.				
Action required	For decision	x	For assurance		
Summary of Recommendations and actions required by the author	The Trust Board is asked to approve the revised vision and strategy for Solent NHS Trust.				

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Gordon Muvuti, Director of Strategy and Partnerships			Exec Sponsor signature:			

Key messages /findings

Our original strategy, which was created in 2016, was framed in context where the NHS had developed the Five Year Forward View, Sustainable Transformation Plans (STP) were emerging, setting out an intention for improved system working, and a blueprint had been developed for the creation of new care models. In March of 2020, our Trust Board refreshed the strategy to reflect the latest context, learning and local and national developments.

Since that time, the COVID-19 pandemic has brought many challenges for the NHS, our service users, communities and system partners. It has also created opporunties and a wealth of learning. Coupled with this, the Health and Care Bill is expected to be enacted in law by April 2022. Once passed, the Bill will formally establish Integrated Care Systems (ICSs) across the country. In light of the latest national and local policy direction, challenges, opportunities and learning from the pandemic, we have taken the opportunity to review and refresh our vision and strategy.

The attached paper outlines the refreshed vision and strategy. The refreshed vision, which describes what we are working to achieve, places a strong focus on the things our communities and staff have told us are important to them today, as well as the things that need to improve for the future.

Our refreshed strategic priorities, which are aligned to our mission to provide great care, create a great place to work and deliver great values for money, describe the latest principles and commitments we will work to, to achieve our vision. This document outlines what the 15 strategic priorities mean to us, our people and our communities and the actions we commit to taking to deliver them.

The content of the document will be used to create an easily digestible document, with stories to illustrate how we work to deliver against our priorites, for internal and external audiences.

Item 8.2

NHS Solent NHS Trust

Our vision and strategy

2021-2025

(Design company will design new version)

Contents

(Subject to change during design)

Welcome

From our Chief Executive and Chair

Solent NHS Trust provides community, mental health and learning disability services to communities in Hampshire and the Isle of Wight. Our dedicated team of over 6,000 staff deliver compassionate, patient-centred care to people close to home, at all stages of their lives.

We are the main community and mental health provider in Portsmouth city and the main provider of community services in Southampton. We also provide a range of specialist services across the Hampshire geography. We have made a firm commitment to support the sustainability of health and care on the Isle of Wight, and we currently provide sexual health, dental and 0-19 services to the island community.

At Solent we share a fundamental belief that the way we work, our behaviours and priorities should be guided by our values – Honesty, Everyone Counts, Accountability, Respect and Teamwork (HEART). We believe in honest, respectful conversations and working together with service users, carers, our staff and people in the communities we work in, to keep more people well and independent throughout their lives.

During the COVID-19 pandemic, the most challenging of times for us all, our long-standing commitment to provide Great Care, make Solent a Great Place to Work and deliver Great Value for Money has remained strong. The commitment and dedication of the people who work at the heart of Solent has been exceptional. Teams have approached an incredibly challenging situation with flexibility. Service transformation has happened at pace and people have stepped into roles that they would not otherwise do; ensuring we have been able to continue to deliver care, respond to the pandemic and support people in our communities and one another. We will always be whole-heartedly grateful to every member of Team Solent.

The COVID-19 pandemic has brought many challenges for the NHS, our service users, communities and system partners. Never more has the need to address health inequalities within our communities been more apparent.

The pandemic has also created some opportunities and a wealth of positive learning, particularly in terms of how health and care partners can best work together to improve care and achieve common goals. And so, as we learn to live with COVID-19, we have taken the time to think about what "beyond the pandemic" looks like for the local health and care system, for our services and for our communities.

Our original strategy, created in 2016, was framed in context where the NHS had developed the Five Year Forward View, Sustainable Transformation Plans (STP) were emerging, setting out an intention for improved system working, and a blueprint had been developed for the creation of new care models. In March of 2020, our Trust Board refreshed the strategy to reflect the latest context, learning and local and national developments.

At the time of writing, the Health and Care Bill is expected to be enacted in law by April 2022. Once passed, the Bill will formally establish Integrated Care Systems (ICSs) across the country and enable improved collaboration between NHS providers, commissioners and other stakeholders, to help health and care partners better respond to today's challenges.

We believe firmly in the NHS Triple Aim, set out in the Health and Care Bill: t*he health and wellbeing of populations, the quality of services provided to individuals, and efficiency and sustainability in relation to the use of resources.* Our mission to provide Great Care, be a Great Place to Work and deliver Great Value for Money, aligns with the Triple Aim and remains at the forefront of our approach.

In light of the latest national and local policy direction, challenges, opportunities and learning from the pandemic, we have taken the opportunity to review, refresh and reframe our vision, ensuring it is stretching, challenging and innovative. Our new vision statement has a strong focus on the things our communities and staff have told us are important to them today, as well as the things that need to improve for the future.

Welcome continued

Our vision statement:
Health and care teams working with communities to make a difference, so everyone has easy access to safe and effective care, keeping more people well and independent throughout their lives.

Our vision reflects the core belief that everyone deserves equitable access to high-quality health and care services which support their health and independence, no matter who they are or where they live. We are working towards a future where health and care teams work seamlessly together to deliver high-quality care, avoid unnecessary handovers between teams and organisations and improve service user experience. A future where people have choice and control over the way their care is planned and delivered and where each individual's priorities, strengths and needs are at the centre of their care.

We have refreshed our strategic priorities to ensure they describe the latest principles and commitments we will work to, to achieve our vision. This strategy explains what each of our 15 strategic priorities mean to us, our people and our communities and the actions we commit to taking to deliver them.

Delivery of this strategy will help Solent continue to improve the services we deliver, support the health, wellbeing and future of our workforce and ensure we use precious NHS resources wisely.

For us, this strategy also reflects a new approach for Solent as an NHS organisation: one where we actively act upon our wider responsibility as an "anchor institution" within Hampshire and the Isle of Wight. Increasingly, we will work alongside communities and partners to tackle the range of factors which affect the health and wellbeing of people in our communities – for example housing, employment, air quality and lifestyle choices.

Through publication of this strategy we commit to helping our communities manage and recover from the impact of the pandemic, and build a fairer future.

Introduction to Solent NHS Trust

Solent services

(A Solent services version of something similar to this is being developed with the design company.)

Solent services to be mapped onto a similar picture:	
Home	Community nursing
	End of life services
	Community urgent response services
	Veteran services
GP surgery	Primary care services
	Homeless healthcare services
School	School nursing
	Immunisations
	Sexual health services
	Mental health services
Health clinics and community settings	Health visiting
	Children's therapies
	Community mental health services
	Sexual health services
	Child and adolescent mental health services (CAMHS)
	Specialist dental services
	Long term conditions support (e.g. diabetes, heart failure, respiratory)
Community hospital	Therapy services (e.g. podiatry and physiotherapy)
	Mental health inpatient wards
	Pharmacy
	Community inpatient wards
General hospital	Urgent response services
	Supportive discharge teams
	Reablement teams

The area in which we operate

Hampshire and the Isle of Wight is one of the largest, most complex health and care systems in the country. There are 4 providers of hospital ("acute") services, 3 main providers of community and mental health services, an ambulance trust, 158 GP practices, working in 42 primary care networks, over 900 suppliers of domiciliary, nursing and residential care, 300 community pharmacies, 200 providers of dental services and nearly 200 providers of optometry services.

The Hampshire and Isle of Wight system faces a number of challenges. We know some communities experience unacceptably poorer access, outcomes and life expectancy than the rest of our population and this has been highlighted more than ever during the COVID-19 pandemic. In common with other systems across the country, there is an increasing financial challenge and we have some difficulties recruiting and retaining the workforce we need. The needs of our city populations are different in some areas to those of our rural communities and, across the county, there is a growing elderly population with changing health needs. We also know there is variable quality and resilience of services, with some people staying in hospital longer than is beneficial.

From April 2022, the Hampshire and Isle of Wight Integrated Care System (ICS) will establish an Integrated Care Board, which will take collective responsibility for managing resources, delivering care, and improving the health of the communities we serve. This is happening as part of the national process to establish a network of Integrated Care Boards across the country, to improve partnership working between hospital and community services, physical and mental health, and health and social care.

The Hampshire and Isle of Wight ICB will develop a plan for the NHS to meet the health needs of the population in Hampshire and the Isle of Wight. It will also help health and care partners develop an Integrated Care Strategy, setting out how the NHS, local authority partners and other key stakeholders will work together to improve the health and wellbeing of our population.

The Hampshire and Isle of Wight partners understand that **by working together we make lives better,** and we will increasingly work in partnership to integrate and coordinate services, provide more consistency of care and reduce inequalities.

As one of the providers of community and mental health services, Solent NHS Trust is a core partner in the Hampshire and Isle of Wight Care System and we deliver some of our services at a county-wide scale. We also operate and collaborate at other levels of scale:

- Alongside GPs and other primary care colleagues, in neighbourhoods
- At a city level – or in groups of organisations surrounding the hospital trusts ("place-based care")
- At a regional level, with health and care colleagues from different counties.

The COVID-19 pandemic has taught us more than ever that collaborating with others at the appropriate level of scale to plan and deliver services is critical to meet local needs.

Increasingly, community and mental health providers are working more closely with GPs and other primary care colleagues in primary care networks, to share learning and resources, often with the aim of developing sustainable, integrated community, mental health and primary care teams which respond to neighbourhood needs and tackle inequalities.

Similarly, groups of organisations are working at place-level, in city and county council footprints and around hospital trusts, to focus on population health needs and outcomes, with the aim of ensuring pathways of care are sustainable, accessible and joined-up, regardless of organisational boundaries.

Where it is appropriate to work across ICS boundaries – for example to deliver highly specialist services such as specialist adult and children's mental health, eating disorders and services for veterans of the armed forces – we are doing so. Working at scale has been enabled by the development of formal Provider Collaborative models, where two or more health organisations work together across multiple places, with a shared purpose and decision-making. Increasingly providers of hospital, community, mental health and ambulance services will work in this way, where it will provide greater resilience, economies, capacity and benefits for patients.

Our strategic framework

These are **our values**. They are embedded in our culture and underpin everything we do.

Honesty | Everyone counts | Accountable | Respectful | Teamwork

This is **our vision.** It is the future we are working to achieve.

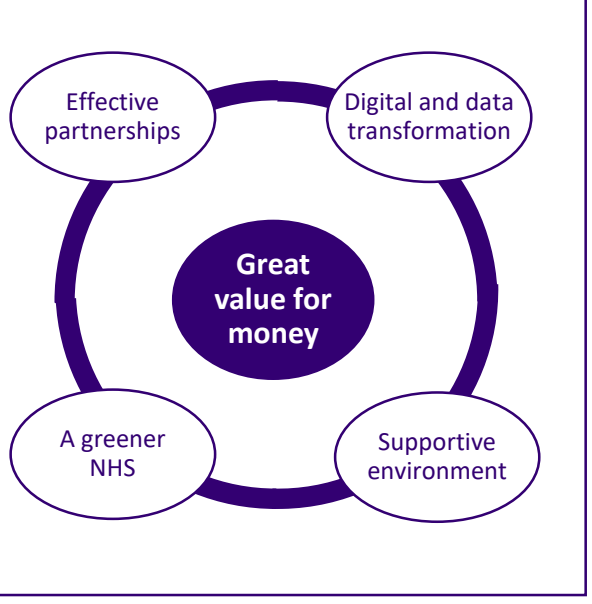
Health and care teams working with communities to make a difference, so everyone has easy access to safe and effective care, keeping more people well and independent throughout their lives.

This is **our mission.** These are the things which drive us.

Great Care

Great Place to Work

Great Value for Money



These are **our strategic priorities**. Our strategic priorities describe the principles and commitments we will work to.

Our values

Solent NHS Trust is a values-led organisation. Living our values enables us to be better at what we do, create a great place for our staff to work and ensure we provide the highest quality of care for our patients.

In creating our values, we spent time listening to our employees. Based on what people told us, we created our HEART values to reflect the deep belief that we are caring organisation at the centre of our community.

We will continue to develop ways of working built on our values, creating a great place to work and a great experience for our patients

Our vision, mission and priorities

(Summary narrative to be produced once strategic framework agreed by Board)

How will we deliver Great Care?

(Note: stories from service users, staff and partners to be added)

We will provide Great Care by focusing on the priorities within our Clinical Framework.

Our Clinical Framework describes the way we provide health services in Solent. It sets out the priorities we will work to, in line with our commitment to deliver *Great Care.* It describes how Solent's clinical services will work to meet the needs of patients, local communities and partners. It guides our leaders, clinicians and teams in their design and delivery of clinical services.

At the heart of our Framework is the Solent commitment to work in a very different way *alongside* our communities. Our clinical principles have been created in response to the things our communities have told us are important.

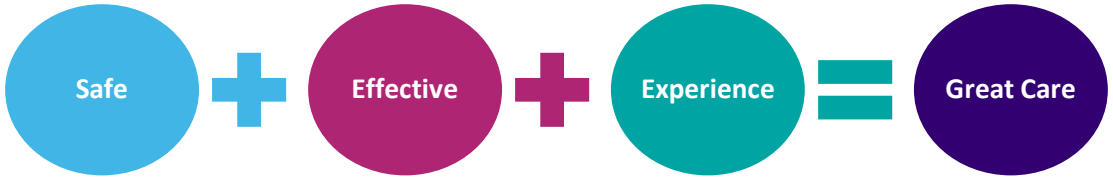
Our strategic priorities are built around the seven guiding principles of our Clinical Framework:

1. We provide **safe, effective services** which help people keep mentally and physically well, get better when they are ill and stay as well as they can to the end of their lives.
2. Our communities are at the heart of what we do and we will work **alongside our communities** to improve the way we deliver care.
3. We will focus on **outcomes that matter**, co-created with the people who know our services best.
4. We will adopt a **life-course approach** which removes barriers and personalises care.
5. We will work collaboratively, at the appropriate scale, as **one health and care team**.
6. We will drive and embrace **research and innovation** to deliver excellent, evidence-based care.
7. We will ensure strong **clinical and professional leadership** is at the heart of delivery and decision making across our area.

GREAT CARE

1. We provide **safe, effective services** which help people keep mentally and physically well, get better when they are ill and stay as well as they can to the end of their lives

Delivering great care is about maintaining high quality standards - standards which improve the experience for patients and staff and enable us to provide safe, effective services. Our formula for great care is a simple as 1,2, 3:



1. **S**afety is paramount
2. Effectiveness is measured
3. Experiences of patients and staff guide us

SEE our formula for great care!

We treat thousands of patients every day and **patient safety** means working proactively to minimise the chance that things could go wrong; if they do we are open and honest with patients and their families about what's happened and we take steps to reduce the chance that the same thing could happen again.

Clinical effectiveness means providing the right care for each individual patient. It means we are constantly thinking about what we do and consider whether it is having the desired result for each patient. If it is not, we will make a change.

Our patients are at the centre of everything we do. By listening to patients and asking them about their **experience**, we will ensure that they and their families and carers are receiving care that is respectful of and responsive to individual patient preferences, needs and values.

Our immediate priorities are:

1. We will implement the Patient Safety Strategy within the mandated 3-year time frame. Patients and Staff will work collaboratively to create a 'Just' safety culture. Investigations will be more thematically focussed and learning from safety incidents will be shared in a way all staff can understand.
2. We will support the delivery and strategic development of the Regulatory Compliance agenda to provide assurance to the CQC, trust board and stakeholders, ensuring strong, effective processes are in place to support compliance across all clinical services.
3. We will ensure people participation is embedded across all services, enabling community members and groups to play an integral part in decision making regarding all aspects of their community and mental health trust. We talk more about this in Principle 2.
4. We will improve access to and experience of using the health services we provide to all members of our local community, promoting health and wellbeing and reducing health inequalities. Our approach to delivery is outlined within Alongside Communities which sets out how we will work closely with our community and partners.

GREAT CARE

2. Our communities are at the heart of what we do and we will work **alongside our communities** to improve the way we deliver care

Alongside Communities is the Solent approach to engagement and inclusion. It was cocreated with people from our local communities including community groups, voluntary organisations and people who work in our services.

Alongside Communities describes our ambitions to **improve health, reduce health inequalities and improve the experience of care** for people who use our services.

We shall do that by enabling people who use our services and members of our local community to actively participate in activities, groups and key decisions, by continuing to extend our reach to the community recognising the skills and expertise they have to offer, and building positive relationships with those individuals and groups who experience inequities in health and health care provision.

Our immediate priorities are:

To deliver the objectives and year 1 targets within the Alongside Communities Delivery Plan 2021-2025, including:

- To improve access to and experience of using the health services we provide to all members of our local community, promoting health and wellbeing and reducing health inequalities.
- To ensure that patients, families, carers, local people and community groups are integral to decision making in all aspects of their community and mental health trust.
- To build trusting relationships with local people and groups by underpinning the way we work with three key questions:
    1. What are the community best placed to do?
    2. What help could we offer if the community asks?
    3. What do we do best and are best placed to do?

GREAT CARE

3. We will focus on **outcomes that matter**, co-created with the people who know our services best

- We will **co-create outcomes** with patients, communities and partners, including those who are seldom heard. We will seek to understand how we can positively impact patients' care experience and health outcomes by listening, understanding how we're doing, continuing to do the things we do right, constantly learning and improving. Outcomes will be **meaningful, measurable** and **transparent.**
- Outcomes will clearly describe the **impact on people and communities and reflect and measure the *effectiveness* of care.** They will be used to:
    - **Improve the way we deliver care** - we will ensure our services are focusing on the priorities which really matter to people and achieving outcomes that count.
    - **Enhance quality, safety and experience of care** - we will be transparent and open when we make mistakes, involving people at every stage to co-produce the learning and improvement.
    - **Improve access to care** - we will work with communities to develop innovative approaches to maximise equitable access to healthcare.

Our immediate priorities are:

1. We will develop a community-led approach to the creation of patient, family and carer outcomes, with the measures of success and the way in which that data is captured and reported cocreated with community partners.
2. We will invest in resources to develop an innovative, meaningful approach to definition, measurement and reporting of outcomes, supported by comprehensive, timely, accessible, business intelligence.
3. We will review clinical governance processes to streamline them, reducing duplication and removing unnecessary bureaucracy, ensuring our processes:
    - Make it easy for our staff to do the right thing.
    - Reflect our culture and values.
    - Involve our people and communities.
    - Help our staff to work safely.
4. Full implementation (by the end of 2023) of the patient safety strategy, ensuring all our reporting focuses on insight, involvement and improvement.

GREAT CARE

4. We will adopt a **life-course approach** which removes barriers and personalises care

- Through our **life course approach** we will focus on maximising potential in childhood and early adulthood, maintaining good health, living successfully with chronic disease and anticipating and responding to decline.
- We will personalise care focusing on the question **'what matters to you?', ensuring people have choice and control** over the way their care is planned and delivered. We will ensure individual priorities, strengths and needs are at the centre. We will tailor this to the needs of specific communities to reduce health inequalities.
- We will work collaboratively to develop seamless pathways which **remove barriers to care** and **reduce unnecessary handovers** between teams/organisations.
- We recognise that each person's health and wellbeing is influenced throughout their life by a wide range of social, economic, environmental and behavioural factors. We will seek to **make every contact we have with our patients count**, encouraging behaviour change, prioritising early intervention and enabling access to a range of services which will enable people to live well.

Our immediate priorities are:

1. We will identify, and work to remove, barriers within and between Solent services to develop an 'ageless approach', focusing on:
    - Consistency of care for young people who are transitioning from Child and Family services to be supported by Adult services.
    - Consistency and comprehensiveness of approach across Adult Mental Health and Older Persons Mental Health services.
2. We will actively seek opportunities to join up physical and mental health service provision.
3. We will work in partnership with colleagues in other community and mental health Trusts, acute Trusts, local authorities, primary care and the voluntary and community sector to develop seamless pathways of care which enable patients to access the care they need without unnecessary referrals, handovers and repetition.
4. We will work with other organisations to support our people to identify, learn, and make changes to services, to enable our clinicians to deliver personalised care.
5. We will design and measure self-efficacy and patient reported outcomes as part of our new approach.

GREAT CARE

5. We will work collaboratively, at the appropriate scale, as **one health and care team**

- **Organisational boundaries in health and care delivery are not important to patients**. We will work alongside our communities, other health and care providers and providers from the voluntary, community and social enterprise sector to create delivery teams which provide appropriate **services at the right scale, according to need**. We will not work in isolation and we will be one health and care team.
- Our services will be delivered at the appropriate level of scale to ensure they meet the needs of our local communities. For us, there are **three key levels of scale:** in neighbourhoods alongside Primary Care and Primary Care Networks (PCNs), place-based at a city/sub-county level and at an Integrated Care System (ICS) level across Hampshire and the Isle of Wight (HIOW).

Alongside Primary Care and PCNs

We will work alongside primary care to provide and share workforce to meet the needs of our communities across the life-course.

We will work alongside PCNs to help improve the long-term resilience of primary care, supporting organisational delivery and enabling PCNs to benefit from our scale and resources (e.g. operational support, governance, estates, facilities, technology and workforce, including wellbeing.)

We will help build trust and relationships with our colleagues working in local communities, focusing on joint working - not competition - identifying clear ways of working and developing the demonstrator hub model based around Solent GP practices.

Place-based

We will work with colleagues in community health, mental health, local authorities and local acute Trusts to develop appropriate models of care and tailor our services to meet local needs at a city/sub-county level.

We will provide specialist, proactive services in partnership with health and social care providers and the Voluntary and Community sector to reduce health inequalities, enable people to live well and ensure people are able to remain in their home environment wherever possible.

We will work in partnership to improve responsive (intermediate) models of care (emergency response, hospital at home, community and mental health beds, Same Day Emergency Care (SDEC), rehabilitation services etc.) to reduce pressure on acute services and help ensure people are treated in the right place at the right time.

ICS-level

As key partners in the HIOW ICS, we will provide clinical leadership to cocreate comprehensive, effective pathways of care across HIOW. We will ensure models of care meet local need at each level of scale, enable people to live well, reduce health inequalities and improve experience of care.

We will adopt the ‘one NHS team’ approach and embrace the new NHS Duty to Collaborate; jointly owning ICS ambitions to provide effective, appropriate, resilient services across HIOW.

Where services benefit from being delivered at scale by a single provider (e.g. integrated sexual health, HIV, specialist dental services) we will lead their delivery, if we are best placed to do so, embracing an ethos of continuous improvement, in line with our Clinical Objectives.

GREAT CARE

6. We will drive and embrace **research and innovation** to deliver excellent, evidence-based care

- Excellent care is underpinned by cultures of learning and innovation; research active organisations are known to have better patient outcomes.
- We will drive and support the development of a strong evidence base around community and mental health care services. We will do this with academic and patient partners.
- We **will continue to increase access to research, innovation and improvement opportunities** for staff and patients, particularly for those not usually included. Research and innovation will be a core part of our workforce and organisational development planning, and a core component of leadership capability.
- We will use structured methods to continuously evaluate and quality improve our services. We will ensure learning is shared locally and nationally.
- We will use research and innovation principles to help us establish **innovative partnership working with other providers, our patients and our communities.**

Our immediate priorities are:

1. We will increase access to research and improvement for both our staff and our patients.
2. We will build research and improvement into workforce development and planning, including the use of joint posts and partnerships.
3. We will make training and facilitated support more bespoke to the needs of services and teams, to encourage them to be critical thinkers, and confident around innovation and measurement.
4. We will continue with the integrated approach to evidencing improvement and outcomes so that services know how well they are meeting the needs of those we look after.
5. We will actively encourage more learning from what goes well, rather than what doesn’t.

GREAT CARE

7. We will ensure **strong clinical and professional leadership** is at the heart of delivery and decision making across our area

- Solent is **proud of its clinicians** who work in multidisciplinary teams, increasingly breaking down traditional professional boundaries. They are at the heart of our organisation, working with patients and alongside GPs and clinicians from other organisations.
- We will empower clinicians at all levels to feel integral to their service and to identify and describe change alongside strong operational support.
- Strong clinical and professional leadership means to us:
    - Inspiring and driving change
    - Focusing agendas around person centred quality, safety and outcomes
    - Being visible and having a voice

Our immediate priorities are:

1. We will develop and implement a robust structure for the professional leadership and clinical standards of Solent Services, ensuring a consistent approach to development of standards and guidance to direct safe clinical practice and implementation of new and emerging clinical roles.
2. We will Invest in clinical leadership:
    - Training programme
    - Refocus the organisation around clinical executive
3. We will cleanse meeting structures to release more clinical leadership time.
    - Quality improvement, research and innovation
    - Clinical leadership visibility internally to Solent and within the wider system
4. We will embrace expert wider system clinical leadership.

How will we be a Great Place to Work and deliver Great Value for Money?

We will be a Great Place to Work

The national NHS People Plan sets out an ambitious vision for the NHS, with more staff, working differently, in a compassionate and inclusive culture. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.

At Solent NHS Trust we are committed to delivery of the People Plan and we will be a **Great Place to Work** by focusing on its 4 key pillars:

1. **Looking after our people** – we will look after the health and wellbeing of our people and prioritise work-life balance.
2. **Belonging in the NHS** – we will create an inclusive, compassionate culture which addresses inequalities.
3. **New ways of working** – we are committed to embedding new ways of working and delivering care.
4. **Growing for the future** – we will develop a workforce which is sustainable for the future.

We will deliver Great Value for Money

The Health and Care Bill 2021 sets out the *Triple Aim* which all NHS organisations should have regard to when setting out organisational strategy and developing decision making arrangements: t*he health and well-being of populations, the quality of services provided to individuals, and efficiency and sustainability in relation to the use of resources.*

At Solent NHS Trust, we will demonstrate **Great Value for Money** and ensure efficient, sustainable use of resources, in line with the NHS Triple Aim, by focusing on 4 key enablers:

1. **Digital transformation** - we will improve the experience of staff and service users by implementing digital solutions that optimise existing practice and innovate new practice
2. **A Greener NHS** - we will be smarter in how we use resources when delivering high quality healthcare, so that we are environmentally, economically and socially sustainable
3. **Supportive environments** - we will ensure our built environments provide best value whilst enabling and supporting changes in healthcare delivery and responding to the needs of the population
4. **Effective partnerships** - we will work in partnership and identify opportunities to work effectively at the appropriate scale to address unwarranted variation, improve NHS and community sustainability and ensure effective use of resources.

GREAT PLACE TO WORK

1. **Looking after our people** – we will look after the health and wellbeing of our people and prioritise work-life balance

- Our people are our most important asset and we will support our people to be physically and mentally well.
- We will look after the health and wellbeing of our people, ensuring we continuously improve the experience of working in the NHS for everyone. We commit to being a workplace which actively supports self-care and helps people to look after themselves.
- We recognise that different people need to recover from the toll the pandemic has taken on them in different ways and we will enable this.
- Staff safety will always remains our priority.
- We commit to creating a workplace which supports work-life balance and helps people manage conflicting demands more effectively.
- We will enable managers and colleagues to work in an agile and flexible way as appropriate to their role and meeting the need of our service users.

Our immediate priorities are:

1. Implementation of our health and wellbeing delivery plan and framework, this includes providing further access to physiological and psychological tools.
2. Delivery of our new ways of working strategy.
3. Delivery of vaccination programme and COVID-19 booster programme to our people.

GREAT PLACE TO WORK

2. **Belonging in the NHS** – we will create an inclusive, compassionate culture which addresses inequalities

We are committed to building greater inclusivity, to build the right culture for our people and our service users. We want to enable every person working in Solent NHS Trust to feel able to bring their authentic selves to work each day, ensuring we all feel visible and our identity is validated and valued. As part of our commitment we will proactively embed effective diversity and inclusion practices across the Trust, with the aim of:

- Developing an inclusive and compassionate culture and addressing inequalities.
- Supporting and empowering under-represented employees, ensuring no one person is disadvantaged through lack of reasonable adjustment to workplace practices and support.
- Creating an environment in which people have an impact on decisions and actions that affect their jobs.
- Redefining a sense of team for all at Solent, with inclusive workplaces where staff feel listened to and empowered.

Our immediate priorities are:

1. To deliver Solent's WRES (Workforce Race Equality Standards) Improvement Plan following the latest national WRES findings and our recent staff survey results.
2. To focus on improving diversity through our recruitment and promotion practices.
3. To implement action plans in response to areas highlighted within our staff survey results which will increase inclusivity and diversity.
4. Undertake the Big Conversation - a series of Trust wide sessions to promote the discussion and learning around discrimination, how it effects our staff, patients and beyond and what we need to do to tackle it.
5. Implementation of a development programme for our senior service leaders, which includes focus on actively creating an inclusive, compassionate culture which addresses inequalities.

GREAT PLACE TO WORK

3. **New ways of working -** we are committed to embedding new ways of working and delivering care

- We are committed to embedding new ways of working and delivering care and we will adopt innovations which make best use of employee's skills and experience, to benefit our patients.
- We will create and implement a digital workforce strategy to help people working effectively. We will developing skills and expand capabilities to create more flexibility, boost morale and support career progression.

Our immediate priorities are:

1. New Ways of Working Continue implementation of the E-Job Planning tool for Allied Health Professionals and Medics through 2021.
2. To improve the capability of e-rostering across the organisation.
3. To implement a line management skills development programme
4. To automate our processes to onboarding new starters, to improve efficiency and the joining experience of new members of staff.

GREAT PLACE TO WORK

4. **Growing for the future** – we will develop a workforce which is sustainable for the future

We need to take steps to sustainably increase the size and resilience of our workforce, to ensure we are able to deliver high-quality, safe, effective care for generations to come. Our focus is on the retention of critical skills, talent management, recruitment and succession planning. We will:

- Develop a local workforce supply plan with a focus on both recruitment and retention.
- Improve collaboration between employers across the ICS to increase overall supply and widen the workforce openings across the health and care system
- Develop our people by ensuring the right amount of clinical placement capacity is available, enabling students to qualify and postgraduate (medical and dental) to follow training recovery plans.
- Provide employment opportunities to the workforce of the future, identifying paths for students and school leavers to follow.

Our immediate priorities are:

1. A refreshed recruitment model to deliver a quality candidate and manager experience.
2. Succession Planning review and approach for senior leaders down to Band 7 level.
3. Career progression model review for Apprenticeships.
4. International Recruitment Strategy for Nurses 21/22 and evaluation of the pilot project
5. Leadership Development – implementation of a suite of line management skills training.
6. Delivering the Generational Retention Programme (over 50s and newly qualified).
7. Review of the Appraisal Process. 350+ Schools Project: Reaching out into schools and colleges to share about the breadth and depth of employment opportunities in the NHS.

GREAT VALUE FOR MONEY

1. **Digital and data transformation** - we will improve the experience of staff and service users by implementing digital solutions which optimise existing practice, innovate new practice and enable effective decision making through excellent data and business intelligence.

As part of our ambition to be a digitally-mature organisation where services adapt and respond to the needs of local communities and service users to deliver the best evidenced outcomes, we will:

- Develop our data quality and business intelligence maturity to ensure effective measurement of meaningful outcomes and enable informed decision making which supports innovation and improvement.
- Simplify and improve the design and operation of our digital solutions, learning from innovations during the pandemic and ensuring consistency and clarity to enable new ways of working and release time to care.
- Improve the usability, support experience and learning experience of the digital tools available to our people and our service users, to build digital competencies and optimise use of digital solutions. This will help us improve productivity, data quality and service user experience.
- Embed a culture of continuous digital improvement, where there are clear, easy ways to turn good ideas from our people and service users into innovative new ways of working.
- Work with our partners across Hampshire and the Isle of Wight to ensure our digital solutions benefit from shared learning and interoperability to enable consistent, joined-up services for our communities.

Our immediate priorities are:

- To continue to accelerate the function and use of our business intelligence platforms and improve data quality through a targeted programme of improvement.
- The introduction of minimum digital literacy requirements and a digital competency framework for our people.
- To create a coordinated organisational mechanism to produce and support new ways of working in all areas of the organisation.
- To ensure our innovation can contribute to improved consistency and experience of the end user (be they patient or colleague) within the Integrated Care System.

GREAT VALUE FOR MONEY

2. **Green NHS** - we will be smarter in how we use resources when delivering high quality healthcare, so that we are environmentally, economically and socially sustainable

Our Green Plan supports "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. Our Green Plan sets out how we deliver this.
- By working together, we will ensure that we are helping create the best future environment for our community, patients and staff whilst supporting the wider environmental challenges being faced.
- We are committed to setting the leadership standard where we can.

Our immediate priorities are:

Our environmental impact, measured in our carbon footprint for 2020/21, amounted to 4,069 Tonnes CO2e. Our Green Plan sets out our approach to minimising, measuring and monitoring this impact. It focuses on four significant areas:

- 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

Key development areas:

- 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.
- Improve 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.

GREAT VALUE FOR MONEY

3. **Supportive environments** - we will ensure our built environments provide best value whilst enabling and supporting changes in healthcare delivery and responding to the needs of the population

- The Estates and Facilities function at Solent is fundamentally a support service to our clinical teams and colleagues. Our core strategy and areas of development and improvement relate to the quality and value of the service we provide, and a continued goal and aspiration to be sector leading and value adding. However, we also find ourselves in a healthcare landscape of significant change, a landscape in which the built environment can have a dramatic impact on patient care and staff wellbeing, and where changes can be a catalyst for great organisational and cultural development.

- The Solent Estates & Facilities operational strategy is one that sees us recognise, respond to and help direct this change. Where built environments provide best value whilst enabling and supporting changes in healthcare delivery and respond to the needs of the population.

Our immediate priorities are:

Change space use and management –There is a significant and increasing demand for physical space within our estate. Whilst many teams have embraced flexible and home working releasing dependency on office space, net demand continues to grow. Community and Mental Health workforce is increasing, Acutes are seeking to place activity away from Hospitals, and Primary Care are seeking to expand their offering. All of this necessitates a wholesale change in our relationships with our buildings.

Deliver and facilitate change – As the healthcare landscape changes so the space it which it operates needs to. With renewed recognition of the importance in having fit for future, flexible and supportive healthcare environments, large scale capital programmes of change are likely. It will become a system level imperative to deliver high quality, high value buildings effectively.

Net Zero Carbon – With a commitment to deliver a Net Zero Carbon NHS for 2040, with 80% by 2032, the NHS Estate collective face possibly one of its biggest challenges. Achieving these targets will require significant physical and cultural change, unseen levels of innovation and inevitably great cost.

Areas of development:

In support of these goals the Estates teams have develop 8 significant areas of ongoing development:

- Training and Succession Planning
- Reports and Governance
- Infrastructure and Technology
- Occupancy and Utilisation
- Business Development
- Design and Quality Management
- Processes and Standards
- Appointments and Resourcing

GREAT VALUE FOR MONEY

4. **Effective partnerships** - we will work in partnership and identify opportunities to work effectively at the appropriate scale to address unwarranted variation, improve NHS and community sustainability and ensure effective use of resources.

- We will work with internal stakeholders and partners across the Hampshire and Isle of Wight Integrated Care System to **develop business opportunities which bring income into the Trust and support sustainability of the HIOW system.**
- We will seek opportunities to develop innovative **new strategic partnerships** which support delivery of the Trust vision and HIOW aims
- We will use evidence, data and business intelligence to inform strategic planning decisions across the HIOW ICS with the aim of **increasing collaboration and reducing unnecessary competition,** while ensuring value for money for the taxpayer.
- As an anchor institution, we are committed to **delivering social value through our commercial and procurement activities** to help our communities manage and recover from the impact of the pandemic, tackle economic inequality and improve the health and resilience of local people and businesses. We will ensure social value is a core element and explicitly evaluated in our procurement processes and support activities which create local employment, support the physical and mental health of local people, increase local supply chain capacity and tackle inequality in employment.

Our immediate priorities are:

1. Engage in and drive HIOW planning conversations, seeking opportunities to develop collaborative provider models which improve quality of care and sustainability of services across the HIOW ICS.
2. Establish business development priorities through the 2021/22 and 2022/23 business planning rounds.
3. Ensure sufficient resource, expertise and time is available to support delivery of business development priorities, supported by comprehensive project/programme and change management/transformation toolkits.
4. Develop, resource and implement a comprehensive approach to delivery of social value as a local anchor institution.

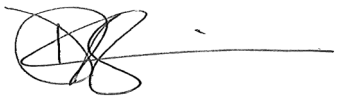
Summary and Next Steps

(To be drafted once final content approved)

Board and Committees

Item 9.1

Item No.	9.1		Presentation to	Public Board, 4th October 2021	
Title of paper	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annual Board Report and Statement of Compliance.				
Purpose of the paper	To provide the NHS England annual update.				
Committees /Groups previous presented and outputs	Responsible Officers Advisory Group (ROAG)				
Action required	For decision	x	For assurance	x	
Summary of Recommendations and actions required by the author	The Board is asked to: • Note the contents, • Chief Executive or Chair to sign to confirm, for return to NHS England.				

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant	X	Sufficient		Limited		None	
Exec Sponsor name:	Daniel Baylis, Chief Medical Officer		Exec Sponsor signature:				

Key messages /findings

The purpose of this paper is to confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Item 9.2

A framework of quality assurance for responsible officers and revalidation

Annual board report and statement of compliance

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G. In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their Annual Board report and Statement of Compliance.

Designated Body Annual Board Report
Section 1 – General:

The board of Solent NHS Trust can confirm that:

An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

The Chief Medical Officer is Solent's Responsible Officer. This year the Deputy Medical Officer has been trained as a second Responsible Officer.

The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes.

An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes, by the CMO Business Manager.

All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes, the Medical appraisal and revalidation policy was recently updated.

A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

At the last external review, Solent NHS trust was found to be demonstrating the highest levels of practice in relation to medical appraisal and revalidation.

A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes. All short term placements are appraised whilst at Solent.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

The Appraisal 2020 method is in use in Solent and has been well received by doctors.

Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

N/A

There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

The Medical appraisal and revalidation policy has been recently updated and agreed with the Doctors and Dentist Negotiation Committee (DDNC).

The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes.

Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Yes, as managed by our Lead Appraiser and Deputy Medical Officer.

The appraisal system in place for the doctors in your organisation is subject to quality assurance process and the findings are reported to the Board or equivalent governance group.

The final appraisal before revalidation is quality assured by members of the Responsible Officer Advisory Group (ROAG).

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 2b – Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Solent NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	**80**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**48**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**32**
Total number of agreed exceptions *(all missed appraisals recorded as approved missed).*	**32**

NB Solent appraisals are carried out April-September each year.

Section 3 – Recommendations to the GMC

Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

All revalidation submissions are reviewed at ROAG where a recommendation is made. The CMO Business Manager then actions the recommendation via the GMC Connect system.

Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes.

Section 4 – Medical governance

This organisation creates an environment which delivers effective clinical governance for doctors.

Yes.

Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes.

There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes.

The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Yes.

There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Yes, Medical Practice Information Transfer (MPIT) forms are used for this purpose.

Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes.

Section 5 – Employment Checks

A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes.

Section 6 – Summary of comments, and overall conclusion

Overall conclusion:

At the last external review, Solent NHS trust was found to be demonstrating the highest levels of practice in relation to medical appraisal and revalidation.

The Trust continues to deliver these standards and has developed them further via enhanced NED and lay-person representation at the Responsible Officers Advisory Group (ROAG) and developing senior clinicians and appraisers within the organisation.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 7 – Statement of Compliance:

The Board of Solent NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _ _ _ _ _ _

Official name of designated body: Solent NHS Trust

Item 10

CEO Report – In Public Board

Date: 24 September 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

Our people all across Team Solent continue to achieve great things and work with compassion and dedication, despite ongoing and ever-changing demands and new challenges.
Our campaigns continue to encourage the take-up of the COVID-19 vaccine, as we reach out to our local communities with our roving clinics across Hampshire and the Isle of Wight. Pop-up Vaccine Clinics at Victorious Festival and at the Isle of Wight Festival has given more opportunities for the younger demographic to receive a jab.

We also saw the closure of Basingstoke Fire Station Vaccination Centre recently, with the centre being handed back to the fire service. COO David Noyes was joined by Basingstoke and Deane Borough Council leader Cllr Ken Rhatigan and deputy leader Cllr Simon Bound, as well as Basingstoke fire station commander Rich Oram and group manager Ryan Thurman, to give their thanks to all the dedicated staff and volunteers who have been working tirelessly since it opened in February.

A COVID-19 commemorative book has been designed to help share the stories and experiences of our people though the pandemic, creating a snapshot of the past 18 months. The book is online and is being printed so staff are able to order copies as a keepsake, sharing these stories and milestones with families, generations to come, and remembering how much they have and continue to do, throughout this unprecedented time.

At the beginning of September, we joined colleagues from across the NHS to celebrate the first ever national virtual Pride. The event recognised the enormous contributions made by our LGBT+ colleagues within the NHS. Beyond Pride week, across Solent and within the NHS it is crucial that we continue to strive for equality and build a culture where everyone is able to be their authentic selves.

A major milestone service was launched in Portsmouth and South East Hampshire in September to help those in need of urgent mental health support. The Harbour is a remote, out of hours mental health crisis service run by Solent Mind and Havant, and East Hants Mind, in partnership with Solent NHS Trust and Health and Care Portsmouth. It aims to reduce the number of people who use the emergency and acute mental health services by preventing people reaching crisis point.

Our plans to centralise and future proof our rehabilitation facilities for patients across the Southampton area took a major step forward recently. Planners gave us the green light to build a new 50-bed rehabilitation wing at the Western Community Hospital. Demolition work is expected to start in the spring of 2022, with the scheme taking an estimated 18 months to complete.

Section 2 – Internal matters (not reported elsewhere)

Executive Team News

David Noyes, our Chief Operating Officer for Southampton and County wide services, has been offered an opportunity with Gloucestershire Health and Care, taking on the new role as their Chief Operating Officer.

David has been with us during an incredible four years, helping us to deliver good outcomes for our communities and latterly overseeing our vaccination programme for Hampshire and the Isle of Wight. Whilst we will be sad to see David leave Solent, I'm sure you that you wish to join me in thanking him for his commitment whilst with Solent and in wishing him every success in his exciting new challenge.

Contemporary update on covid recovery

As previously reported to Board, we are seeing the impacts and risks of the protracted pandemic period on those who use our services, in terms of waiting times and ensuring timely access to our services, and, significantly on our already tired workforce.

Increased demand and waiting lists

Across all care groups Covid recovery actions remain in place, albeit currently in the context of extremely high levels of system pressure, more akin to winter months.

- Our Childrens services in Southampton & Portsmouth, and in particular, Child & Adolescence Mental Health Services (CAMHS) and Health Visiting, remain areas of key concern due to pressures in demand and associated workforce challenges. We have held an internal deep dive attended by Children & Families West service and the Chief Operating Officer, along with our Chief People Officer to explore ways in which we can enhance and sustain our workforce in these areas. Learning from this is being shared with Children & Families East. We continue to work with our Local Authority partners on a potential short term residential offer in Southampton.
- To address the long waits in Musculoskeletal services (MSK) we are delivering additional clinics, which commenced in September, and will continue through the Autumn.
- As previously reported, we have been successful in achieving improved access to theatres for our Special Dental patients who need a General Anaesthetic (GA) procedure, the backlog (coupled with very high levels of demand on theatres from other specialities) means that this will take some time to return to pre-pandemic levels.
- Work continues across the organisation to improve the reporting of waiting lists, standardise our approach where appropriate and identify any gaps in assurance. This will be considered at the Executive Officer Group on 29 September and reported to the Quality Assurance Committee.

Workforce sustainability

- General sickness absence is currently 4.8% and comparing the reasons for sickness to last year we are seeing a notable increase in anxiety, stress, depression related illnesses (29.4% 2020 - 33% 2021) and also Infectious diseases. A key factor in increasing illnesses is that we have a fatigued workforce. Annual sickness has also been increasing from 4.4% in April 21 to 4.8% in August 21 with Solent being above the peer median of 3.9% (benchmarked against other similar trusts).

- We continue to implement practices aimed at workforce retention, including programmes specifically aimed at retaining our 50+ age group, as well as our newly qualified employees and we are now embarking on the Winter Wellbeing Plan. In line with the new People Partner model we have aligned a Health and Wellbeing Lead to each service line to give proactive support to our people and signpost them to our wellbeing self-help tools e.g. the navigational video on SolNet. The intention is that managers will identify those who require long term sick support and the Health and Wellbeing team will help individuals to self-manage. The post covid support has also now been extended.
- As a Trust we recognise that our workforce are our most important asset and with the increase in demand and system pressures, we equally recognise that we must take steps to support our workforce before and during the winter months. Whilst maintaining delivery to our patients, we will ensure our people are recognised and praised for their work through recognition programmes and a culture of compassion. We will provide leadership and training opportunities that will shape their thinking and career opportunities and encourage their continued development in their roles. Most importantly, we will provide opportunities for our people to come together to discuss how we can support them, retain them and encourage them, through local action groups.

Further information can be found within the performance report.

H2 Financial Envelope and Plan Submission

As of 24 September, no national guidance has been issued. Our draft plan was submitted to the Integrated Care System (ICS) on 10 September; a review of the overall plans across the ICS will be undertaken. A contemporary update will be provided in Confidential Board.

Quarterly Pulse Survey Results

To ensure regular measurement of employee engagement, quarterly Pulse surveys have been implemented nationally, in addition to annual surveys. In Solent we ran this between 1 and 31 July 2021 and received 964 responses. Results were shared with all staff, in an easily digestible way, in August.

Positive responses included how well informed and supported people feel they are, people also continued to say that they would recommend Solent as a place to work and, if a friend or relative needed treatment, for the care we provide. The results do also give some really helpful information about what will make the biggest difference to people at work, right now. The top 3 things people said would make the biggest difference to them at work:

- Enhanced IT support
- Greater flexibility to working schedule/ pattern
- More updates on changing operations/ ways of working

We scored overwhelmingly higher than the NHS overall on most questions, with some lower scores than the NHS in the 'practical support' area. The results are being used to assure that we are focusing in the right areas within the ongoing Staff Survey improvement plan and we also aim to implement additional listening opportunities e.g. via the Chief People Officer Roadshow to understand the responses further. We launch our annual staff survey and communication campaign on 27 September 2021, with results being shared in the Spring 2022.

Big Conversation

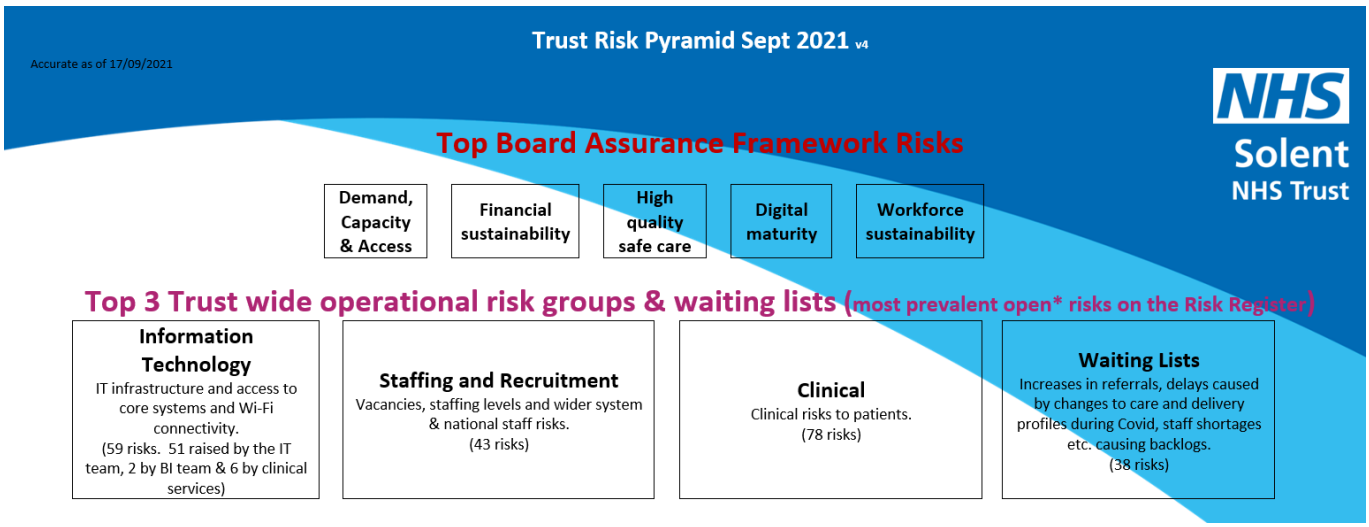
Earlier this year I offered to sponsor the Big Conversation, a work-programme which explores discrimination in the workplace with the aim of educating and growing together, as an organisation.

As part of the prework the team have embarked upon a series of Rapid Insight sessions, to ensure that the Big Conversation is informed by our people. Utilising the application 'Slido' participants are asked to complete a set of four questions related to their working experience, all answers are confidential. To date, over 250+ individuals have participated including the Board at our September workshop. The output of the Rapid Insights will be thematically analysed and triangulated with existing data sets including our Staff Survey, Freedom to Speak up data, and our Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES), which will feed into four facilitated Big Conversation sessions to be held later this year.

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 three risk groups, and waiting lists is the top risk domain. All are being actively managed through our care groups and assurance is sought at the relevant Board Committees.

By adding risk domains, we have developed our Risk Management System to enable us to assign risks to multiple risk groups and domains, enabling us to further understand risks and impacts.



The organisations strategic risks, within the Board Assurance Framework are summarised as follows:

BAF Risk	Raw Score	Residual Score	Target Score
Demand, capacity and accessibility	S5 X L5 = 25	5S x 4L = 20	16 – by End Oct 2021 12 – by end July 2022
Financial sustainability	S5 x L4 = 20	S4 x L4 = 16	S3 x L2 = 6 – by end June 2022
High quality safe care	S5 XL5 = 25	S5 x L3 = 15	S5 x L2 = 10- by end Q3 202/23
Digital Maturity	S5 X L4 = 20	S5 x L3 = 15	S4 x L3 = 12 – by end March 2023
Workforce sustainability	S4 X L5 = 20	S4 x L4 = 16	S4 x L3 =12 – by summer 2024/25
3rd party contractor assurance	S4 x L4 = 16	S4 x L3 = 12	S3 x L2 = 6 – by end June 2022
Strategic Partnerships	S5 x L4 = 20	S4 x L2 = 8	-----

New Ways of Working

The pandemic has enabled greater flexibility in our working environments and the New Ways of working programme will provide opportunity for our people to work in a hybrid way of office/clinic/home environments supported with the appropriate tools and technology. In Quarter 3 we will be engaging with appropriate colleagues with an aim to introduce a “flex desk” booking system enabling our people to book meeting rooms and/or desks at both St Marys and Highpoint sites, whilst encouraging flexible hybrid working. During the early part of 2022 we will also be improving on our spaces at these locations, enabling enhanced partnership access and working.

Section 3 –System and partnership working

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

We continue to work actively with our partners in HIOW as we cocreate our future Integrated Care Board (ICB) and Integrated Care Partnership. On 14 September, a workshop was held with Chairs and CEOs of the health providers within HIOW facilitated by the HIOW ICS Chief Executive and the Executive Director of Strategy.

Contemporary update on Urgent Care pressures

- Both the acute hospitals in Southampton & Portsmouth are experiencing intense pressure and unprecedented heightened demand for this time of year. This demand, alongside a national domiciliary care workforce shortage is impacting on community services in the two cities. The shortage of domiciliary care is delaying discharges from our community beds for patients ready to go home. In Southampton, we have increased our community bedstock by more than 10% and in Portsmouth we continue to work with our social care partners on optimum configuration of community beds to support discharge from hospital. System planning for additional surge capacity is ongoing with our partners to ensure we have robust plans for the winter. However, there will be a huge system challenge to generate sufficient workforce to mobilise capacity into a capability.
- We are working with our partners in South Central Ambulance Service to ensure we are able to support those who call 999 to ensure they are offered the right support for their needs in the right place.
- We have now gone live with our CAMHS liaison team in the emergency department at University Hospital Southampton (UHS) NHS Foundation Trust which is already proving effective. In anticipation of a surge in Respiratory Syncytial Virus (RSV), in partnership UHS, we are mobilising our Children's Hospital at Home service. Both of these services are already in place at Portsmouth Hospitals University (PHU) NHS Trust.
- Across the whole HIOW footprint we have continued to deliver Covid vaccinations; which is not only providing good levels of protection to the population, but also eases the burden on hospital services by preventing illness, and on primary care colleagues enabling them to focus on their core business, and ultimately easing some system pressures.

'Right First Time' – The Independent Review into Southern Health NHS Foundation Trust

In February last year, NHS England and Improvement published an investigation report after Nigel Pascoe QC independently reviewed the historical cases of five people who died in Southern Health's care between 2011 and 2015. The report recommended a second stage process to look at how the Trust has improved in the intervening years and the further developments planned – the report was published on 9 September 2021

We will be reviewing the report and reflecting on any learning applicable to us at Solent, reporting via our Quality Assurance Committee.

Item No.	11			Presentation to	In Public Board		
Date of paper	20/09/2021			Author	Zoe Pink, Interim Head of Performance		
Title of paper	Trust Board Performance Report						
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.						
Committees /Groups previous presented and outputs	N/A						
Statement on impact on inequalities	Positive impact (inc. details below)			Negative Impact (inc. details below)		No impact (neutral)	X
Action required	For decision			For assurance	X		
Summary of Recommendations and actions required by the author	The In Public Board is asked to: • Note the report						

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Andrew Strevens, Deputy Chief Executive & Chief Finance Officer			Exec 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 July to September 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) and Executive Board Review Dashboard

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 21 September 2021.

The COVID-19 Integrated Dashboard continues to replace the usual operations dashboards in this month's report. Development has begun to identify a range of more meaningful operational metrics for the Board to consider to demonstrate performance across the Trust, however this is being undertaken cautiously 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.

Staff Vaccination

The Vaccination team are completing rounds of data validation of all staff ensuring the information supplied is accurate. Figures cited below include Bank staff who are not currently reported as part of the automated reporting. Figures are as follows:

Double vaccinated	91.85%	5007 staff
1st dose awaiting 2nd	2.79%	152 staff
Declined	1.30%	71 staff
No record of vaccination	3.43%	187 staff
Queries	0.62%	34 staff

Headlines

- 94.64 % of staff have had at least one vaccination
- Queries are due to the inability to recognise data across different datasets, however, statistically this is not significant.
- No Record of vaccination is used is cases which have no information held on the systems, but individuals have not opted out or responded to communications.
- The number of unvaccinated totals c 250 (4.7%) staff.

Waiting Times

Waiting times continue to be one of the biggest areas of concern for the Trust. Services utilise automated Power BI reporting to regularly validate and manage their waiting lists. This active management alongside waiting list forums, and a multi-disciplinary team (MDT) approach, provides oversight and assurance on the waiting lists.

The quality of the information held on the waiting lists continues to improve. This will be aided with the appointment of four Data Assurance Officer roles. These were created to facilitate this improvement; however, the first round of recruitment has proved unsuccessful. These roles are being re-advertised, with support from our communications team to increase visibility and applications to these roles.

Our clinical service lines continue to experience an upsurge in referrals, seen across all service and sub-services. Workforce and workload pressures are increasing, which exacerbates current waiting times.

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

Referrals to our CAMHS services are consistent during July and August, however numbers during the last 6 months have shown to be above the previous levels for this period, indicating the adverse impact of COVID-19 on children and young people's mental health.

Despite this slight reduction overall 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 1: Number of clock running at the end of the month – CAMHS Services

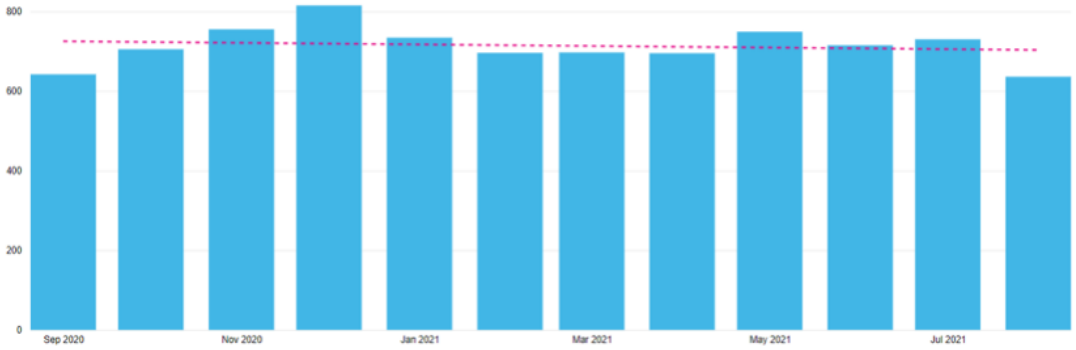
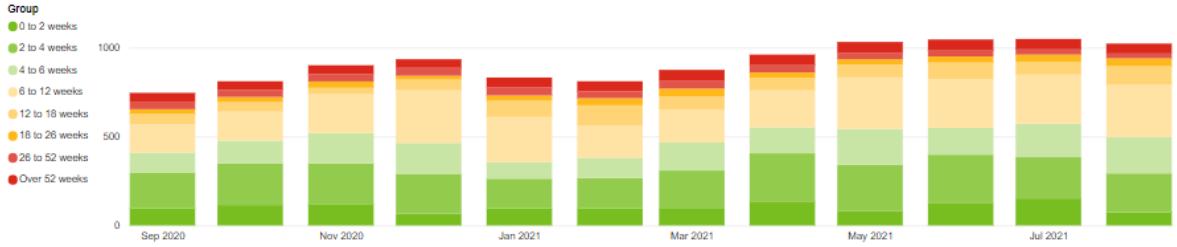


Figure 2: Snapshot of patients on the waiting list at month end – CAMHS Services



In our Special Care Dental Services, capacity to see patients for General Anaesthetic Procedures is still not back to pre-COVID levels due to infection prevention issues around aerosol generating procedures and lack of theatre availability. In the period April-August 2021 525 episodes of GA have been completed with additional lists at St Mary's and IOW secured for September and October which will clear backlogs in this area.

The services are exploring solutions to increase availability of slots for patients with special care needs, working with teams to convert sessions to accommodate them.

Elective Recovery Framework (ERF)

Data

Variation continues between local and System reporting, which the Trust have queried. Performance and Business Intelligence are working closely alongside NHS South Central and West (NHS SCW CSU) to understand the disparity between local and system figures. The rationale being that the variation is most likely due to differing underlying source data (i.e. pre/post validation).

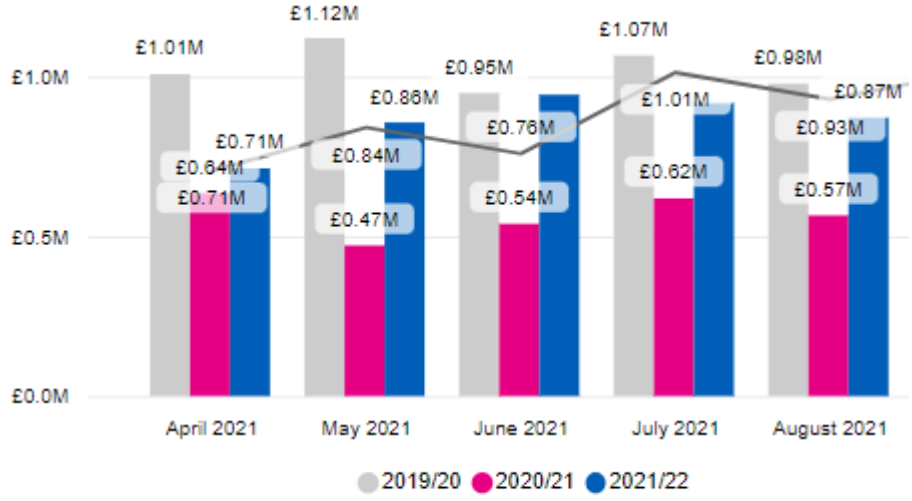
The aim is for Solent to obtain access to the ICS reports (alongside local reporting) to aid system agreement.

Performance

Based on the freeze data the is an over performance of £7k in April and £100k in May. June also looks positive showing a favourable 99%, but confirmation of the final figures has not been received as yet.

Whilst July and August continue positively, as shown in below for financial value generated at 85% and 89% respectively (Figure 1), this is now below the ERF target of 95%.

Figure 1: Performance against threshold for ERF eligible services (locally reported)

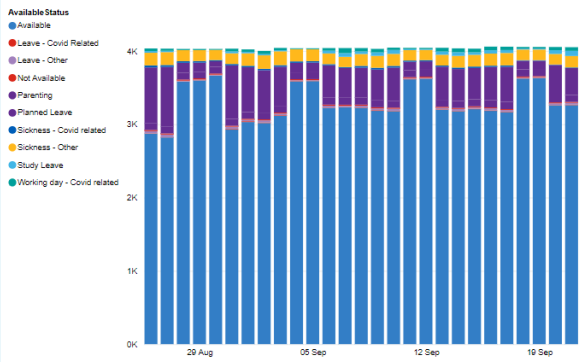


1.2 COVID-19 Integrated Dashboard

Solent NHS Trust

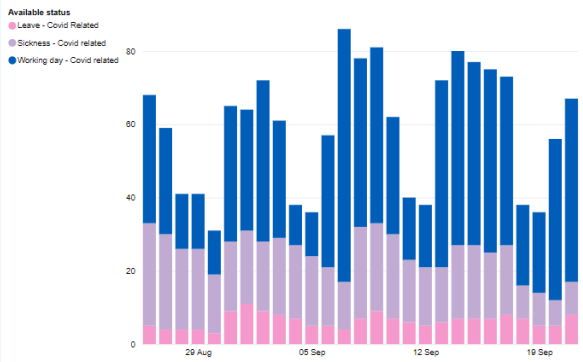
Workforce: Staff availability (HealthRoster)

REFRESHED: NOW



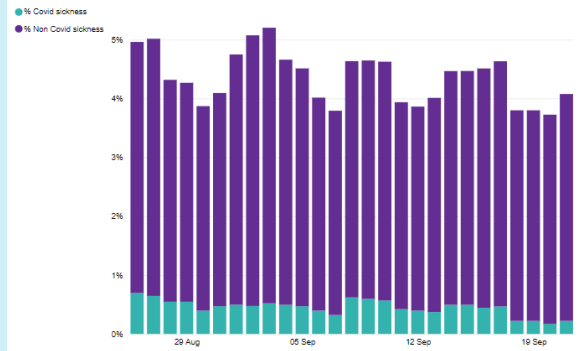
Workforce: Sickness and Covid related absence (HealthRoster)

REFRESHED: NOW



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

REFRESHED: NOW

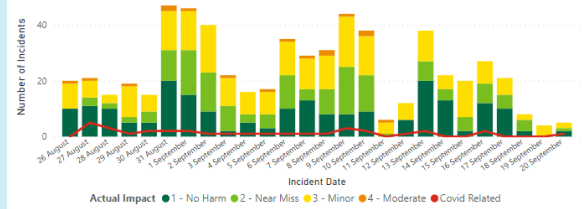


Operations: Inpatient Occupancy/ Capacity (SystmOne)

MOST RECENT POSITION • REFRESHED: 09:03:26

Cost Centre	Total Capacity	Total Occupied	Total DToC	Available Beds	Occupancy %	Date Recor
402550 Orchards PICU - Maples	16	8	1	8	50%	20/09/2021 23
402555 Orchards Acute-Hawthorn	0	0	1	0	NaN	20/09/2021 23
403074 Lower Brambles Ward	24	24		0	100%	20/09/2021 23
403076 Fanshawe Ward	19	19		0	100%	17/09/2021 20
403080 Snowdon Ward	16	15		1	94%	20/09/2021 23
403088 The Kite Unit	10	6	1	4	60%	20/09/2021 23
403130 Spinnaker Ward	16	10	2	6	63%	20/09/2021 23
403156 Brooker	22	11		11	50%	20/09/2021 23
403160 Jubilee Hse Contnu Care	12	10		2	83%	20/09/2021 23
Total	**135**	**103**	**4**		**76%**	

Quality: Number of Incidents (Ulysses)



Quality Community Deaths

COVID - 19 DEATHS (ULYSSES)

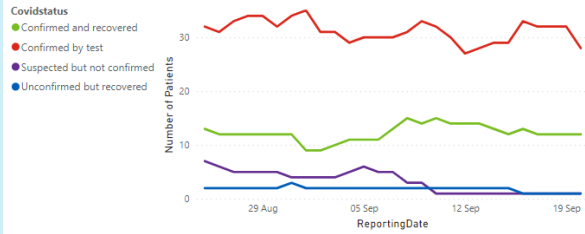
114

Quality Inpatient Deaths

COVID - 19 DEATHS (ULYSSES)

15

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



Quality: RIDDOR

FROM 01/04/2020

7

Workforce: Clinical Supervision Compliance %

74%

1.3 Chief Operating Officers' Commentary and Performance Subcommittee Exceptions

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

Waiting times

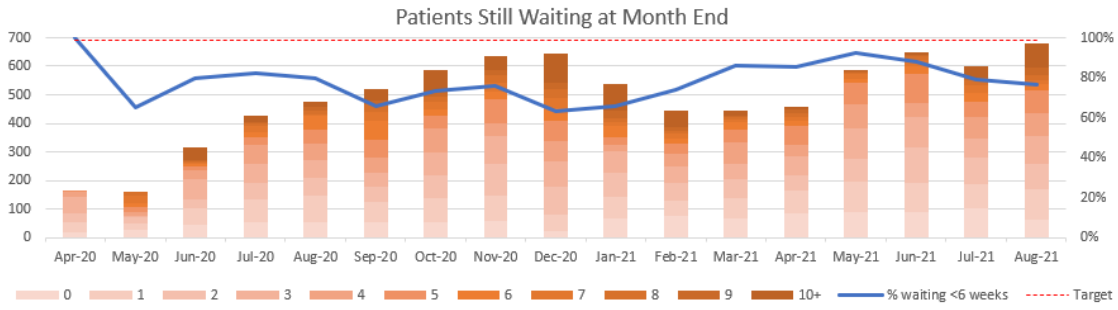
Our clinical service lines continue to experience an upsurge in referrals, seen across all service and sub-services. Workforce and workload pressures are increasing, which exacerbates current waiting times. Wheelchair waits continue to cause concern, with 43 patients waiting over 53 weeks.

Diagnostic performance

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

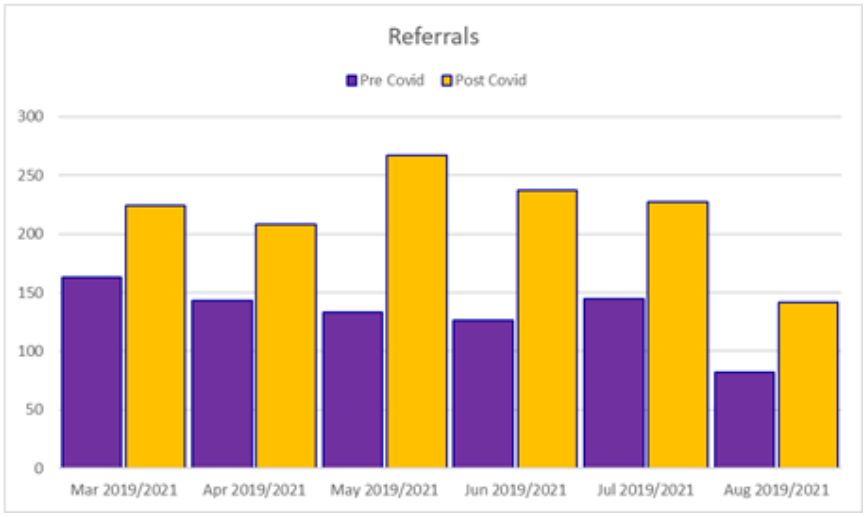
Since December 2020 performance has been on an increasing trend, reaching 92% in May 2021 before showing a slight reduction in in the following months June-August (76%).
Patients seen in month was significantly lower in August, potentially due to staff annual leave reducing capacity after an exceptional level of activity in July (354 patients seen). The waiting list has been increasing for the past five months, reflective of the increased referral rates to diagnostics services as MSK services restore.

MSK diagnostic referral rates are now on average back to 2019 levels. The service is now at 80% capacity, with some additional clinics covered by excess hours. The aim is to achieve 95-100% capacity by December, despite continuing IPC measures.

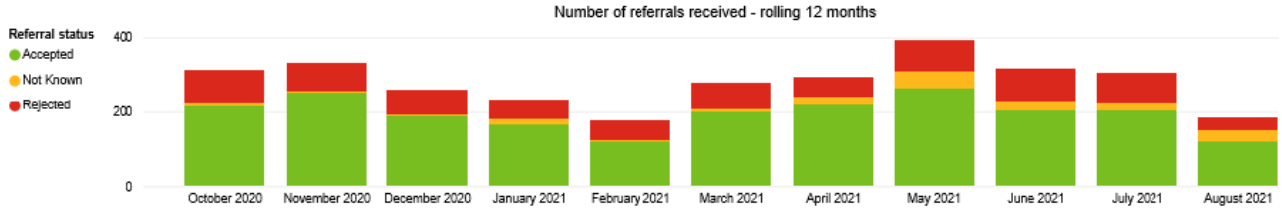


CAMHS West

During August 2021, CAMHS experienced the usual seasonal decrease in referrals, with 132 received, however numbers during the last 6 months continue to be consistently above the same 6-month period in 2020. From March to August 2021, the average monthly referral numbers have been 225, 87 higher than the average for the same average in 2019, before the pandemic, both continuing the increasing national trend but also showing the adverse impact of COVID-19 on children and young people's mental health.



Prior to the August seasonal dip in referrals, with the reopening of the ADHD pathway in May, the service received heightened demand and pressure. The service continues with its mitigations to manage the prescribing practice pressures on the service for ADHD, including continual recruitment attempts, limited allocations of new patients and tendering for the pharmacy project. The service has just advertised for a number of new posts across the Specialist CAMHS team which, if successful in filling, will greatly assist in the most pressurised areas of service.



Eating Disorders Service

The caseload for the Eating Disorders Team has started to plateau over the summer months (currently at 88). However, it is too soon to tell if this will remain the case and we will be watching this as schools return. A revised RAG pathway has been completed and will be reviewed at Clinical Voice. A visual pathway will be used to ensure the needs of young people are met at the right level; this may mean altering current provision models as we previously have done. Previously young people were offered individual work if they had disordered eating, the service would now refer to BEAT following triage if there are no additional complexities or risks that would need to bring them into Specialist CAMHS. In order to best support young people in the community and prevent ongoing admissions in UHS where possible, joint work has occurred between CCNs and Specialist CAMHS regarding the management of NG tubes in the community.

Podiatry

Average 820 referrals a month over past 4 months, with usual average being 664 per month this is up again from 800 last month. Discharge rate is 20% more than referral rate which is a positive. It is of note that 45% of referrals continue to be 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.

Waiting lists show a slight increase but we have seen a drop in waiting times to under 9 weeks on average.

Single Point of access

Single Point of Access

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	
2021	19142	17311	22681	22685	24996	28976	25898	22713	0	0	0	0	184402	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	**19894**	**18256**	**20889**	**18435**	**19790**	**20129**	**21809**	**20904**	**17774**	**18053**	**16846**	**13688**	**226467**	

In 2021 to date we continue to see an increase on 2019 (pre pandemic) we have received 33.400 more calls in the first 8 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.

Musculoskeletal (MSK)

We continue to see an increase in demand, particularly in the west. Some targeted work to address the waiting lists mean the position is an improving one overall but with an increased demand of c20% on 2019/20 volumes for both physiotherapy and specialist physiotherapy in Southampton it does mean longer waits and the additional activity is only able to help us maintain rather than improve the backlogs. MSK Physio West waiting times are increasing but there are a number of different strategies being implemented to address this challenge.

Service	Urgent Wait	Routine Wait
MSK Physio East	2 weeks	10 weeks
MSK Physio West	2 weeks	18 weeks
Specialist Ports	2 weeks	2 weeks
Specialist Southampton	2 weeks	17 weeks
Specialist FG&SEH	2 weeks	6 weeks

Speech and Language Therapy (SLT) – Southampton West

The recovery of the waiting list position within SLT is progressing well. The proportion of patients waiting and particularly those with long waits is reducing, demonstrating that the mitigations in place, (in the form of additional workforce through the system investment) is having a the required impact. The service continues to prioritise data quality with support from their Analyst Lead to ensure continued improvement and accuracy of waiting lists.

Community Neuro Rehab Team (CNRT)

Ongoing impact seen within the size of the waits within CNRT due to the extensive redeployment of this team during COVID. Signs of recovery continue with the average wait at 16 weeks and the numbers of patients waiting over 26 weeks reducing. Mitigations are in place in the form of additional staff members secured through the system investment process, with plans 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 skilled workforce has not be possible to source. A working group is being convened to review and consider future options to address current waiting times. An option under consideration is in the form of a bank consultant in psychiatry.

Special care Dental Service

In the period April-August 2021 525 episodes of GA have been completed. Additional lists at St Mary's, IOW have been secured in September and October which will clear backlogs in this area.

Current waiting times demonstrate that a maximum wait of 47 weeks for children in 2019/2020 has now increased to 137 weeks, and a maximum wait of 39 weeks for adults in 2019/2020 has now increased to 157 weeks. Figure 1 (below) shows median waits for each ICP area.

The service is exploring solutions to increase availability of slots for patients with special care needs, working with teams to convert sessions to accommodate them. New patient referrals are being prioritised to allow GA bookings to be optimised on lists accommodating less complex children.

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.

Age Group	ICP Area	Median Wait (weeks)
Children	Southampton	8.5
	Portsmouth	11.5
	Isle Of Wight	10
	North & Mid Hants	11
	New Forest	13
	East Hants	14
Adults	Southampton	14
	Portsmouth	14
	Isle Of Wight	13
	North & Mid Hants	10.5
	New Forest	19
	East Hants	9

Figure: 1 GA median waiting times, special care Dental services.

There was an agreement that Solent Special Care patients should be considered alongside patients waiting for other elective care via the clinical prioritisation processes. However, at present this would only allow P2 patients to be allocated additional slots. These patients can largely be accommodated on our existing lists and thus far we have not negotiated additional capacity for our large number of P4 patients.

Sexual Health

Vasectomy

The service has seen an improving position within their procedure waiting list for Vasectomy despite having had some issues gaining the sterilised kit to enable procedures to be undertaken. The service has worked with the procurement team to obtain the equipment needed but it is in short supply across the country as providers return to operating. In September there were 27 patients waiting.

The assessments waiting to be undertaken has increased in number. There were 281 people waiting for the pre-operative assessment. Sexual Health are reviewing the healthcare staff available to undertake these assessments. Competing capacity issues and sickness absence seen a reduction of staff available which may have an ongoing effect as services return more fully and children return to school. The team will monitor this closely and attempt to put on additional sessions to improve the position.

The assessment time is on average 6 weeks, with operation waiting times all within 8 weeks.

Data Quality audits are in train to ensure all data is being captured accurately.

Psychosexual Counselling

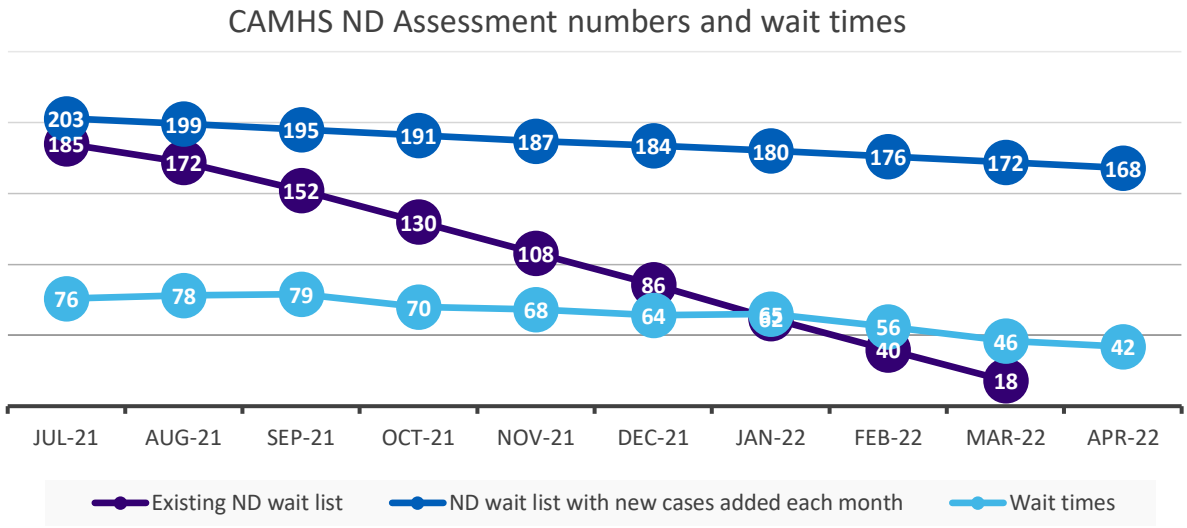
The service is in the process of recruiting to a vacant post following a retirement.
Clients waiting for Initial assessment is 78. No client is waiting for more than 12 weeks for an appointment.
First Therapy appointment waiting time is also a similar position to last month with 22 patients on the list. No client however is waiting longer than 18 weeks.

Solent East Care Group Chief Operating Officer's Commentary

Waiting lists

CAMHS East

The trajectory below shows an improving position for neurodiversity assessments by the end of the financial year with the longest wait reducing from 76 to 42 weeks and a slow but steady decrease in the number of children waiting for an assessment.



Paediatric Therapies

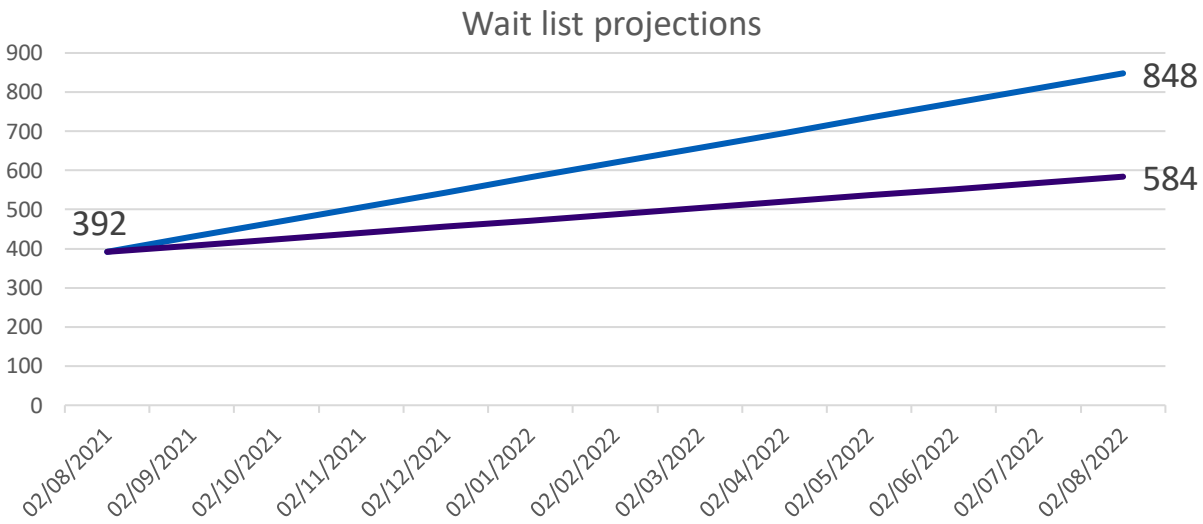
Therapy waits are of particular concern. There are a couple of known data quality issues which have yet to be resolved which will have a positive impact on these numbers.

As with all Solent waiting lists, the service is proactively reviewing the waiting list to ensure those with the greatest need receive treatment.

	Distinct waiters	Average Wait in Weeks	12-18 week waiter	18-26 week waiter	26-52 week waiter	52+ week waiter
Paed Therapies Portsmouth	418	15.3	79	54	87	1
Paed Therapy SE Hants FG	776	17.1	154	132	173	4

Speech & Language Therapy

There is a sustained impact of 1st and 2nd wave redeployments from the SLT team on the waiting list. The introduction of Advice & Guidance for Care Homes shows an improved trajectory (bottom line in the graph below) but still does not keep pace with new referrals.



Wait list plus average monthly accepted referrals minus average monthly discharges

The service continues to focus on clinically urgent/high risk patients and long waiters.

Total number of patients waiting:

- 358 (up from 342)
- 53 over 18 weeks (15%)

	0-18 weeks	18-29 weeks	30-39 weeks	40+ weeks
19-Aug	306	54	6	0
11-Jul	293	40	10	5

Pulmonary Rehabilitation

A change in delivery has been provisionally agreed with commissioners subject to QIA for a temporarily change from 2 x week for 6 weeks to 1 x week for 6 weeks:

- Reliant on patients exercising once a week+ at home between sessions
- Condensed education sessions (covering all topics but some in less detail, supported with full course handouts and signposting to further information)

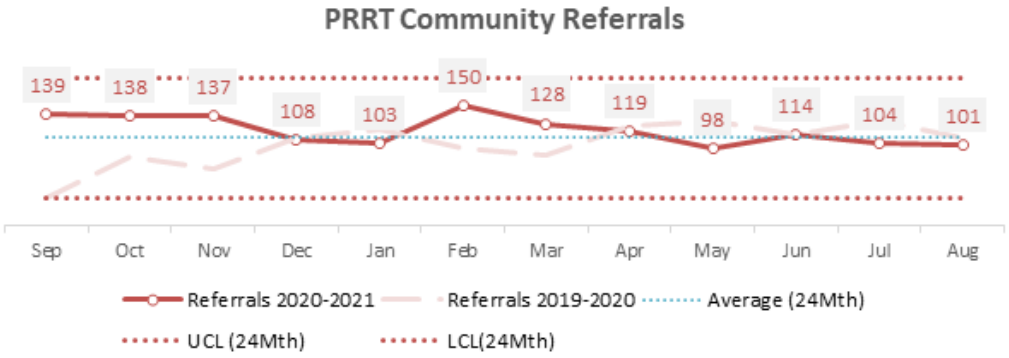
This will clear venue backlog by December 2021, allowing for targeted new referrals from October 21 to commence patient assessment.

- Aim to be able to accept referrals this winter given likely increase in breathlessness
- Will monitor patient outcomes and review at 3 / 6 months

- Monthly meetings with commissioners
- New referral criteria TBC to prioritise patients who will benefit the most and stabilise to sustainable demand levels

Urgent Community Response (PRRT)

PRRT referrals are fairly steady but sickness, vacancies, limited bank and agency cover is causing a reduction in capacity for PRRT (and subsequently a reduction in caseload). This reduction in capacity and challenges with domiciliary care within the city of Portsmouth is increasing delayed transfers of care out of Solent / PCC community beds and PRRT, affecting system flow from the acute hospital.



1.4 NHS Improvement Oversight Framework

Month: Aug-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%	4.8%	?	
	Staff turnover (rolling 12 months)	I	14%	10.7%	P	
	Staff Friends & Family Test - % Recommended Employer	I	80%	*	*	*
	Proportion of Temporary Staff (in month)	I	6%	4.5%	?	
Caring	Written Complaints	I	15	17	?	
	Staff Friends & Family Test - % Recommended Care	I	80%	*	*	*
	Mixed Sex Accommodation Breaches	E	0	0	P	
	Community Friends & Family Test - % positive	E	95%	97.1%	?	
	Mental Health Friends & Family Test - % positive	E	95%	99.1%	?	
Effective	Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	E	95%	100.0%	?	
	% clients in settled accommodation	I	59%	70.0%	P	
	% clients in employment	E	5%	3.6%	?	
Safe	Occurrence of any Never Event	E	0	0	?	
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	3	?	
	VTE Risk Assessment	E	95%	99%	?	
	Clostridium Difficile - variance from plan	E	0	0	P	
	Clostridium Difficile - infection rate	E	0	0	P	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	E	0	0	P	
	Escherichia coli (E.coli) bacteraemia bloodstream infection	E	0	0	P	
	MRSA bacteraemias	E	0	0	P	
	Admissions to adult facilities of patients who are under 16 yrs old	E	0	0	?	
Operational Performance						
	Maximum 18 weeks from referral to treatment (RTT) – incomplete pathways	E	92%	96.9%	P	
	Maximum 6-week wait for diagnostic procedures	E	99%	100.0%	?	
	Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0	P	
	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50%	100.0%	P	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score**	E	95%	91.0%	F	
	Improving Access to Psychological Therapies (IAPT)					
	- Proportion of people completing treatment moving to recovery	E	50%	50.6%	?	
	- Waiting time to begin treatment - within 6 weeks	E	75%	90.0%	P	
	- Waiting time to begin treatment - within 18 weeks	E	95%	99.5%	P	

Use of Resources Score					
Use of Resources Score	E	2	2		

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

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

1.5 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 2021/22 a new System Oversight Framework has been developed to replace the current Oversight Framework. Work is underway to review the guidance and develop local monitoring of this information. This will replace the existing oversight metrics in due course.

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

Complaints

Written complaints have seen a rise to 17 in August, after a fall in July, bring the figures in line with the first quarter reporting. The number of formal complaints made year to date in 2021/22 has been 61.7% higher than in 2020/21, and it is likely to remain higher due to services returning to being fully operational. Last year's figures were not a true reflection due to the impact of COVID on services, therefore the increase in number of complaints should be taken within context.

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

The current DQMI score remains consistent at 91% for the last six months, which sees the 95% target not achieved. The expectation is to realise an improvement over the following months through the restart of internal workstreams to improve quality of the information within the MHSDS submission. The trust is also engaged in a wider System MHSDS group, with the aim to share best practice.

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. Four Data Assurance Officer roles have been created to facilitate improvement; however the first round of recruitment has proved unsuccessful. These roles are being re-advertised, with support from our communications team to increase visibility and applications to these roles. it is envisaged that this team will be overseen centrally but managed locally within and to individual service lines.

Maximum 6 Week Wait for Diagnostics Procedures

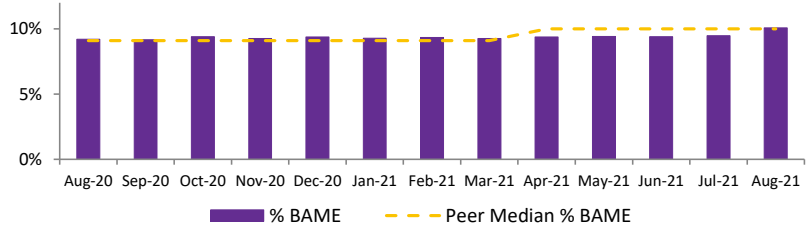
The % performance for individual service lines in the last two months has remained below target at 76-79%. There has been a reduction in the number of scans undertaken by Inhealth, which has contributed to an increase in the waiting list, this can be attributed to the time of the year and annual leave contributing to this reduction in performance. It is anticipated that this will begin to improve again over the next few months.

2.1 Workforce Integrated Performance Report

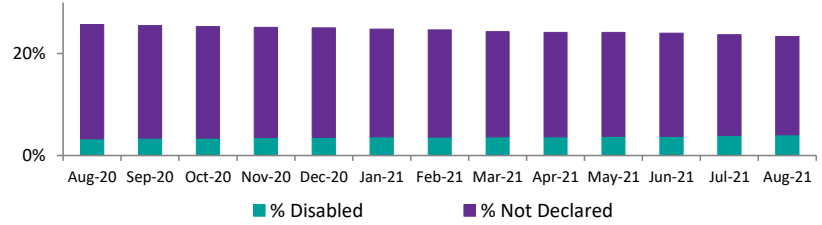
Month: Aug-21

Planning

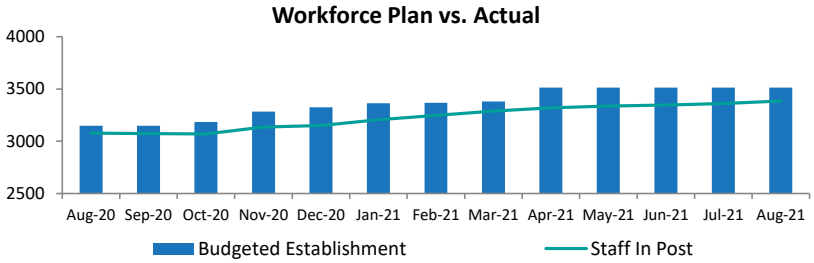
WRES



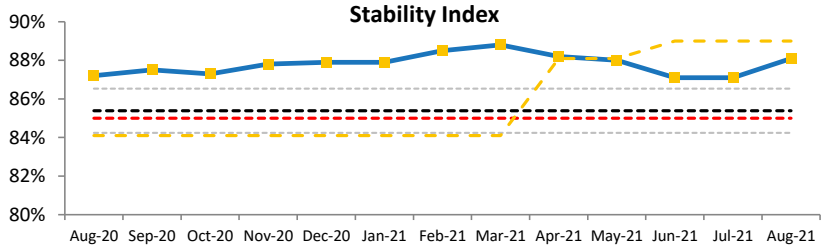
WDES

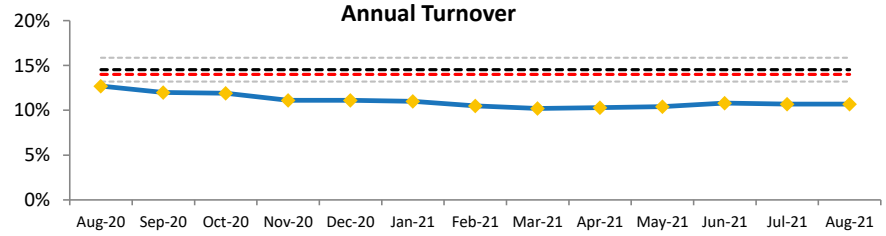


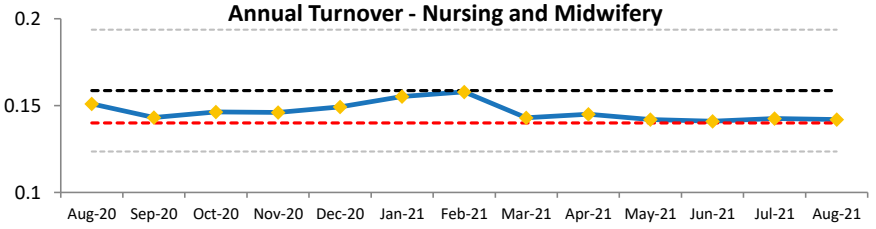
Actual vs. Planned



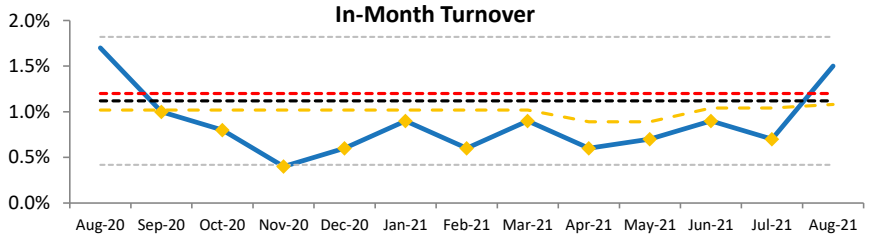
Stability Index







Turnover



Budgeted Establishment has been updated to reflect M1 - M5 following the H1 workforce plan submissions. Plans are in place to update the budgeted establishment with H2 budget during M6 ready for M6 reporting. Stability Index has increased by 1% this month to 88.1%. 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.

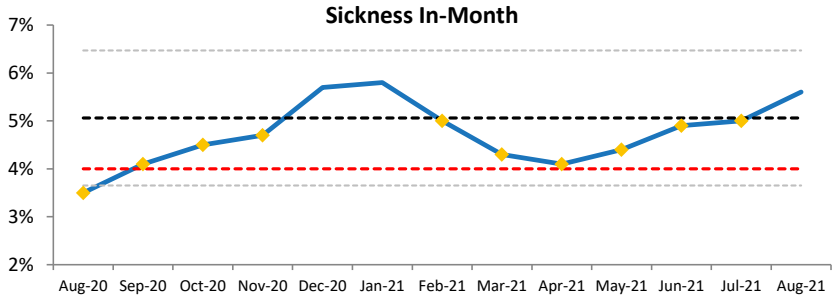
During August we can see our in month turnover increase, this is mainly due to doctor rotation within medical staffing and is consistent with August 20. Annual turnover remains the same as last month. With turnover of staff increasing we can expect the stability index to decrease if leavers are within their first year of employment with the Trust.

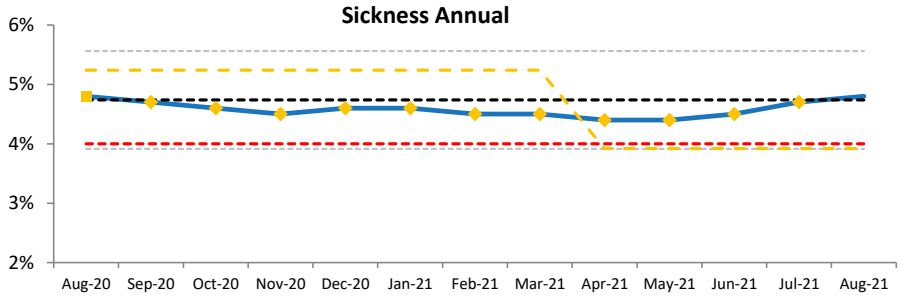
Deployment

Month: Aug-21

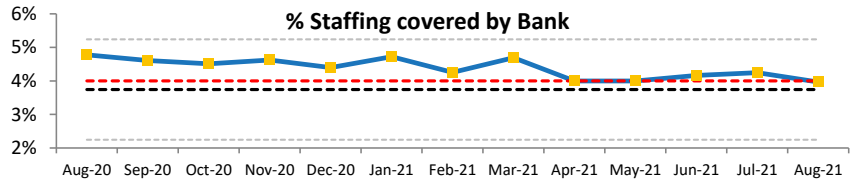
Key: Data | Target | Mean | Upper / Lower Control Limit | 6 Points Above/Below Mean | Rising/ Falling Trend (6 points) | Peer Median

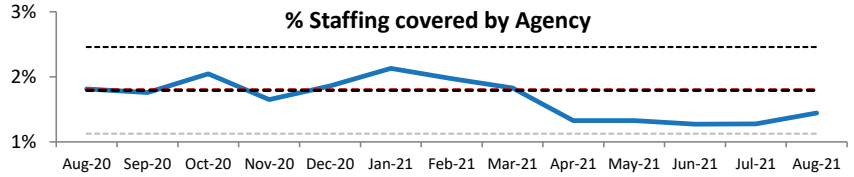
Sickness

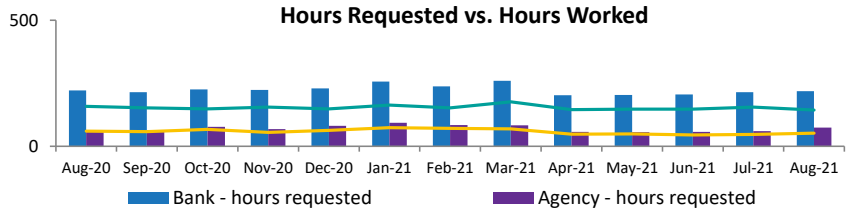




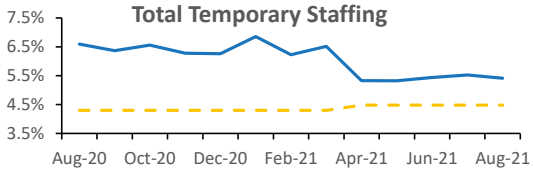
Bank & Agency







In Month Cost: Bank - £319449 Agency - £208711



Rostering

Current Position: 1 / 4

Sickness in-month has increased from 5% to 5.6% during August 21. In month sickness has been increasing over the last 3 months and now exceeds the Solent Mean of 5%. 0.8% of in-month sickness relates to COVID-19 absence, this increased from 0.7% in August.

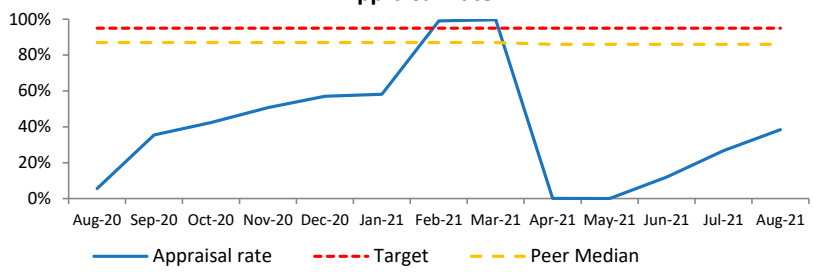
Annual Sickness has also been increasing from 4.4% in April 21 to 4.8% in August 21. Annual sickness was previously reporting below the peer median, however having updated the peer median, Solent are now above the peer median of 3.9% when benchmarked against trusts of the same type at July 2020 (latest data available). We expect to see annual sickness increasing over the coming months based on in month sickness.

Use of Bank and Agency has remained static through August with overall demand totalling 4731 shifts. Bank cover remains at 75% of all requests. Agency cover accounting for 19% of cover. Off framework has increased due to acuity and additional beds on Kite and Fanshawe, along with 1:1 nursing requirements, Sickness and late cancellations. Due to issues with ESR/healthroster data we have also experienced 'No Shows' due to system clearing booked shifts, this has now been resolved. MH Services remain highest user of bank and agency cover.

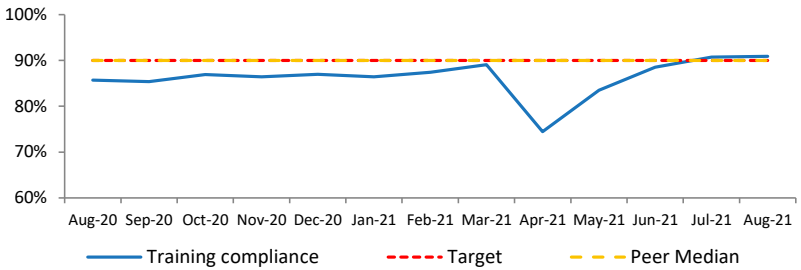
Development

Month: Aug-21

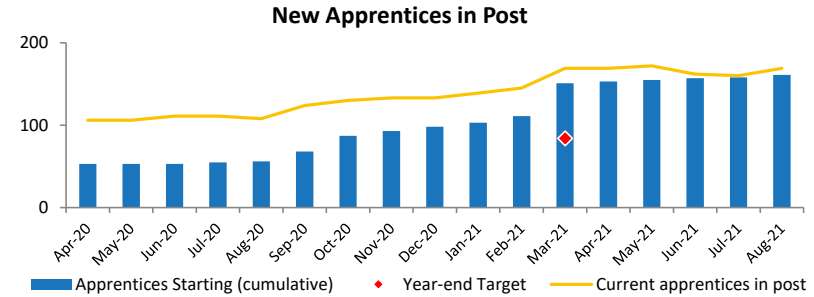
Appraisals



Stat & Mand Training



Apprentices



The LMS platform, My Learning continues to receive good feedback that it is clear and easy to use. The target remains at 90% and by the end of August compliance was 91%. The team are continuing with the development of bespoke tiles for services. The link which will enable data feeds is now in place and work is underway on building data uploads to the BI dashboards for end of September 2021. Manual updates on leavers and new starters are still occurring and manual compliance reports.
Phase 2 is the addition of the appraisal functionality and currently appraisal compliance is at 40%. Phase 3 Design work commences in September, addition of the Nurse Revalidation module. Phase 4 commences in October, design of a new appraisal process that will run from the My Learning System enabling direct data entry and reporting of key development areas from the system.

Of the 191 apprentices on programme, 46 have started in this financial year with further intakes to come and the target being 90 for 21/22. Our top 5 apprenticeship Programmes are; Business and Admin level 3, Registered Nurse Degree, Trainee Nurse Associate, Senior Healthcare Support Worker and Customer Services Level 2. We have procured 3 new apprenticeship programmes during August and will commence advertising and shortlisting during September / October 2021.

Following a successful bid for funding through the generation vanguard retention programme we are

Friends and Family Test (FFT)

Staff Survey

Engagement

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.

Percentage of Staff who would recommend Solent as an Employer

76%

2020/21

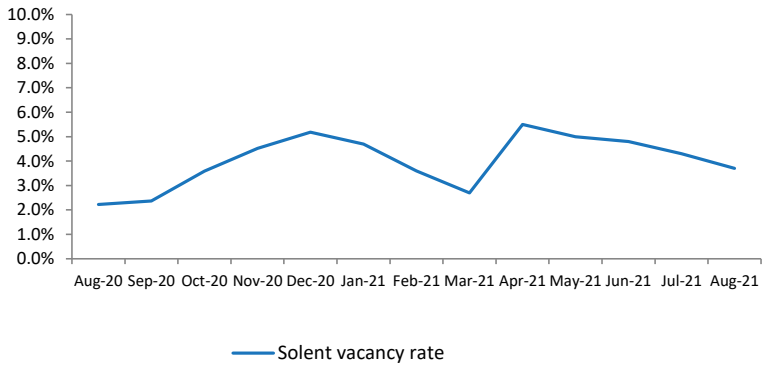
focusing on 2 workstreams; 1) development of a preceptorship plus programme aimed at registered staff post one year of qualifying. A leadership programme is embedded within preceptorship plus as is decision making, prioritisation skills and managing your own and other staffs wellbeing.
2) developing a later life career strategy, ensuring staff have developmental opportunities, aware of career and retire and return opportunities.

Acquisition

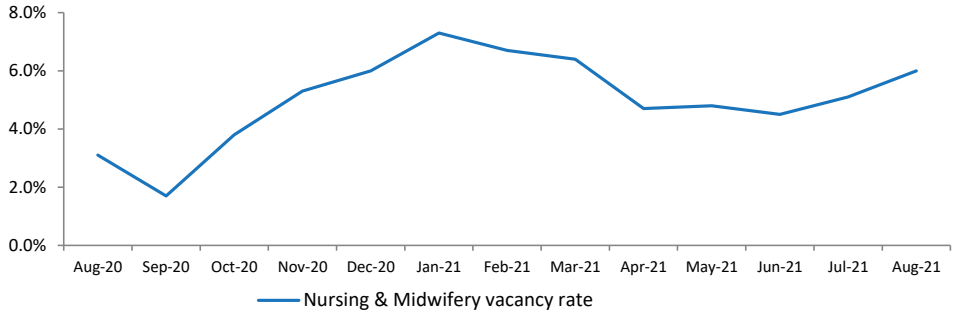
Month: Aug-21

Vacancy Rate

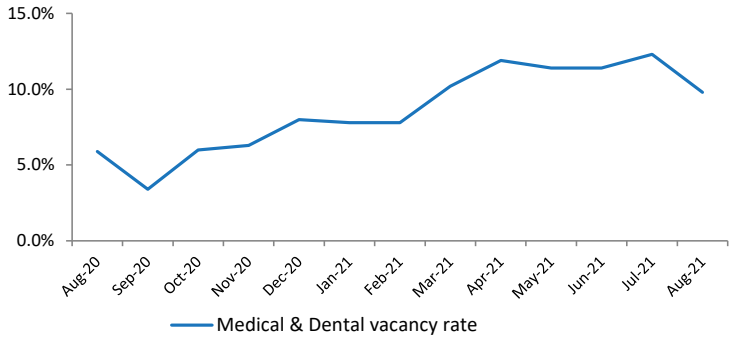
All Staff



Nursing & Midwifery (N&M)



Medical and Dental (M&D)



The Trust vacancy rate has decreased from 4.3% in June to 3.7% in August. The current vacancy rate of 3.7% equates to 129 FTE across the trust. Vacancy rates are highest in Facilities Management and Estates (FME) at 19.6% which equates to 50 FTE, contributing to just over a third of the Trust's vacancy rate. FME substantive recruitment is now making good progress with some successful appointments. A revalidation exercise of listed vacancies is also underway which will help to resolve that vacancies in ESR do not currently match the information that Finance hold. This is due to be updated ahead of M6 reporting where we can expect to see a more accurate reflection of the lower vacancy rates filter through. Mental Health Services vacancy rate 8%, equates to 37 FTE.

We continue to recruit Mental Health Nurses into the Acute/PICU setting in Portsmouth with a total of 8 nurses arriving this month. We aim to recruit a further 5 RMNs which will need to be in the UK by 31st December. Recruitment efforts for general nursing will continue into the final phase for Southampton inpatient units this month. Community Nursing pilot continues to progress, planning the programme prior to opening the vacancy for applications. Further international recruitment activity for 2022 will be reviewed and planned in mid-October.

Leadership and Culture

Month: Aug-21

Learning

The My Learning system is now embedded as the new location for learning content and includes statutory and mandatory training, leadership development content and essential skills. The team are continuing to develop their skills in creating e learning content in house. One of the many benefits of the new system is that it is quick and easy to create a course, assign it to specific groups or services and links to sites such as E Learning for Health can be accessed directly from the system with an option to mark as complete or self declare completion by uploading a certificate.
In August we continued to run the staff induction virtually and held a face to face induction for Junior Doctors. The '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

Results from the first National Quarterly Pulse were shared with all staff, in an easily digestible way, in August. The results include some very positive responses, particularly around how well informed and supported people feel they are. And, people also continued to say that they would recommend Solent as a place to work and, if a friend or relative needed treatment, for the care we provide. However, the results gives some really helpful information about what will make the biggest difference to people at work, right now.

The results are being used to assure that we are focusing in the right areas within the ongoing Staff Survey improvement plan.

Leadership

We continue to promote, via Managers Matters and social media, our programme of Line Management and Leadership Development interventions which combine a mixture of reference guides, e-learning, short videos, reading suggestions and programmes of learning.
The Leadership Development area on the My Learning site continues to be added to. To date:
• Under Line Management Skills (90 minute online workshops): 21 staff have attended 'Making Virtual Meetings Work' and 76 have attended 'Managing an Appraisal'. The first 'Supportive Conversations', using the MECC model to develop conversations that support wellbeing ran with 12 attendees and there are two further workshops to run. The first two Wellbeing Essentials workshops- to support embedding health and wellbeing as a key priority within management practice- are both fully booked with further dates to be announced.
• Under Leadership Development : we have cohorts running of Level 1 Programme 'Stepping in to Management' and Level 3 Programme 'Leading beyond the team'. We have also invited applications from staff for the future cohorts and will be working with the service lines to ensure there is equity of offer and a good mix of service lines for each level.
• Following an accreditation programme earlier in the year, the Learning Development Partner team have started delivering the Team Management Profile (TMSDI) workshop to teams. This is a unique management and team development tool that gives more perspectives on individual performance, high energy teamworking and organisational culture.

Inclusion

WRES and WDES returns were submitted ahead of deadline and the reports and action plans are being developed. Stonewall Workplace Equality Index continues with Stonewall staff survey link circulated (this forms part of the audit). Solent Equalities Monitoring animation finished and ready to be circulated internally and to our service users. Rapid Insight sessions being held for staff ahead of the Big Conversation. They focus on staff views/experiences of discrimination to help inform our externally facilitated sessions further down the line so we can get the most up to date picture on staff experiences of discrimination in addition to WRES, WDES, Staff Survey & Pulse data to give us a real 360 of where we are at as an organisation. Working with the ICS on plans for Black History Month.

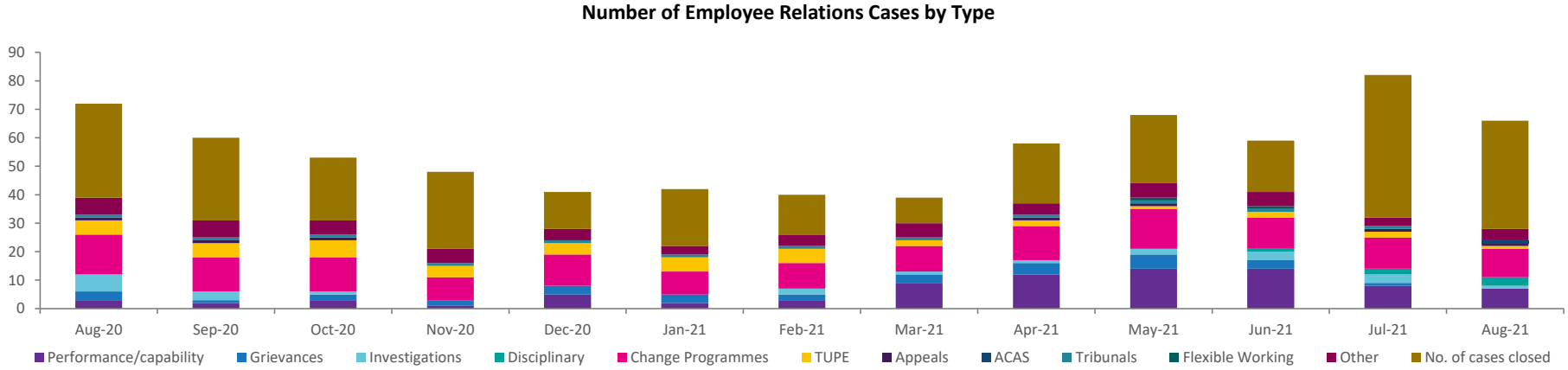
Wellbeing

Occupational Health provision continues to predominantly be anxiety, depression and a range of mental health needs, followed by increasing covid related needs and MSK with a marked increase in sickness absence. Our development work around system metrics will ultimately help us to maximise data information to inform more fully on OH usage, service take up and inform service delivery needs. Referrals continue to be routinely complex and multifaceted requiring longer appointment times and extended periods of input impacting on resource and availability. We continue to review our service delivery options/ resources to respond to the increasing needs through phases of covid 'living' and recovery impacts and wider wellbeing needs for example Stress management courses, Energy management, resilience and 'burn-out' concerns etc planned to target groups of staff and preserve individual resource needs and are attempting to maximise feedback and engagement through 'Lived experience' sessions, Care Groups and Champions network, Our Wellbeing team continue to work with/ respond to managers and teams however capacity impacts on our ability to fulfil all requests to attend meetings and away days and instead, offering resources to be used within teams and ideally via the Champions/MHFA's local resource. We have undertaken a review of Wellbeing Champions/MHFA numbers and spread and are planning strategy review to maximise these roles and their objectives. We are also working with the newly linked people partners to support staff care groups and HIOW network groups to maximise our offer to staff and explore potential developments as well as share our experience and good practice.

Change and Employee Relations

Month: Aug-21

Employee Relations



There are 100 cases currently being managed as at the 31st August 2021, a reduction of 13 compared to end of July 2021. 9% of the 100 open cases are BAME employees, of this total, 6 cases relate to a variety of Employee Relation (ER) issues, 1 of which are absence management, the other 3 cases are attributed to long-term COVID support from OH in collaboration with the People Partnering team rather than formal action, thus would reduce 9% to 6%. For reference of the total staff in post in the Trust, 9% are BAME. There are 11 change management cases, 1 of which is TUPE.
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 2 live informal resolution cases being managed in the month of June by the Resolution Hub which will be transferred to People Partnering plus 1 already within People Partnering 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

100%

Target - 100%

Notes

Month: Aug-21

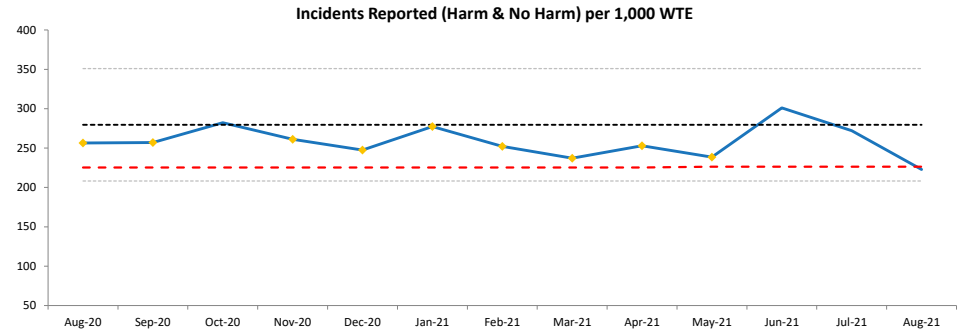
	Metric	Benchmark
Benchmarking	Workforce Ethnicity (WRES) - % of staff who are BAME	Peer median based on the trusts within our STP at April 2021
	Stability Index – Staff retention rate	Peer Median based on the trusts within our STP at March 2021
	Turnover In Month	Peer Median based on the trusts within our STP at May 2021
	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

4.1 Quality Performance Dashboard

Month: Aug-21

Safe

Incident Reporting Rates



YTD	Moderate & Above Incidents	
2021-22	126	
2020-21	109	▲ 15.6%

YTD	Serious Incidents (SI) Raised	
2021-22	7	
2020-21	2	▲ 175%

YTD	Physical/Verbal Assaults to Staff	
2021-22	259	
2020-21	213	▲ 21.6%

Narrative

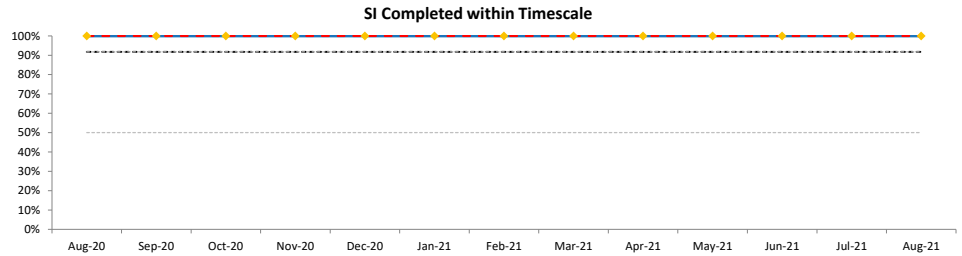
Moderate & above incidents continue to increase steadily. This is attributable to increased numbers of pressure ulcers (PU grade 3 or above). PU form 97% of moderates & above and have increased from 105 in 2020/21 to 119 in 2021/22.

SI declared year to date (YTD) has increased sharply compared to the same period last year; reflecting the impact COVID-19 had on overall incident numbers last year. The number YTD is still below the totals declared in 2019/20.

The number of physical or verbal assaults against staff reduced last year in-line with overall incident numbers. The total for 2021/22 is comparable to the figure for 2019/20.

Effective

SI Investigation and Closure



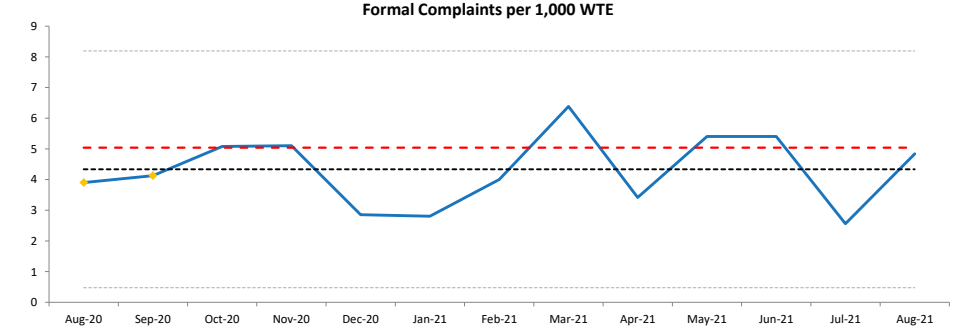
No associated data feed

Narrative

All SI continue to be submitted within agreed timsescales.

Experience

Formal Complaint Rate



YTD	Complaints Received	
2021-22	76	
2020-21	47	▲ 61.7%

Complaints Closed to Timescale		
Target	Actual	
80%	87%	●

YTD	Unsolicited Plaudits	
2021-22	362	
2020-21	277	▼ -23.5%

Narrative

The number of formal complaints made year to date in 2021/22 has been 61.7% higher than in 2020/21, and it is likely to remain higher due to the fact that services have reopened and returned to being fully operational. Last year's figures were not a true reflection due to the impact of covid on services, therefore the increase in number of complaints should be taken within that context.

87% of complaints made YTD have been closed within the agreed timescales. Whilst this is above the target of 80% the Complaints and Pals team works closely with services striving to achieve 100%. Of those complaints received during July and August, 100% were closed within the agreed timescales.

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

3.2 Chief Nurse Commentary (July - August 2021)

Current Events to Note

- **IPC Update: Use of Lateral Flow Devices for asymptomatic testing**
  New Standard Operating Procedure and Frequently Asked Questions cascaded nationally and shared with all teams for information and action. Discussions are taking place to agree the process for providing assurance to the Board as testing kits are no longer being provided directly to and distributed by the organisation which in turn will impact on the reporting.
- **AHP Conference:** Plans are underway for the annual AHP conference which will be held virtually. Nominations for AHP of the year are underway with a closing date of Monday 20th September. This year's conference is being run in partnership with colleagues in the Isle of Wight.
- **Vaccination programme:** The team are currently planning for the delivery of the 12–15-year-olds vaccination programme and the over 50's booster programme in line with national directives. The former will be delivered primarily by the School Aged Immunisation service utilising the expertise within the current Covid vaccination team from the large vaccination centres. There will be additional targeted session for this group in the large vaccination centres to ensure we maximise the opportunity for young people to access their vaccination. The latter will continue to be provided by the large vaccinations centres once the national protocols are updated.
- **Queen's Nursing Institute (QNI) international Recruitment visit and Conference:** Recently colleagues from NHSE/I visited the team who are leading on international recruitment for the Trust and were very impressed and complimentary about the work we have done to support the new recruits, particularly in relation to the pastoral support provided. The team have also recently presented to the QNI international recruitment conference.
- **Nursing Times Nurse Leader of the year:** Angela Anderson, Deputy Chief Nurse, has been shortlisted for the Nursing Times Award of Nurse Leader of the Year. Angela attended the interview with the judging panel on Friday 10th September and will hear the outcome at the awards ceremony on Wednesday 27th October 2021.

Professional Leadership & Clinical Standards

International Recruitment

Within July and August 2021, we have welcomed a further 6 mental health nurses, 4 within The Orchards and 2 for The Kite Unit. All of the nurses have successfully passed their OSCE Exam and currently working through their induction programme.

We continue to participate within the national pilot to introduce international nurses to community nursing. We are in the process of designing and developing a programme to support the transition of nurses to develop the knowledge and skills to work autonomously within the community. The pilot is a national pathfinder model and we hope to be able to share the tools and resources we have developed with other NHS Trusts, supporting them with international recruitment.

We have liaised with both internal and external specialists including:

- A driving instructor to design a programme to support nurses to drive in the UK.
- Our Trust Mobility Lead to source and develop a robust mechanism to enable nurses to have access to pool cars and / or electric cargo bikes.
- Our IT Team to ensure our nurses have the knowledge and skills to use our IT systems and be mobile, accessing the appropriate technology.

- To source accommodation
- To create a robust programme to ensure our nurses have the correct clinical skills.

The pilot has immense support from the community teams in both Portsmouth and Southampton, who are keen to participate and develop our programme.

Perfect Ward
During July and August, we have taken the opportunity to review our audits within the Perfect Ward App. This is to ensure the audits can be undertaken within all our inpatient areas.
A workshop event was held to review and from there we have engaged with the IPC and Medicines Management Team.
We are currently reviewing the existing audit programme with the Clinical Effectiveness Team to establish further audits that can be completed via the App.

July – August 2021 Performance

Incident Updates

Overall incident numbers have continued to rise in July & August 2021, as shown in the table below. Of particular interest is the sharp increase in incidents classified as Near Miss, which has increased tenfold compared with 2019 and more than doubled since July & August 2020. This is partially offset by a 37% reduction in the number of incident reports graded as No Harm in 2021. This indicates a shift towards the reporting of incidents which can be learned from, and actions taken, to prevent future harm occurring.

Four High Risk Incidents were reported in July & August 2021, compared with 9 in 2020 and 4 in 2019. Included in these is the investigation of how a patient was able to start a fire which prompted the evacuation of staff and patient's a Brooker Ward. Feedback from the Fire Brigade at the time of the incident praised the staff concerned for their professionalism in handling the evacuation.

The number of Incidents classed as Moderate reduced significantly in July & August 2021 when compared with the same months in 2020 and 2019 (see table below). However, the proportion attributable to Category 3 or above Pressure Ulcers remains static at 91%. Of the 3 non-pressure related Moderate incidents, 2 are being investigated as Serious Incidents and 1 as a High-Risk Incident. The learning and actions from these will be presented at upcoming Learning from Incidents & Deaths Panels.

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	1648	-	41	-	29	70.7%
2020	1635	-0.8%	46	+12.2%	42	91.3%
2021	1754	+7.3%	34	-26.1%	31	91.2%

Serious Incident (SI) Update

In July & August 2021, we declared one Never Event and 1 Serious Incident investigation (see table below for details). This compares to twelve Serious Incidents in July & August 2019 whilst none were declared in the corresponding months last year.

Service Line	Cause Code	Description
Special Care Dental Service	Never Event	A dental prop was left in the mouth of a

	Equipment – Non-medical	10-year-old patient after surgery.
Adult Services Portsmouth	Diagnosis	Troponin levels were not included in the blood test of a patient experiencing epigastric pain, which meant a cardiac incident was not immediately diagnosed.

The Serious Incident noted above, which occurred in Adult Services Portsmouth, is being investigated using a case review methodology. This approach, if successful, will be used more frequently as we move towards implementation of the Patient Safety Strategy.

Six Serious Incident Investigation reports were submitted to Commissioners in July 2021 and all have been agreed and closed. Four of these related to individual cases of HCAI following the Outbreak of COVID-19 on Brooker Ward. For the second time this year, the learning from these reports was presented in the form of a thematic review at an Extra-ordinary Learning from Incidents & Deaths Panel.

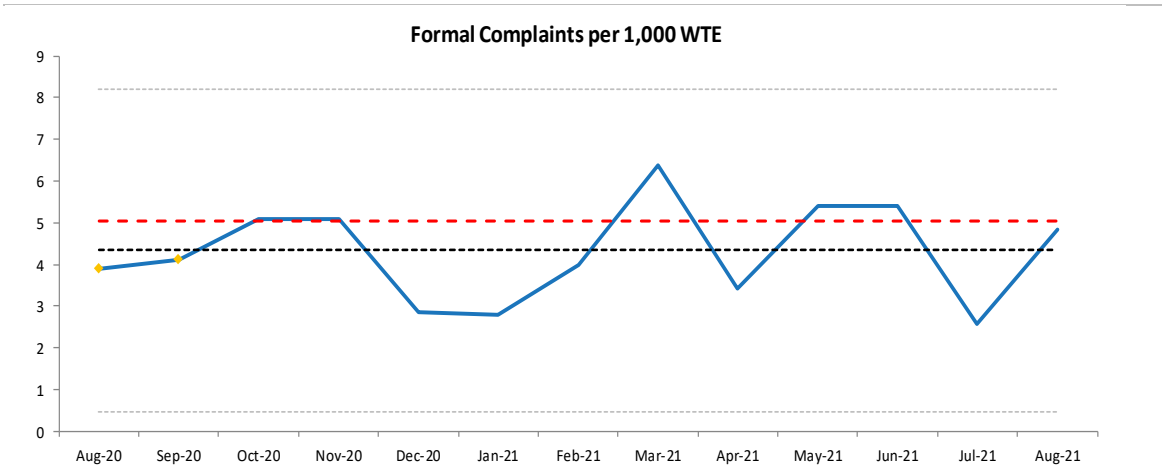
Complaints Update

In July and August, the Trust received a total of 26 formal complaints. These complaints include 1 MP complaint and 3 escalated service concerns. During this period a total of 9 Professional Feedbacks have also been received.

It should be noted that the July/August formal complaints data shows a reduction of 13 from the complaints that were made in May and June. All service lines across the Trust saw a decrease in complaints (except corporate services which increased from 1 to 2 complaints). The most notable decrease was seen by Adults Portsmouth which decreased from 9 complaints to 2 over this period.

The SPC chart below shows the complaints data per 1,000 WTE and does not indicate any statistically significant variation. Year to date data shows that there have been 76 complaints received which is 61.7% higher than the same period in 2020/21. This is a further reflection of services operating more normally in 2021 than in 2020, with more people using Trust services.

It should be noted that of all the complaints received in July and August, 100% were completed within the target timescales. However, across the year from August 2020 only 87 percent were closed within the timescales this is still above the Trust target of 80%.



Themes of Complaints

The top three themes for complaints in Q2 - looking at July and August only, are, clinical complaints which had the highest number of complaints at 13, followed by complaints regarding the attitude of staff which had 6 complaints followed by complaints regarding communication and information given to staff.

The team is putting in place a number of measures to support the service lines including:

- Exploring the development of a visual representation focusing on the role of the team and support that can be provided by the team is being developed to help build stronger relationships with the service lines.
- Exploring starting a QI project focussed on addressing communication complaints.
- New PALS & Complaints manager appointed and started in role 6th September 2021.
- We shall be piloting the NHS Complaints standard framework with the Children and Families service line. We are currently in the process of developing the framework with staff and parents and families with the aim of fully starting the pilot later this year.

Friends and Family Test (FFT)

Review of approach to reporting FFT
We are in the process of reviewing how we report our FFT figures and will be moving away from the 95% threshold held locally, which we have reported against previously. This direction of travel is in line with updated national guidance which now makes it much clearer that FFT is not to be regarded as a benchmarking nor a performance tool. Therefore, we are transitioning to a position of reporting the themes and addressing how we have responded as an organisation to this feedback.

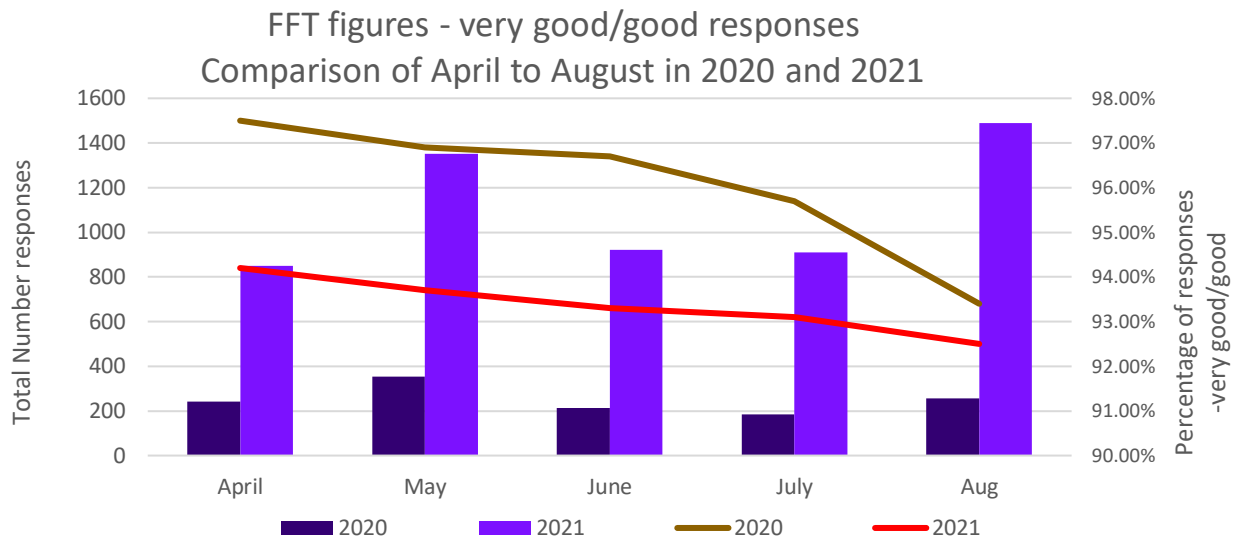
The chart below clearly illustrates the significant increase in the number of FFT responses in 2021 in comparison to the responses received in 2020, for example the increase in August was from 257 in 2020 to 1488 in August 2021.

The increasing number of FFT responses in 2021 are a reflection of services being reopened and being normalised following various stoppages that occurred in 2020 due to the pandemic.

Based on the much lower number of responses, the percentage of those that responded very good/good (see line chart below) were consistently higher in 2020 than 2021. However, in both years there was a steady downward trend from April to August.

The graph below illustrates the trend in FFT responses of all those who responded Very good/good in the period between April and August 2020 and over the same period in 2021.

It should be noted that in both years the percentage of those who said poor or very poor was consistently below 5 %.



Themes for FFT responses

The themes of the feedback from those who said very poor/poor continues to broadly be around waiting times for appointments and telephone waiting times.

The main themes over the past two months have been:

- Waiting time for appointments
- Telephone waiting time
- Limited service
- E Consult – problems with the link, not opening

This reflects the pressures that most services are under as they tackle the backlog of work whilst services return to business as usual.

Some of the comments made are highlighted in the table below:

E and phone consults	• Would feel better if I actually got seen by a Dr. I think it's incredibly irresponsible to diagnose over the phone. • Waited 1hr 5mins to talk to receptionist. Waited 8 HOURS FOR DOCTOR TO PHONE. This is disgusting.
Waiting Times	• It's impossible to get an appointment, and when you do get one you are fobbed off. The amount of time I had to wait for the appointment was frankly dangerous and damaging. Had to wait about 11wks for an appointment. • The Dr only contacted us back last week which was approximately 10 weeks after we placed the request to have an appointment and speak to a Dr.

Supporting Service Lines

There are a number of activities that we have put in place to support the service line, these are outlined below:

- A large number of complaints/concerns and FFT were received during June/July, regarding the length of time it took one particular service line to answer the telephone. In August 2021, with the support of our volunteers, the Patient Experience Service did a Mystery Shop on the service line concerned. The Mystery Shop took place over a two-week period (including weekends) and the findings were shared with the service line. The calls were made at different times throughout the day and 43 calls were made in total of which:
  - Average time to answer the call was 1 minute or less (23 calls being made)

  - 14 calls took between 1 minute and 10 minutes
  - 6 calls took longer than 10 minutes and one took 30 minutes to answer the call.
- Working with the Data Warehouse team to make sure other patient systems R4 and inform are suitable for sending SMS – the same way as SystmOne
- At the quality review meetings, we make the professional leads aware of the response rate for each team
- One to one (or) team training sessions on CIVICA
- Personalising / Designing service specific surveys

4.1 Chief Finance Officer Commentary

Month 5 Results

The Trust is reporting an in month adjusted deficit of £194k, £19k favourable to plan. Year to date the Trust is reporting an adjusted deficit of £743k, £555k favourable to plan.
The in-month favourable variance is due to recruitment delays in specific services, reduction in COVID expenditure and recognising HDP income to match costs incurred to date, partially offset by recognising sexual health under activity with Local Authorities and costs associated with our IT reprocurement.

Covid-19 Expenditure

The Trust continues to incur additional expenditure because of Covid-19. The reported in-month costs were £209k compared to an expenditure budget in the plan of £435k. Year to date costs are £1,578k compared to an expenditure budget of £2,408k

The Trust will continue to receive a COVID block and top-up and growth funding allocations covering April to September 2021. The Trust is awaiting confirmation from the ICS regarding H2 allocations.

Covid Vaccination Centres Expenditure

The Trust incurred expenditure in month totalling £698k (£3,211k 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.

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 awaiting 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 £79k (£738k year to date) and spend will increase as projects progress through the approval process.

Cash

The cash balance was £34m at 31 August 2021, £1.6m higher than the previous month. The increase is a result of Q1 vaccination centre funding received in month and a number of overdue Local Authority invoices being paid.

The forecast cash balance at the end of the financial year is £28m.

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.

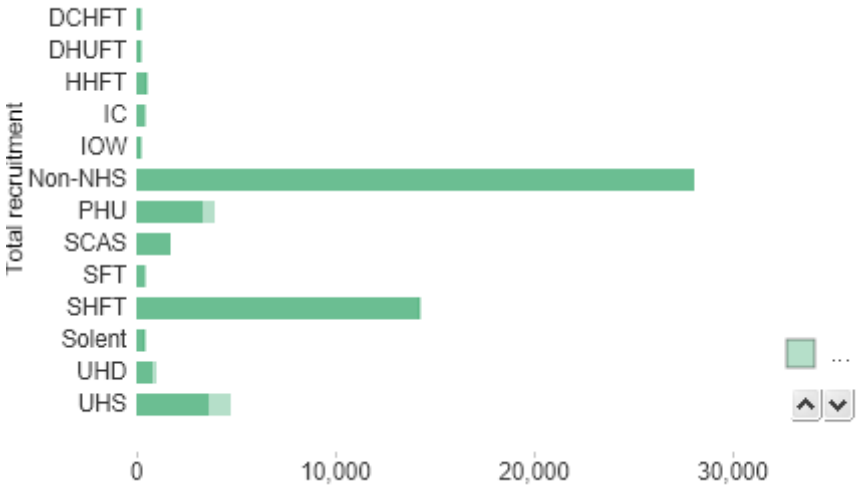
Aged Debt

The Trust's total debt was £3.2m at the end of August, a decrease of £1.5m on July, primarily due to receipts from Local Authorities. 91+ days overdue debt at the end of month was £0.3m, a decrease of £0.3m from July, being the result of 2 invoices that were 91+ days overdue being paid.

5.1 Research and Improvement Commentary

Research

National 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. ▪ Approximately 70% of research staff resource is still required to run COVID studies limiting the scope for additional work currently. ▪ The Siren Study has been extended for a further year which will impact on resource ▪ We have negotiated with the CRN an exit strategy for staff currently working at the vaccine research hubs. The majority will be leaving by the end of November. This will free up time to concentrate on non-COVID research. ▪ 23 trials are currently opened to recruitment, of which 12 have opened within the last month. ▪ A further 6 trials are expected to open over next 4-8 weeks. ▪ We have recruited over 450 new participants to trials since April 2021 ▪ The table below shows comparative participant recruitment across Wessex. Please note, vaccine trial participants mapped only to PHU and UHS. Southern Health high recruitment is due to one study, The Psychological impact of COVID – 19. 

Audit and Evaluation

108 local audit and evaluation reports were received during 2020-21 which equated to 107 received the previous year. The table below shows the numbers of projects received since 01.04.21.

	Local Projects		
	Projects on plan	**Reports received**	**Completion rate**
Adults Portsmouth	31	6	19%
Adults Southampton	42	5	12%
Child & Family	36	7	19%
Mental Health	19	0	0%
Primary Care - MPP	39	6	15%
Primary Care - Other	3	2	67%
Sexual Health	28	3	11%
Specialist Dental	22	2	9%
Totals	**220**	**31**	**14%**

The completion rate of 14% to date equates to the same rate at this time last year i.e., most reports come in during quarters 3 and 4.

6.1 NHS Provider Licence – Self Certification 2021/22 – September 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 are regularly reviewed.

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 are regularly reviewed.

Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. Established escalation processes allow staff to raise concerns as appropriate.

Requirement

6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Response

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

Details of the composition of the Board can be found within the public website.

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

Item No.	12.1			Presentation to	Trust In Public Board		
Title of paper	NHS Staff Survey action planning update						
Purpose of the paper	Example: The aim of this paper is to update the Board on the actions we are taking in response to the 2020 NHS Staff Survey results to improve working experiences. The paper also provides an overview of the results from the first National Quarterly Pulse Survey, undertaken in July 2021.						
Committees /Groups previous presented and outputs	Long term action team plan presented to September Workforce and Organisational Development Committee.						
Statement on impact on inequalities	Positive impact (inc. details below)	x		Negative Impact (inc. details below)		No impact (neutral)	
Positive / negative inequalities	Everybody's voice counts; the annual and quarterly surveys encourage diversity of voice from across the Trust.						
Action required	For decision			For assurance	x		
Summary of Recommendations and actions required by the author	The Board is asked to: • Note the NHS Staff Survey long term action plan • Note the Quarterly Pulse Survey results and their link to the long term action plan						
To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Jas Sohal, Chief People Officer			Exec Sponsor signature:			

Item 12.2

NHS Solent NHS Trust

NHS Staff Survey action planning

Board update

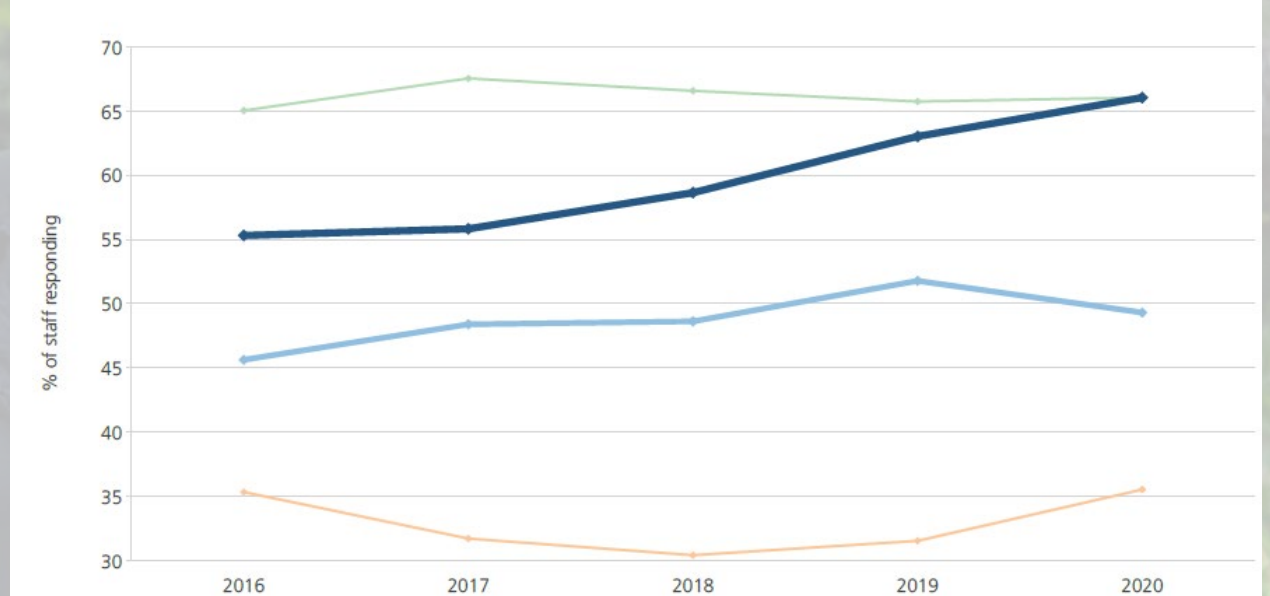
2020 NHS Staff Survey – Response rate reminder

66% completed survey

2,378 respondents

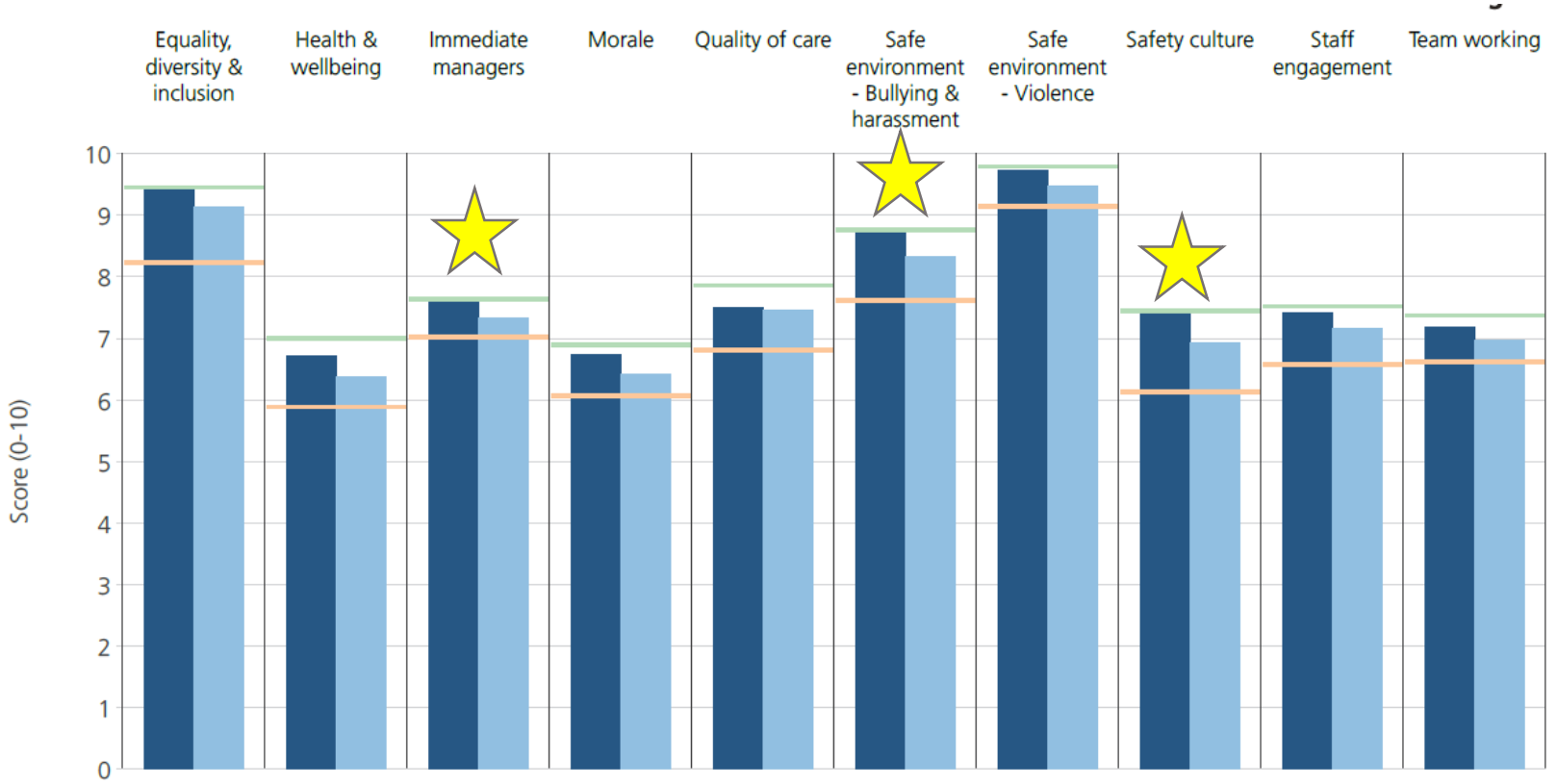
63% previous response rate

49% average response rate for similar Trusts



	2016	2017	2018	2019	2020
Best	65.0%	67.5%	66.5%	65.7%	66.0%
Your org	55.3%	55.8%	58.6%	63.0%	66.0%
Median	45.6%	48.4%	48.6%	51.8%	49.3%
Worst	35.4%	31.7%	30.5%	31.6%	35.6%

Theme results – Overview reminder



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.4	6.7	7.6	6.7	7.5	8.8	9.7	7.5	7.4	7.2
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	2,347	2,367	2,361	2,364	2,027	2,336	2,354	2,365	2,372	2,317

Best performing:
3 themes

Above average:
9 themes

Average:
1 theme

A reminder of how we identified areas for improvement

Solent NHS Trust

Themes where we score closest to ‘worst’ organisation or where we score average

Lower scoring themes

Lower scoring questions (benchmark of 60%)

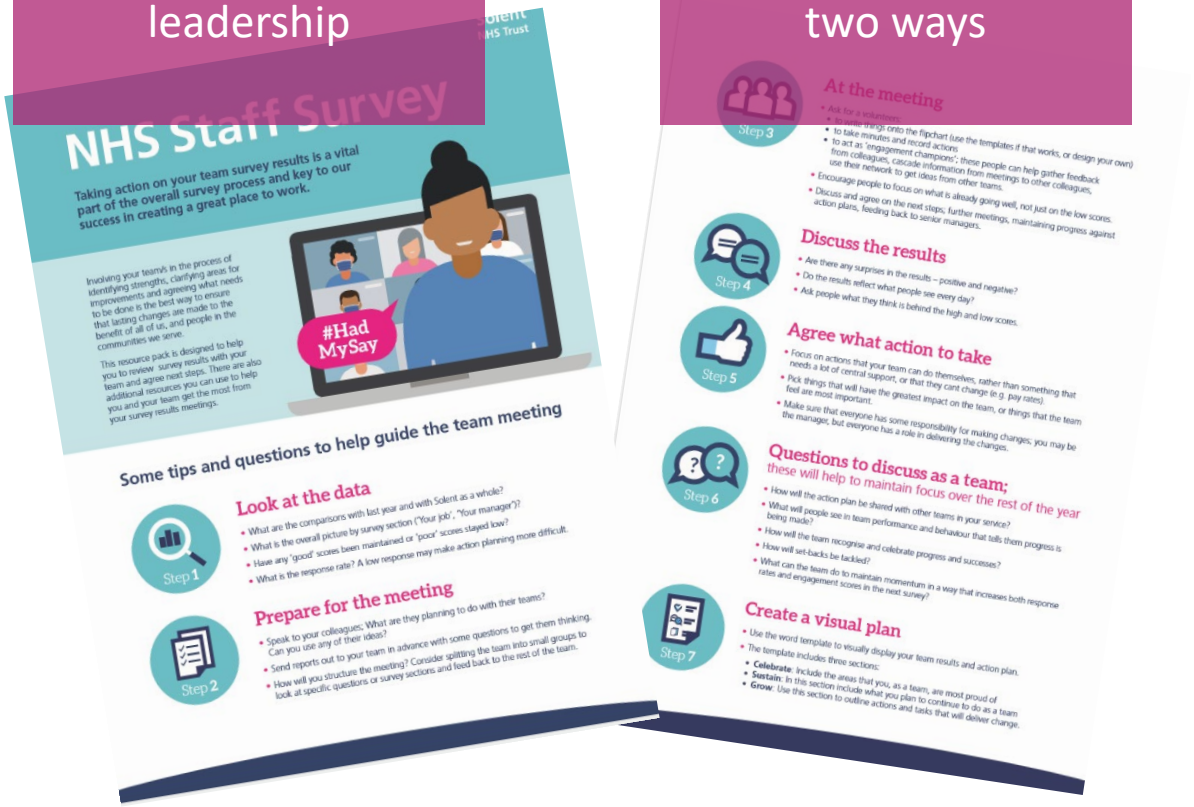
Analysis to highlight key themes

Action planning at Trust wide and local level

Not an additional job – intrinsic part of leadership

Top down and bottom up – conversation is two ways

Toolkit developed to support curious conversations: **Celebrate, Sustain, Grow**



NHS Quarterly Pulse Survey

July 2021 headlines

964 people took part

Colleague feedback:

84.1%
of people said they felt informed

73.5%
of people said they felt supported

67.7%
of people said they could have a work-life balance

81.1%
of people said they have confidence in local leaders

How did people feel the day before they took the survey?

62.5% of people said they felt calm

24.9% of people said they felt anxious

58.9% of people said they felt motivated

24.3% of people said they felt unmotivated

The top three things people said would make the biggest difference to them at work

- Enhanced IT support
- Greater flexibility to working schedule / pattern
- More updates on changing operations / ways of working

Engagement

These questions reflect how people say they feel whilst at work; engaged staff will recommend the Trust as a place to work and receive treatment.

62.4% said
they look forward to going to work

75% said
they are enthusiastic about their job

80.5% said
time passes quickly when they are working

69.3% said
there are frequent opportunities for them to show initiative in their role

73.8% said
they are able to make suggestions to improve the work of their team/ department

62.5% said
they are able to make improvements happen in their area of work

85% said
Care of patients and services users is the organisation's top priority

72.6%
said they would recommend Solent as a place to work

80.6%
said if a friend or relative needed treatment, they would be happy with the standard of care provided

Three pieces of feedback

about the NHS response to COVID-19 people said they would like to share

- Thank you / well done / NHS has responded well
- Improve safety guidelines / improve guideline enforcement
- Colleagues are overworked / tired / workload is too high

NHS Solent NHS Trust

Trust-wide improvement themes

NHS Solent NHS Trust

HEALTH AND WELLBEING

A workplace that supports self-care, helping people to look after themselves so that they can better care for people and support their colleagues.

GENUINE INVOLVEMENT

Creating an environment in which people have an impact on decisions and actions that affect their jobs.

MANAGING THE BALANCE

Creating a workplace that helps people to manage conflicting demands more effectively and which supports work-life balance.

DIVERSITY AND INCLUSION

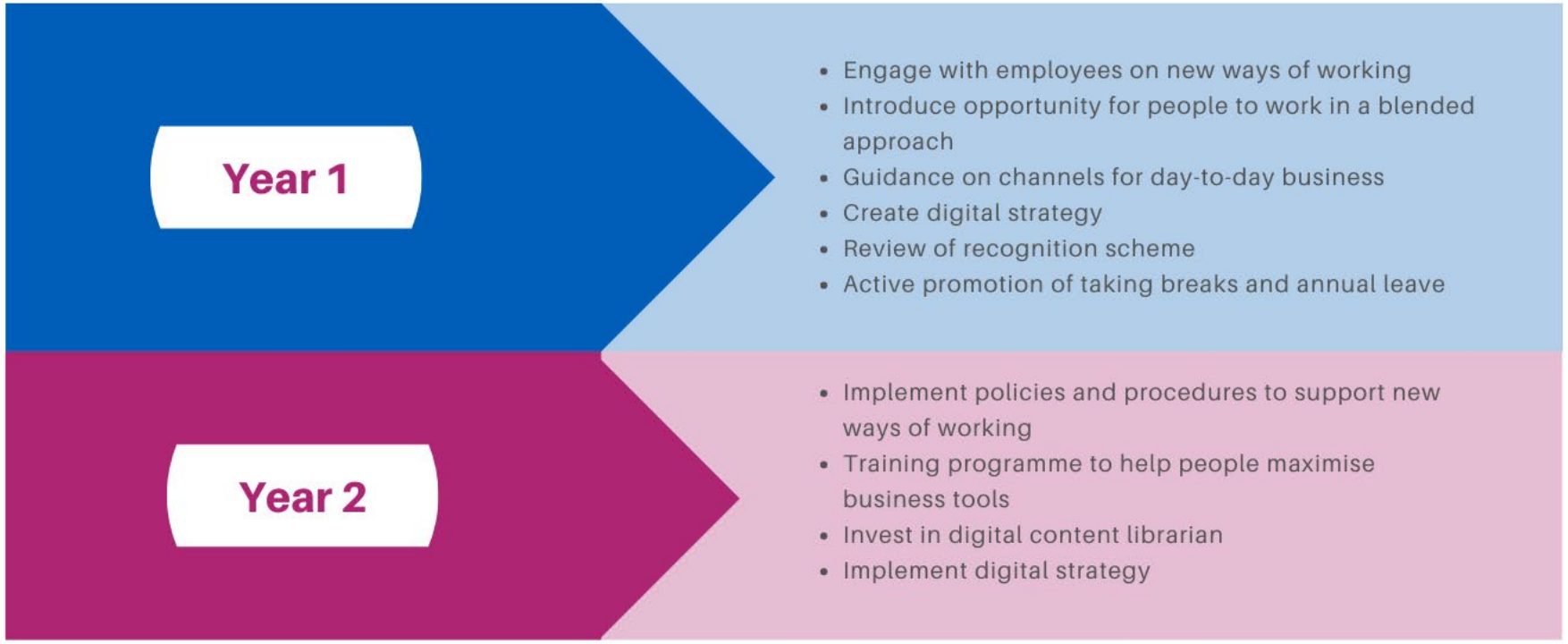
Building greater inclusivity to build the right culture for our people and our service users.

Genuine involvement action plans

We will know that we have made improvements when...

- Our staff engagement survey score is at 7.6 or above
- Our immediate managers staff survey score is 7.7 or above
- Evaluation from engagement events say that people have enjoyed the opportunity and they have made a difference to them
- There is a high response rate to the quarterly survey

Managing the balance action plan



We will know that we have made improvements when...

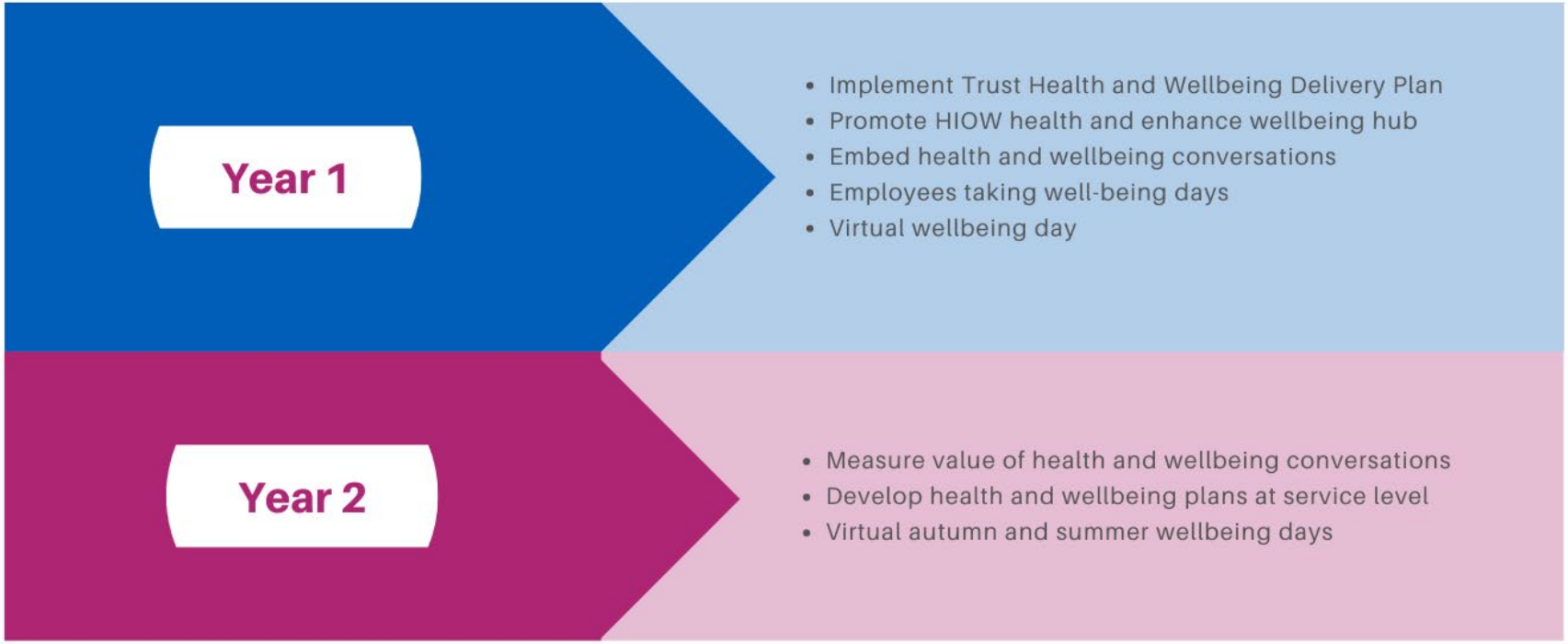
- Feedback from colleagues is that they have flexibility in their roles
- More people are nominating their colleagues for Solent Awards
- More people are using Teams to communicate and there is less email traffic

Diversity and inclusion action plan

We will know that we have made improvements when...

- Our equality, diversity and inclusion theme score in the Staff Survey is 9.5 or above
- No colleagues experience discrimination at work, reported via the Staff Survey
- All service lines have proportionately represented staff, in line with the latest census data
- Our employee networks have an increase in membership

Health and wellbeing action plan

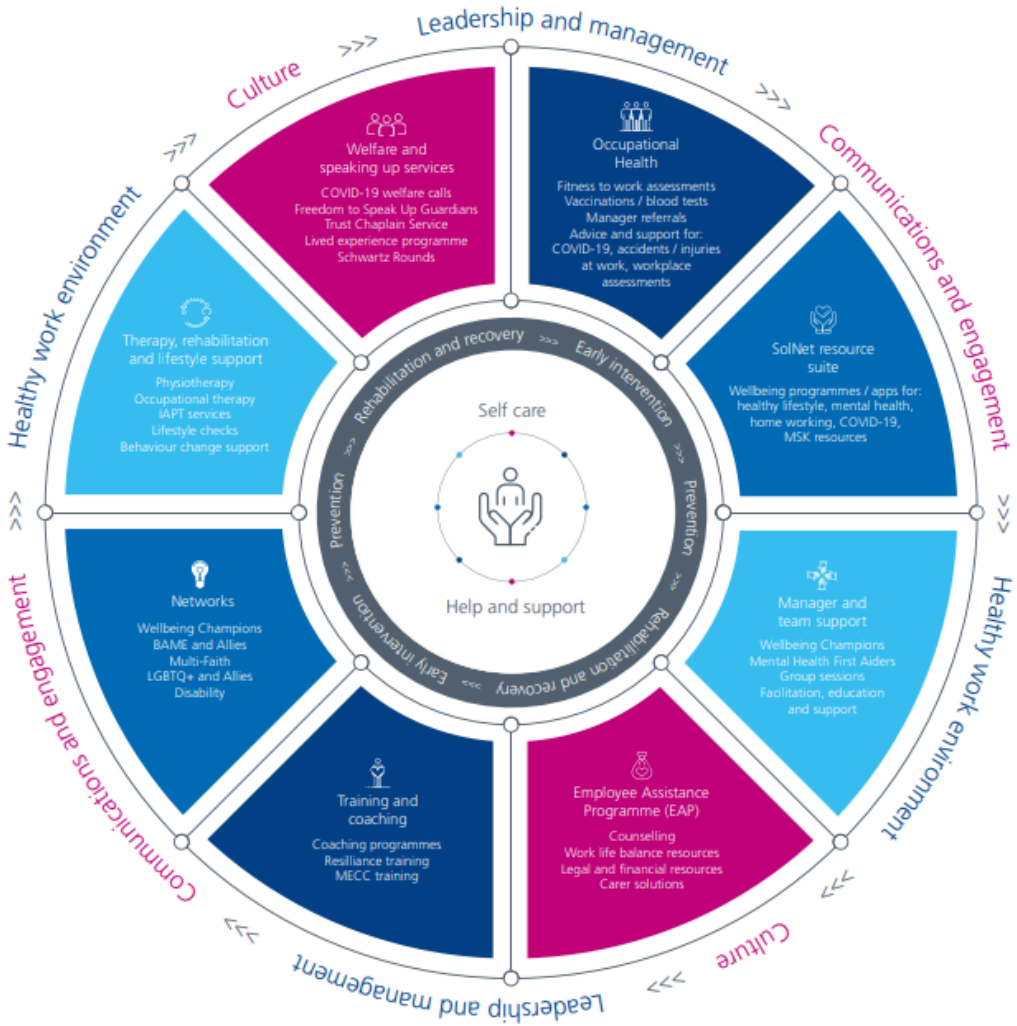


We will know that we have made improvements when...

- Our staff survey health and wellbeing theme is 6.8 or above
- All eligible staff have had a well-being day
- All colleagues are having well-being conversations
- The health and wellbeing hubs are seeing use by Solent employees

Wellbeing, rehabilitation and recovery

Team Solent health and wellbeing package



Our priorities

1. Self-care and facilitating teams / managers to establish sustainable wellbeing support within their service.
2. Easy access to mental health support services and reducing workplace stigma.
3. Home working: physical and psychological impacts and different ways of working.
4. Supporting long COVID-19 impacts through wellbeing support interventions.

For more information visit the Occupational Health and Wellbeing pages on SolNet.

Report template- Board and Committees

Item 13.1

NHS Solent NHS Trust

Item No.	13.1			Presentation to	Trust In Public Board		
Title of paper	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2021**						
Purpose of the paper	The aim of this paper is to update the Trust Board on emergency planning arrangements and response to Covid-19.						
Committees /Groups previous presented and outputs	Emergency Planning Group approval						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X	
Action required	For decision		For assurance	X			
Summary of Recommendations and actions required by the author	To provide an oversight of the EPRR operational response. The impact of Covid-19 locally and nationally has been genuinely unprecedented. However, as an organisation we have always taken a planning approach of planning for the worst. As the board are aware, last year the Trust achieved full compliance against the NHS England EPRR assurance framework which meant that we were in a strong position to adapt or use existing plans throughout the response and on to the recovery phase. Clearly, no plan ever really covers all the bases, but our processes, conceptual approach and ability to implement and adapt plans has served us well. The Board is asked to receive the report.						

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	David Noyes, Chief Operating Officer			Exec Sponsor signature:			

Item 13.2

ANNUAL REPORT FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE 2021

Contents Page

1. Introduction

As all NHS-funded organisations are expected to meet the requirements of the Civil Contingencies Act (2004), the Health and Social Care Act (2012), the NHS Standard Contracts, and the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR), this report identifies work undertaken to ensure that that Solent NHS Community Trust (henceforth known as Solent) is compliant with these statutory requirements. The report therefore outlines the current position of emergency preparedness, resilience and response through the key activities that have taken place during the last year 2020-2021.

2. Requirements and Principles of EPRR

2.1. The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level. As a category one responder, the Trust is subject to the following civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance coordination
- cooperate with other local responders to enhance coordination and efficiency.

Category 2 responders for health are Clinical Commissioning Groups (CCG's) who have a lesser set of duties but are expected to co-operate and share relevant information with other category 1 and 2 responders. They are likely to be involved in planning of the response especially with incidents such as the covid-19 response and any incidents that affect their own sector. Outside health category 2 responders who may offer support are transport providers, highways agency, telecommunications providers and the health and safety executive.

The need to prepare, plan and exercise for a Major Incident is not only a statutory requirement under the Civil Contingencies Act (CCA), but also a requirement under the NHS England Emergency Preparedness Framework, and a requirement for the NHS Standard Contract (SC 30).

3. Assessment of Risk

The Emergency Preparedness Framework clearly outlines the requirement for risk assessment to underpin emergency preparedness. Solent NHS Trust has clear and effective risk processes in place and contributes to the review and updating of not only our own but also the Hampshire and Isle of Wight Local Resistance Forum (HIOW LRF) community risk register, as part of the work undertaken by the Local Health Resilience Partnership (LHRP).

In accordance with the national and local risk assessments, the highest risks and any subsequent plans are reviewed regularly. Local potential business continuity risks are also included in the trust risk register. These are also reviewed regularly as part of the normal business continuity management process with plans such as adverse weather, widespread electricity loss and pandemic reviewed via the LRF as part of an ongoing process. The Psychosocial plan owned by the LRF and

written by Solent has recently been peer reviewed as part of this process and been updated accordingly by Solent's EPRR team.

HIOW LRF also added to their risk register a new risk 'Human and animal disease' as the covid-19 pandemic was found to be very different from the assumptions used to assess the impact of a flu pandemic. The IPC team reviewed the Covid-19 and flu plans and subsequently made changes to the reporting process which is now done online by one of the IPC team.

LRF Risks (High and very high)	Solent NHS Trust Risks
Influenza Type Disease	Pandemic / capacity & demand (risk no. 1197 & 1212)
Human and animal type disease which includes Ebola	
Severe Weather (snow, heatwave, coastal flooding etc)	Adverse weather (Risk no. 1205, 1207, 1194, 1196 & 1195)
Environmental pollution & industrial accidents	
Loss of critical infrastructure such as prolonged electricity outage	Widespread electricity failure (risk no. 1206)
Fuel Shortages	Fuel shortages (risk no. 1210)
Transport Accidents	

4. Emergency Preparedness Plans

Although in previous years we have always focused on developing and refining the Solent NHS Trust Emergency Preparedness plans, events this year have necessitated a different approach. However, following the response to covid-19 in 2020, along with all NHS organisations the relevant plans will be reviewed to include specific information in responding to an incident over many months with significant impact (which has already commenced). Any lessons identified from the response and or recovery phases will also be included in the updates.

The key areas reviewed this year were:

- Incident Response plans
- Psychosocial care following a mass casualty event (as part of the system wide planning group LHRP) will now include information regarding response to a major incident which is not a mass casualty event
- Winter preparedness and contingency plans
- Adverse weather and travel disruption planning

As detailed in last year's annual report the Incident Response Plan (IRP) has been reviewed and updated. The document is now more concise and user friendly and is titled as the Emergency Planning Framework. This is accompanied by the appropriate action cards which have also been updated.

The Psychosocial Plan was updated by Solents EPRR team (as the plan authors) with clinical aspects updated by Drs Tom Richardson, Mahdi Ghomi and Laura Roughan respectively. The plan was invoked in early September as a result of the withdrawal of coalition forces in Afghanistan which led to the Afghan Relocation and Assistance Programme (ARAP.) Approximately 300 Afghani nationals

are being temporarily housed in three 'bridging' hotels across Hampshire. The CCG are co-ordinating the response and Solent NHS trust are involved in the clinical and administrative process.

The winter of 2020/21 saw no major weather related disruption to services or staff but winter, adverse weather and travel plans were all updated, an MOU between Solent and the Hampshire & Berkshire 4x4 team has also been put in place.

5. Business Continuity Management

Contingency plans continue to include a risk based, prioritised (RAG) list of services and the capability/capacity that the trust could mobilise in the event of an extreme set of circumstances over and above normal system business continuity. The previous years work and the principles we applied have proven invaluable in our continued response to Covid-19. It also showed its worth in the delivery of the mass vaccination programme which had many staff seconded to one of the four mass vaccination sites. The winter contingency plans are incorporated into the Trust business continuity plans and are reviewed and updated every year and are now embedded in service response planning and can be used for any incident that may impact upon services.

As requested last year service lines reviewed their business continuity plans against assumptions (due to Covid-19) of a reduction of up to 50% of their staff. Thankfully we never saw an impact as high as 50% but in several areas we did approach a 30% absence rate. This year's winter plan has seen returns from each of the service lines which have showed themes which are common across each of the service lines. All mention the implementation of BCPs which has highlighted there worth to the Trust and so proved to be very worthwhile implementing and continually updating. This year the addition of lessons learnt from Covid-19 was also included and again the responses all showed common themes.

Service Level Planning Template			
Area	**Actions**	**Lead**	**Risks/Mitigation**
Demand and capacity			
Effective management of demand pressures			
Staffing			
Infection control			
Covid-19 implications			
Releasing additional capacity			
Partner organisations			
Learning from previous winter			
Severe weather			

The 8 completed Service line planning documents are held on Solnet in the emergency zone.

Common winter themes from each of the service lines where:

- Staffing – working differently, different location / department
- Weather – mitigations in BCP and LRF
- Flow – from acute trusts
- IPC and influenza jab – to reduce infections and sickness
- Communication – with the Acutes, local authorities and staff
- Prioritisation – risk assessed against greatest care need
- BCP's – instigated when required

The overall impression is one of resilience and an agile response to problems that may arise. On the question of staffing, working from home (or from their nearest Solent building) if possible, in adverse weather, taking up the flu jab and following IPC guidance to reduce infection are all mentioned. Close communication with partners and patients, triage via telephone or teams and the priority of urgent care are also listed for every service line. The completed returns templates can be found on Solnet.

Solent NHS Trust will continue to work in close partnership with other community trusts, the acute Trusts and CCG's to provide not only a response to the expected challenges and surge management but also a response to the unexpected actions required due to covid-19. Quarterly meetings have been organised with community partners from Dorset, Kent, Surrey and Sussex to share learning and improve on current practices.

6. Events and planning

6.1 EU exit, outcomes

The planning around EU exit has proven to be beneficial to the trust. Previously unthought of problems had contingencies identified which led to new processes being put in place enabling the trust to respond more effectively to a constantly changing picture.

6.2 Covid-19 pandemic

We are still responding to the everchanging effects of the covid-19 major incident with the AEO acting as the Incident Commander supported by the other executive directors in leading the response to the incident.

The ICC was opened in February 2020 and since then meetings have flexed to meet the peaks and shallow troughs seen throughout the pandemic. At its peak meetings were held three times a day 5 days a week with at least one gold call each day during the weekend.

With the introduction of the vaccine rollout in December 2020 and the continued downward trend in new infections. Calls were reduced from daily to weekly and then to a once a week 'report by exception' model and subsequently suspended. The Trust has the ability to commence meetings again, and, if necessary, open the ICC as required. This could be a response to any changes in Covid infection rates, exceptional winter pressures or to take account of staff welfare going forward at the appropriate level.

Any future gold command meetings will continue to follow the EPRR framework with a standardised agenda including all possible areas that may be affected such as staffing, PPE, safety and care

provision, which includes the welfare of our own staff. The attendance list always includes the AEO and executives, EPRR representative, decision loggist, minute taker and senior representation from all service lines and corporate services as requested by the incident commander.

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

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

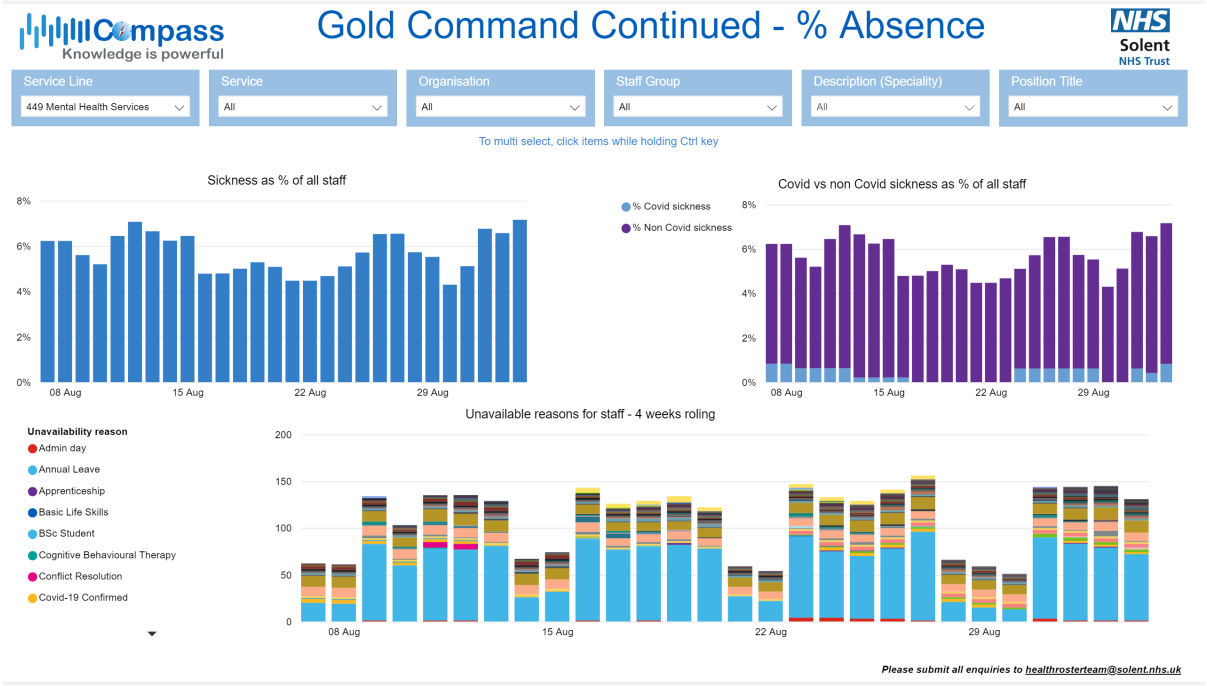
The AEO also attends the Hampshire IOW Health and Social Care cell which is part of the local resilience forum. The meetings were initially twice weekly however more recently these meetings have reduced to once a week.

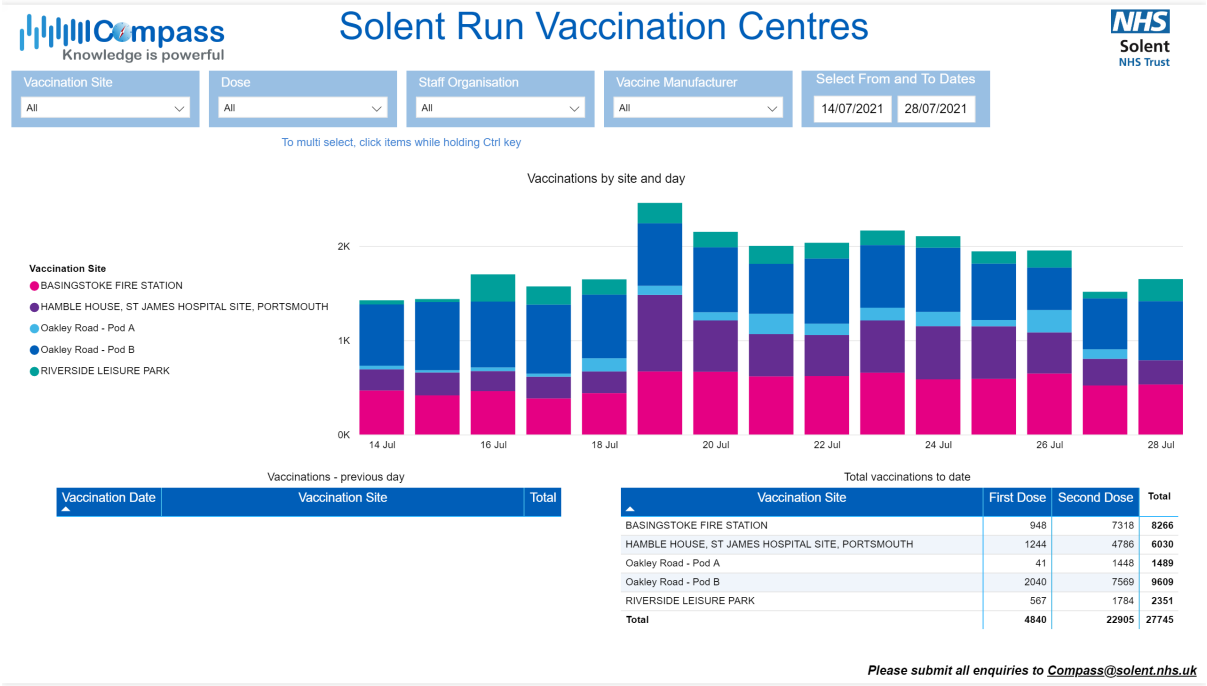
6.3 Information flow

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

The Business Intelligence dashboard was introduced by the Performance team to provide an online tool with visualisation of Solent NHS data giving access to multiple data sets and a one stop shop for clinical, workforce, finance and quality data. This provided a strong, high level, command support tool for Gold. The implementation of this system has proven to be very successful and is an integral part of the organisations response to emergency incidents such as Covid-19.

The diagrams below reflect the level of detail that can be seen with the ability to be easily read.





Using the power BI tools it is possible to interrogate each area further if required or simply get a visual snapshot of performance.

7.0 Learning (EPRR)

Running the ICC gave a high level of expertise and support with managers from all service lines involved, there was a solid rational for all decisions and all decisions were logged. Due to the nature of the pandemic and its ever-changing severity the intensity of the ICC flexed in line with service needs, the requirements of Government and NHSE guidance at the time. A direct result of this is the trusts emergence as a much more robust organisation that is willing, and importantly able, to carry out significant change, at pace, whilst still maintaining our core business. The extensive use of BCP's has proven there worth none more so in relation to relocation of staff to cover shortfalls in areas of high absence due to Covid related shielding, isolation, sickness or secondment to other areas of the trust.

There is a renewed sense of teamwork and support to do innovative things. Home working, remote working, turning a health centre into a 70-bed unit or setting up the vaccination centres in record time. All were done in line with the service need, lessons learnt from Wave 1 improved our response to Wave 2, BCP's were further improved and there was greater confidence at all levels with regard responding to the unknown.

The fire at Hawthorns on the 16th of July 2021 showed just how well the trusts staff respond to an unexpected incident. Despite the fact there was a severe fire in one of the patient's rooms staff safely evacuated the building whilst simultaneously informing the emergency services and security of the situation. The BCP was enacted and all patients were re-housed in other wards on the St James's site.

8.0 Put in Place Arrangements to Warn and Inform the Public.

Solent NHS Trust has continued to work in partnership with other health providers and commissioners to provide information to both staff and the public. The Incident Response Communications strategy is a comprehensive document which enables the trust spokesperson to deliver a consistent message that conveys the organisation's reaction to a crisis. The spokesperson will be guided by a member o the comms team, there is also an incident response plan communication action card as an aide memoire.

Throughout the year the following information been placed on the staff web site when required, for covid-19 this was originally daily but this has now moved to twice weekly unless required.

- severe weather warnings,
- flood warnings
- Covid-19 documents

Seasonal plans for summer and winter are also placed on Solnet for staff, this years winter plan will be promulgated on the 15th of September.

This information allows staff to stay informed and to plan for adverse incidents in a timely manner.

9.0 Co-operate with Other Providers

Co-operation between organisations is fundamental to robust emergency preparedness. Solent NHS Trust continues to participate as a member of the Hampshire and Isle of Wight (HIOW) Local Health Resilience Partnership (LHRP), represented by the Chief Operating Officer. This cooperation has been particularly evident in the covid-19 response with agreements and joint working on various projects such as:

- Community Testing Service
- Vaccination Centres set up
- Cruise ship crew testing
- Outreach pop ups such as fire stations and mosques etc.

The Emergency Planning Lead (EPL) also regularly attends local health resilience meetings and feeds back relevant information to the emergency planning group. The EPL also works in partnership with Southern Health Foundation Trust and also with the HIOW acute trusts to ensure all work undertaken is consistent across the area and that there is a greater understanding of EPRR within the organisations. Working together in this way supports the requirements of the Civil Contingencies Act and allows for joint learning and the sharing of EPRR documents and work plans.

A water outage incident in May 2021 led to the trust placing the LRF's water shortage plan on Solnet and also to meetings with the estates team and Southern water to have a tanker plan to ensure continued water supplies at Solent's in-patient sites.

As part of the system response to covid-19 Solent NHS trust have worked by providing mutual aid to other providers if required and have participated in the management of the community testing which provides clinicians to deliver testing at a drive through site and also a car service that is used to visit those identified as requiring a test and unable to leave their home. This service was due to end in August 2021 but funding from the CCG and HHFT guarantee its continuation until March 2022.

10.0 Training and Exercising

A number of training events planned this year have been delayed, however several training events and table-top exercises were still carried out. Hazmat training was completed for all reception staff, on call manager training and director training for strategic decision making and lockdown procedures for the vaccination centres.

It is important to note that although the training completed so far is below expected all staff have developed skills responding to a major incident and the use of plans during the current crisis.

Further training will be available as soon as possible and can be tailored to service/individual needs.

11.0 Core Standards

Having achieved full compliance in 2019/20 under the NHSE Assurance regime we are now working on 2021 – 2022's assurance. This year the self-assessment of the core standards shows that we are fully compliant. The deep dive this year is mainly aimed at acute trusts and their piped oxygen supplies.

The trust has the capability to provide piped oxygen to each bed on two wards (Bramble and Fanshaw) both within the Royal South Hants Hospital (RSH.), although this isn't a capability that we

use often, given the nature of our rehab work at this site. The system was successfully strength tested in April 2020 as part of our Covid contingency planning, but in the event we did not need to use it. The supply and maintenance of oxygen is undertaken by NHS property Services and in the event of failure of the piped supply banks of back up cylinders ensure a continuous supply. There is also a separate cylinder store on the RHS site.

12.0 Work plan

- Continue with annual review and testing of Business Continuity plans.
- Continue to work as part of the response and recovery phases to the ongoing incident
- Continue to offer further training particularly in incident management skills and knowledge, including familiarity with the Incident Coordination Centre (ICC) related procedures and offer training to teams who do not normally participate in on call.
- Further develop the current training programme at all command and control levels.
- Work with IT to establish a more robust communication system and look at the use of new technologies in emergency planning and business continuity.
- Review all the learning from the response to covid-19 and ensure all actions are complete
- Continuous review of the incident response plans and action cards

13.0 Summary

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

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

Services have used their business continuity plans effectively particularly in the early days when they needed to identify which services could be scaled down, made available in a different way or placed on hold.

Despite the huge challenges and the often very dynamic nature of the crises, Solent NHS trust's EPRR framework and arrangements have proven their worth during this incident. There will, of course, be lessons learnt, and we will continue to seek to improve and review our plans during the recovery phase.

Report template- Board and Committees

Item 15.1

NHS Solent NHS Trust

Item No.	15.1			Presentation to	In-Public Board Meeting		
Title of paper	Workforce and OD Committee Exception Report						
Purpose of the paper	To summarise the business transacted at the Workforce and OD Committee held on 23 September 2021.						
Committees /Groups previous presented and outputs	N/A						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X	
Action required	For decision		For assurance	X			

Summary of Recommendations and actions required by the author

- The **Workforce & Sustainability Report** was received, and key areas highlighted including:
  - Our aging workforce, and skill gaps in CAMHS, specialist services, community nursing and health visiting; recruitment process overhaul planned to enable greater opportunities.
  - Sickness rates increased - key themes: anxiety/stress, and viruses within the community - respiratory and gastroenteritis. Workforce also feeling fatigued. Occupational Health and Wellbeing team are now aligned to services to provide focused support. Committee keen to be alerted of early warning signs.
  - Vacancy rates are high in FM and Estates; data quality check taking place to ensure accuracy.
  - Retention at 10.7%, below target of 14% - external labour market research to be carried out to contribute to a future discussion on whether 14% is realistic and sensible.
  - Statutory and mandatory training currently at 91.58% - above target and fantastic achievement. Target is 90% across the NHS as a whole; management practice via clinical supervisions and safer staffing meetings will always endeavour to reach 100% however with continual new starters to the Trust it was noted that it is not possible to achieve 100%.
  - Safer staffing discussed; committee comfortable that uncovered shifts are risk assessed and mitigated via triangulation (also discussed at Quality Assurance Committee).
  - New Learning Management System (LMS) commended by committee and advised of positive feedback received from staff.
- The **Employee Relations Assurance Report** was received, and key areas noted including:
  - Figures have changed since report production; a further 6 cases have been closed (now at 94 cases).
  - With new People Partnering structure in place, expect to see a shift within next 6-8 months
  - People Partnering team working closely with line managers, holding workshops on absenteeism and how to handle this.
  - Report will alter for future committees, to follow the Dido Harding recommendation and provide a greater overview of all protected characteristics.
- The **Workforce Risk Appraisal** was received, and key areas noted including:
  - 11 risks added with the majority being from the Fraud Bribery and Corruption assessment, also workforce fatigue and winter wellbeing – a current focus for the Occupational Health and Wellbeing Team.
  - Working with service leads, ensuring risks across the Trust are being scored reasonably from both an organisation and service perspective (also being discussed at Quality Improvement & Risk Group and Quality Assurance Committee).
  - E-Rostering audit discussed; findings are being actioned – nothing key to be highlighted.
- The **Board Assurance Framework** report was received, and key areas noted including:
  - The Committee discussed the need to revise the residual/target scores.
  - Proposed changes: amend the residual score to 16 (Severity 4 x Likelihood 4) and amend target score to 12 (Severity 4 x Likelihood 3). Proposals agreed by the committee.
  - For noting: the Board Assurance Framework is a live document; to be reviewed at each meeting with a focus on risk score.
- The **Q1 Communications Update** was received, and key areas noted including:
  - Press cuttings target already achieved in Q1.
  - Continuing with social media engagement monitoring; ensuring correct content is posted for each audience, including how we enable better health outcomes for the community.
  - In October 2021, Trust stakeholders and how our reputation is viewed will be a focus area.

- **Escalation reports** received for the **Joint Consultative Negotiating Committee**, **Wellbeing Oversight Meeting** and **Doctors and Dentist Negotiation Committee.** No meeting held to report for People and Organisational Development Group.
- **People Pulse Results and Staff Survey Action Planning** was received, and key areas noted including:
  People Pulse Results: New mandated survey took place in July; organisation-wide. Focussed on key themes of the annual survey, around engagement. Results were very positive; long-term action plan being developed. Will be carried out quarterly to check on staff motivation and engagement.
  Staff Survey Action Planning: 2020 annual staff survey took place at the end of last year; immediate and long term (live) action plans created to focus on key improvement areas, including Diversity and Inclusion. 2021 annual survey is approaching, with further opportunities for engagement also, such as: Chief People Officer roadshow, Lightbulb listening tool, and Board to Floor.
- The **NHS People Plan Update** was received, and an overview was provided of the changes made since January 2021 progress update. These include: improved RAG status for Flexible Working and Growing the Workforce and Occupational Health and wellbeing. A review of the status for Equality Diversity and Inclusion since further national actions have been received has resulted in a return to amber status with a focus on improving recruitment practices.
- The **Future of the NHS HR & OD Programme** paper was received and discussed with an overview provided. A review of NHS people practices commenced in January 2021 with Trust feedback provided to the national team. Draft findings show that Solent are broadly in alignment with the future topics. Recommendations to be received by end of November 2021.
- A verbal update was provided for the **Orchards Deep Dive.** Completed report expected end of October 2021; investigative team included individuals both internal and external to Solent. No urgencies addressed from the findings, however known issues do require some robust action to take place.
- The **WRES/WDES Reports** were received, with the reports to be published internally and externally, October 2021. For noting: figures are solely for substantive staff currently – committee agreed for the future, bank staff should also be included in the data collection, but this would need to be agreed nationally.

  Key areas noted included:
  WRES
  - Slight increase made this year for BAME employees – 8.1% to 10.2% (national target is 19% across all bands by 2025) – could be an artificial increase due to the intake of our international nurses.
  - Discrimination has increased since March – looking to reverse this trend by working with Operational Directors.
  - Committee agreed the national target we are aiming to achieve, needs to reflect the population we are serving.

  WDES
  - Disability status declaration rates have increased slightly; staff reminded to update their disability status on ESR. Also, fewer disabled staff at senior levels has been reported; action in place to achieve target of 4% for bands 8 and above.

  Committee agreed, after minor amends discussed, for reports to be published. *Reports & action plans provided as supplementary papers to the Board (items 15.2-15.5).*
- The **Delay of Reciprocal Mentoring for Inclusion Programme** was discussed – programme is delayed from National, with the hope to re-start in the summer.
- The **3% Pay Review** was discussed – individuals on the Agenda for Change and/or Doctors and Dentists contracts/pay scales will have their pay amended from this month; back dated to April 2021.
- The **Flu Vaccination Programme, Care Home and UHS Vaccinations** were discussed:
  Flu Vaccinations: commenced, with 1000 bookings taken via new paperless system within the first week – 10% of eligible staff are already vaccinated.
  Covid Boosters: pilot will be taking place at Oakley road for staff only; practicalities being finalised.
  Latest Vaccination Data: 91.85% are double-vaccinated, 1.3% have declined, and unvaccinated staff currently stands at 4.7% (for noting: we do not have all records of vaccinations, if completed elsewhere).

	Care Homes: only double-vaccinated staff can work in care homes – guidance has been sent out to line managers, if required. UHS: any patient-facing staff are to be double-vaccinated. This impacts Solent as we have students, secondees, etc. in post there, however, we have not been made aware this has made a large impact to our staff. Consultation in place, awaiting the outcome. ○ The **2021 Staff Survey Target Response Rate** was discussed. 2020 target was 66%. For 2021, new target of 67% was agreed by the committee. ○ A **100% virtual Psychiatrist post** was discussed; created a mixed reaction externally – innovative idea and first substantive post of its kind. Many applications being received from the UK and globally – success measures being implemented.

To be completed by Exec Sponsor – Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Jasvinder Sohal, Chief People Officer			Exec Sponsor signature:			

Board and Committee Report

Item 16

NHS Solent NHS Trust

Item No.	16		Presentation to	Trust In Public Board		
Title of paper	Community Engagement and Inclusion Committee Exception Report- September 2021					
Purpose of the paper	To provide a summary of activity to support the implementation of Alongside Communities – the Solent approach to engagement and inclusion.					
Committees /Groups previous presented and outputs	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.					
Statement on impact on inequalities	Positive impact (inc. details below)	**Y**	Negative Impact (inc. details below)		No impact (neutral)	
Positive / negative inequalities	The activities highlighted in the report are having a direct impact on addressing inequalities as they are targeted at different parts of our communities helping to ensure their voices are heard to help our services to meet their needs.					
Action required	For decision	**N**	For assurance	**Y**		
Summary of Recommendations and actions required by the author	The delivery of Alongside Communities – the Solent approach to engagement and inclusion is on track for delivery on schedule. The Board is asked to note the summary from the Engagement and Inclusion Committee September 2021. A wide range of methods including filming, storytelling and increased conversations are being used to introduce the community voice into projects and conversations, the aim being to move us towards engagement simply being the way we do things in Solent. Key highlights from our work includes: 1. Sharing our learning - We have shared our journey thus far internationally at the Beryl Institute Engagement Webinar in July, with colleagues from the local ICS and those further afield, and with people leading end of life care in partner systems 2. Making this sustainable- We are introducing the concept of community voice into our internal programmes of work, but also recognising, valuing and supporting the expertise of our communities in leading local initiatives for local people, by people. 3. An infrastructure comprising community engagement and experience team (CEET) leads, community partners and service representatives has been created to drive and monitor implementation. 4. The Community Partners' Programme now includes 210 individuals and organisations, with an estimated potential reach (based on organisations' membership) of 400,000 people.					

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Jackie Munro, Chief Nurse		Exec Sponsor signature:	JAMunro			

Board and Committees – Trust Board

Item No.	18.1		Presentation to	In Public Board		
Title of paper	Audit & Risk Committee Exception Report					
Purpose of the paper	To summarise the business transacted at the Audit and Risk Committee held on Thursday 5th August 2021.					
Committees/Groups previous presented and outputs	N/A					
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Action required	For decision		For assurance	X		
Summary of Recommendations and actions required by the author	The Board is asked to: • Note the report from the Committee					

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Non-Exec Sponsor name:	Calum Mercer, Non-Executive Director (Committee Chair) Andrew Strevens, Deputy CEO & CFO		Exec Sponsor signature:				

Summary of business transacted:

- The Chief Finance Officer presented the **Single Tender Waiver** report submitted during the period of 1 April to 30 June 2021 and themes were shared. The Committee noted the report.
- A report outlining the **Losses and Special Payments** processed since the last meeting was reviewed. Rationale and subsequent queries regarding process, learning and links to safeguarding were discussed. The report was noted by the Committee.
- A report on **Year end Audit- Lessons Learned** was presented to outline the main audit challenges experienced in finalising the Trusts annual accounts, and application of learning for future audits. The Committee noted the report.
- An update in relation to **IT Asset Management** was received and extensive discussions were held regarding actions plans and associated timescales. The Committee were briefed on investigation outcomes and next steps. Discussions were held regarding internal process controls/contract management and it was agreed to provide a deep dive at the next meeting.
- The Trusts' internal auditors, PwC presented the **Internal Audit Progress Report**, including review against the 2021/22 audit plan:

Review to be undertaken	Executive Sponsor	Audit Sponsor identified	Scoping meeting(s) held*	Terms of reference approved	Fieldwork dates planned	Fieldwork completed	Report issued to Solent	Review complete
Key Financial System	CFO	Completed	Scheduled		Q2			
Cyber Security	CFO	Completed	Scheduled		Q2			
Risk identification, escalation and reporting	Chief Nurse	Completed	Scheduled		Q4			
Data Security Protection Toolkit	CFO	Completed	Scheduled		Q4			
Business Intelligence (BI) and data management	CFO	Completed	Scheduled		Q3			
Estates, Facilities and Transport	Strategic Transformation Director & Director of Estates	Completed	Scheduled		Q3			
Follow Up	CFO	Completed	Scheduled		Q4			

- Ernst & Young shared the **Auditor's Annual Report- Year ended 31 March 2021** and summarised the key conclusions from the 2020/21 audit, including Value for Money summary and additional audit fee agreed. The Committee noted the report.
- The Local Counter Fraud and Security Specialist presented the following reports:
    - **Counter Fraud, Bribery and Corruption Annual Report-** The Committee were briefed on annual work and proactive exercises undertaken. The Annual Report was noted.
    - **Counter Fraud Progress Report-** An overview of further progress was provided, including progress against proactive exercise and the status of investigations. The Committee noted the report.
- The Freedom to Speak Up Guardian attended to share the **Freedom to Speak Up Annual Report** *(included as supplementary paper to the Board- item 18.2).* An overview of requirement completion and proactive activities were reported. Ongoing consideration of reporting methods and introduction of a new Communications plan was highlighted. Outputs from the Freedom to Speak Up Index Report were summarised and positive position was shared. The Committee noted the report.
- **External reviews/(un)announced visits-** it was reported that a CQC Mental Health inspection had taken place, with a number of actions agreed and being addressed. It was confirmed that a further CQC visit to the Sexual Assault Referral Centre was expected in August.
- The **Committee Mid-Year Review** was noted.
- The **Committee Terms of Reference** were approved, following annual review.
- **Any other business**- it was noted that the Trust would be undertaking an external audit tender, as a good practice exercise, to consider regulator environment changes and fees.

Decisions made at the meeting:

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

Recommendations:

There are no specific recommendations to note.

Other risks to highlight (not previously mentioned):

There are no risks to highlight.

Board and Committees- In Public Board Exception Report

Item 19

NHS Solent NHS Trust

Item No.	19		Presentation to	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 24th September 2021.				
Committees /Groups previous presented and outputs	N/A				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Action required	For decision		For assurance	X	
Summary of Recommendations and actions required by the author	The Board is asked: • To note the report from the Committee				

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Non-Exec Sponsor name: Exec Sponsor name:	Thoreya Swage, Committee Chair Jackie Munro, Chief Nurse		Exec Sponsor signature:	JAMunro			

Summary of business transacted:

- There were no **Freedom to Speak Up Concerns** to report.
- **Urgent Matters of Safety-** The Committee were briefed on publication of the Pascoe Report. Consideration of recommendations and potential internal learning was discussed, and it was confirmed that a full report would be submitted to the November Committee.
- **Partnership governance arrangements**- Continued system-wide challenges in relation to the Child and Adolescent Mental Health Service (CAMHS) were highlighted.
- The Committee received a **Safeguarding Deep Dive**. Challenges, actions and mitigations were shared. Comments from the Committee were taken and relevant assurance provided. It was agreed to provide a further update in 6 months to ensure effective oversight.

- The Committee **noted** the following reports presented:
    - **Safeguarding Quarter 1 Report**- The Head of Safeguarding shared the report and discussions regarding the evolving strategy were held.
    - **Experience of Care Insights Quarter 1 Report-** The Head of Community Engagement and Experience shared ongoing activity and learning, including review of themes in relation to complaints and FFT results.
    - **Patient Safety Annual Report and Quarter 1 Report**- The Head of Quality and Safety explained focus on thematic learning and impact of the pandemic on incidents/near miss reporting. The Committee were assured of key ongoing work pieces, including development of the Patient Safety Response plan and deep dive of medicine incidents.
    - **Infection Prevention and Control Q1 Report**- The Chief Nurse informed of ongoing work and effective management of actions taken in relation to Covid-19 outbreak. Discussions in relation to guidance for Personal Protective Equipment (PPE) were held and the importance of balance emphasised.

    - **LD Strategy 6 Month Update**- Activity was shared, including commencement of work delayed due to Covid-19. Strong service engagement was highlighted and positivity of dedicated support in the Sexual Health Service discussed.

- The **Self-Declaration on Same Sex Accommodation** was **approved** by the Committee, for onward submission to Trust Board *(included as item 7 of the In Public Board papers).*
- The Committee reviewed the updated **Risk Management Framework** and commented on usefulness of the governance structure established. Ongoing work was acknowledged, and amendments suggested. The Committee **approved** the framework, for onward submission to Trust Board *(included as item 6 of the In Public Board papers)*.
- An **Exception Report from the Quality Improvement and Risk (QIR) Group and Chief Operating Officers** was **noted**. Key updates were provided from the Southampton and Portsmouth Care Group and exceptions arising from the QIR Group. An update on vaccinations was provided and ongoing service pressures shared.
  Challenges regarding spinal imaging within the MSK services were reported. Assurance of mitigation and action plans in place were provided.
- The Committee **noted** the **Board Assurance Framework (BAF) consideration and oversight of risks Report**. Risks regarding demand and capacity risk were highlighted and it was agreed to include safeguarding on the BAF going forward.
- **Ethics and Caldicott Panel Exception Report**- An update on key panel activity was **noted**.
- The Committee received a verbal update on **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)**. The Chief Nurse informed of monthly meetings held with the CQC to proactively share service activity. Positive outcomes from recent publication of the Isle of Wight CQC report were highlighted.
- The Committee noted the **Committee Mid-Year Review**.
- The Committee approved the **QIR Terms of Reference**, subject to minor amendment.

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.

Report - Board and Committees

Item 22.1

NHS Solent NHS Trust

Item No.	22.1	Presentation to	Solent NHS Trust Board		
Title of paper	Charitable Funds Committee Exception Report				
Purpose of the paper	To summarise the key business transacted at the recent Charitable Funds Committee meeting, 17 August 2021				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	x
Action required	For decision		For assurance	x	
Summary of Recommendations and actions required by the author	The Board is asked to receive the above summary of business transacted.				

To be completed by Exec Sponsor - Level of assurance this report provides :							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Gaurav Kumar, NED – Committee Chair David Noyes – Executive Sponsor		Exec Sponsor signature:				

Key messages /findings

The Committee:

- Received the **Quarter 1 2021/22 Finance Report** – it was acknowledged that the charity had a surplus of **£269.00** and that public donations received in the quarter totalled **£780.00. T**he committee noted that management and administration fees for the quarter totalled **£493.00** and investment income received in the quarter amounted to **£6.00**.
- **Agreed** to a proposal to transfer funds into an alternative account, to generate significantly favourable interest rates, to be spent on administrative outgoings etc. The committee further **agreed** to a split of holding 10% funds in a cash account and 90% in the high interest investment account (with 60-day notice draw down).
- Noted the date of the **official Memorial Gardens opening** in Portsmouth as **26 October 2021, 11am**, to be opened by the Chief Executive.
- **Agreed** to have oversight of all non-monetary donations made to the Trust and to receive a report at the next charitable funds committee on all Covid-19 related donations, to provide assurance all gifted for intended purpose.
- Received a report on **NHS Charities Together** grants, to provide assurance that all conditions to the fund award being met.
- **Agreed** the charity's Annual Accounts (**Appendix 1**) for signing and submission to The Charity Commission, ahead of the 31st January 2022 deadline
- **Agreed** the Letter of Representation, for signing and submission to The Charity Commission.
- Received an update from the Estates teams, noting that the Multi Use Games Area (MUGA) currently in progress aligned to the refurbishment of Maples, to be completed early 2022. The committee **agreed** to receive a proposal from the Estates team at the next Charitable Funds Committee, to review future estates work, aligned to charitable monies and the generation of fundraising activities
- **Acknowledged** the importance of Communications presence at the Charitable Funds committee and the alignment of charity work with branding, engagement, promotion, and communication
- **Noted** the minor changes to the Charitable Funds committee Terms of Reference
- **Recognised** possible future opportunities to work at an ICS level collectively on the charity agenda.

REGISTERED CHARITY NUMBER: 1053431

REPORT OF THE TRUSTEES AND

UNAUDITED FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2021

FOR

SOLENT NHS CHARITY

SOLENT NHS CHARITY

CONTENTS OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2021

REPORT OF THE TRUSTEES
FOR THE YEAR ENDED 31 MARCH 2021

The charity's annual report and accounts for the year ended 31 March 2021 have been prepared by the trustee in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities (Charities SORP (FRS 102) and the Financial Reporting Standard 102 applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011, and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

Charitable funds received by the charity are accepted, held and administered as funds held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990.

OBJECTIVES AND ACTIVITIES

Review of the Finances, Activities, Achievements and Performance

The purpose of the charity is to further the objectives as specified in the declaration, namely "For any charitable purpose or purposes relating to the National Health Service".

The strategy of Solent NHS Charity is to support its related constituent bodies by providing funds to benefit patients and staff. It does this by providing funding for developments and activities which would otherwise be unaffordable.

The charity relies upon the generosity of patients, their relatives and other donors who are familiar with, or have experienced the care provided by Solent NHS Trust, or who are sympathetic and generous in their support to their local NHS service.

During 2020-21 NHS Charities Together's (NHSCT) Covid-19 appeal raised over £150m thanks to the amazing efforts of Captain Sir Tom Moore and thousands of others. NHSCT reached out to member charities to access these funds through Grant awards. During 2020-21 the charity secured £159,500 of Grant award funding to support the urgent and immediate needs of staff, volunteers and patients, physical health of staff and patients. The funding received has been used to provide external seating areas at the Western Community and St James Hospitals. A wellness garden was created in St Marys Hospital, and works to deliver an outdoor games area for mental health patients are underway.

Public benefit

The trustee is aware of their responsibilities under charity law in ensuring the maintenance of public benefit in all aspects of their work. Funding patient and staff welfare, improvements and amenities is, by definition, meeting public benefit.

REPORT OF THE TRUSTEES
FOR THE YEAR ENDED 31 MARCH 2021

OBJECTIVES AND ACTIVITIES
Achievements and Performance
The main direct charitable expenditure is in relation to activities that further the charity's objectives.

The table below gives a breakdown of the charitable expenditure headings.

Charitable Expenditure	Total £
Medical & surgical equipment	-
Patients' welfare & amenities	1,098
Staff welfare	111,413
Other charitable expenditure	2,575
Total charitable expenditure	115,086

The charitable expenditure amounted to £115,086 in 2020-21 (£9,976 in 2019-20).

In 2020-21 the charity benefited from donations, legacies and grants of £168,734 (£2,469 in 2019-20).

Financial review
The policies that have been adopted in order to further the objects of the Charity are:

i) The "Procedure notes and policies" for charitable funds, identifying the procedures to be followed in the administration of the funds.
ii) The charitable fund does not currently hold any investments other than cash held on account at bank. Should the fund rise to a level requiring investment to be made, an investment policy will be agreed with the broker which will detail ethical restrictions on investments and set out the level of risk the fund can be exposed to.
iii) The "Charitable funds reserves policy", highlights that balances should not generally be built up year on year, unless there are specific projects or items which require funds to be accumulated over more than one year. In this context the term "reserves" excludes restricted funds, and unrestricted funds included in performance related investments (statement of recommended practice 2015).

During the year the Charity spent £112,511 (£7,365 in 2019-20) on charitable activities including patient and staff welfare and amenities as detailed in note 4 of the accounts. Included within the total resources expended of £115,086 (£9,976 in 2019-20) shown in the statement of financial activities are the costs of administering the funds of £2,575 (£2,611 in 2019-20).

At the end of the year the charity held cash at bank of £389,301 (£226,790 at 31 March 2020).

The Charitable Funds Committee has monitored the performance of the funds.

Thank you
On behalf of all the staff and patients who have benefited from the improved services due to donations and legacies, the Corporate Trustee would like to thank all patients, relatives and staff who have made charitable donations, NHS Charities Together, and Captain Sir Tom Moore who did so much to raise the profile of NHS charities during the pandemic.

REPORT OF THE TRUSTEES
FOR THE YEAR ENDED 31 MARCH 2021

STRUCTURE, GOVERNANCE AND MANAGEMENT

Governing document

The charity was created by Trust Deed on the 24 November 1995 and was named as Portsmouth Healthcare NHS Trust Charitable Fund.

On 31 March 2002 the charity was renamed as Portsmouth & South East Hampshire Charitable Fund. Due to the NHS reforms the governance of the charity was transferred to Solent NHS Trust on 22 December 2011 and the charity was renamed Solent NHS Charity. The statutory instrument carrying out the transfer included the transfer of funds held by Southampton Hospital Charity.

Solent NHS Charity inherited a number of funds that had previously been classified as restricted. The unrestricted funding available is held to further the objectives of the charity. The restricted funds are held for any charitable purpose relating to the National Health Services, wholly or mainly for the fund specified. Based on the criteria in the NHS Charities Guidance, the Charity reclassified all restricted funds apart from the Chapel Fund to the unrestricted general fund in May 2017 in order to maximise the potential for the strategic development of the Trust and public benefit.

The corporate trustee is Solent NHS Trust. The Executive Directors and Non-Executive Directors of the Trust Board share the responsibility for ensuring that the NHS body fulfils its duties as corporate trustee in managing the charitable funds. The Chair and Non-Executive Directors were appointed by the Secretary of State via NHS Improvement (and previously the Appointments Commission) and the Chief Executive and Executive Directors were appointed by the Non-Executive Directors of the Trust.

The Board of Solent NHS Trust, on behalf of the corporate trustee, has delegated responsibility to manage the charitable funds to the Charitable Funds Committee. Solent NHS Trust Chief Finance Officer is responsible for the day-to-day management and control of the administration of the charitable funds and reports to the Charitable Funds Committee. The Chief Finance Officer has responsibility to ensure that spending is in accordance with the objects and priorities agreed by the Charitable Funds Committee; that the criteria for spending charitable monies are fully met; that full accounting records are maintained; and that devolved decision making or delegated arrangements are in accordance with the charity's policies and procedures.

The membership of the Charitable Funds Committee for the financial year 2020-21 was made up as follows:

Chair

Gaurav Kumar	Non Executive Director

Members

David Noyes	Chief Operating Officer Southampton and County Services and executive strategic lead for Charitable funds
Rachel Cheal	Chief of Staff and Corporate Affairs
Vickie O'Leary	Deputy Director of Finance

REPORT OF THE TRUSTEES
FOR THE YEAR ENDED 31 MARCH 2021

STRUCTURE, GOVERNANCE AND MANAGEMENT

Induction and training of new trustees

As part of their induction programme new Executive and Non-Executive Directors of Solent NHS Trust are made aware of their responsibilities as the corporate trustee of Solent NHS Charity. This induction includes an introduction to the objectives, scope and policies of the Charitable Funds, Charity Commission information on trustee responsibilities and copies of the previous three years of the charity's annual reports and accounts together with a copy of the governing documents for the constituent charitable funds. The same information is provided for new members of the Charitable Funds Committee.

The Executive Directors of the Trust in 2020-21 were:

Sue Harriman	Chief Executive (seconded 28 September 2020 - end of February 2021)
Andrew Strevens	Chief Finance Officer (Acting CEO from 28 September 2020 - end of February 2021)
Gordon Fowler	Strategic Transformation Director and Director of Estates (Acting Chief Finance Officer from 28 September 2020 - end of February 2021)
Sarah Austin	Chief Operating Officer Portsmouth and Commercial Director (left 26 April 2020)
David Noyes	Chief Operating Officer Southampton and Countywide Services
Helen Ives	Chief People Officer (seconded to Vaccination Programme from 28 September 2020)
Jackie Ardley	Chief Nurse (Acting Deputy CEO from 28 September 2020 – end of February 2021)
Jas Sohal	Acting Chief People Officer (from 28 September 2020)

The Non-Executive Directors of the Trust in 2020-21 were:

Catherine Mason	Chair
Calum Mercer	(joined 1 February 2021)
Jon Pittam	(left 31 March 2021)
Michael Watts	
Stephanie Elsy	
Gaurav Kumar	
Thoreya Swage	

REFERENCE AND ADMINISTRATIVE DETAILS

Registered Charity number

1053431

Principal address

Solent NHS Charity
c/o Solent NHS Trust
Highpoint Venue, Bursledon Road
Southampton
Hants
SO19 8BR

Trustees

Solent NHS Trust

Independent Examiner

P Underwood
FCCA
Morris Crocker
Chartered Accountants
Station House
North Street
Havant
Hampshire
PO9 1QU

REPORT OF THE TRUSTEES
FOR THE YEAR ENDED 31 MARCH 2021

REFERENCE AND ADMINISTRATIVE DETAILS

Solicitors
Bevan Brittan
Fleet Place House
2 Fleet Place
Holborn Viaduct
London
EC4M 7RF

Bankers
CAF Bank Ltd
25 Kings Hill Avenue
Kings Hill
West Malling
Kent ME19 4JQ

STATEMENT OF TRUSTEES' RESPONSIBILITIES

The trustees are responsible for preparing the Report of the Trustees and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales, the Charities Act 2011, Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources, including the income and expenditure, of the charity for that period. In preparing those financial statements, the trustees are required to

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charity SORP;
- make judgements and estimates that are reasonable and prudent;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustees are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the charity and to enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Approved by order of the board of trustees on 17 August 2021 and signed on its behalf by:

.....
Solent NHS Trust - Trustee

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF SOLENT NHS CHARITY

Independent examiner's report to the trustees of Solent NHS Charity
I report to the charity trustees on my examination of the accounts of Solent NHS Charity (the Trust) for the year ended 31 March 2021.

Responsibilities and basis of report
As the charity trustees of the Trust you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the Trust's accounts carried out under section 145 of the Act and in carrying out my examination I have followed all applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement
I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the Trust as required by section 130 of the Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a true and fair view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

P Underwood
FCCA
Morris Crocker
Chartered Accountants
Station House
North Street
Havant
Hampshire
PO9 1QU

Date: 18 August 2021

SOLENT NHS CHARITY

STATEMENT OF FINANCIAL ACTIVITIES
FOR THE YEAR ENDED 31 MARCH 2021

	Notes	Unrestricted funds £	Restricted funds £	2021 Total funds £	2020 Total funds £
INCOME AND ENDOWMENTS FROM					
Donations and legacies	2	9,234	159,500	168,734	2,469
Investment income	3	155	2	157	556
Total		9,389	159,502	168,891	3,025
EXPENDITURE ON					
Charitable activities	4				
Patient welfare and amenities		1,098	-	1,098	150
Staff welfare and amenities		-	111,413	111,413	1,869
Medical and surgical equipment		-	-	-	5,346
Other		2,575	-	2,575	2,611
Total		3,673	111,413	115,086	9,976
NET INCOME/(EXPENDITURE)		5,716	48,089	53,805	(6,951)
RECONCILIATION OF FUNDS					
Total funds brought forward		222,214	3,144	225,358	232,309
TOTAL FUNDS CARRIED FORWARD		227,930	51,233	279,163	225,358

The notes form part of these financial statements

BALANCE SHEET
31 MARCH 2021

	Notes	2021 £	2020 £
CURRENT ASSETS			
Debtors	8	1,440	1,068
Cash at bank		389,301	226,790
		390,741	227,858
CREDITORS			
Amounts falling due within one year	9	(111,578)	(2,500)
NET CURRENT ASSETS		279,163	225,358
TOTAL ASSETS LESS CURRENT LIABILITIES		279,163	225,358
NET ASSETS		279,163	225,358
FUNDS	11		
Unrestricted funds		227,930	222,214
Restricted funds		51,233	3,144
TOTAL FUNDS		279,163	225,358

The financial statements were approved by the Board of Trustees and authorised for issue on 17 August 2021 and were signed on its behalf by:

.....
Solent NHS Trust - Trustee

The notes form part of these financial statements

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2021

1. ACCOUNTING POLICIES

Basis of preparing the financial statements
The financial statements of the charity, which is a public benefit entity under FRS 102, have been prepared in accordance with the Charities SORP (FRS 102) 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019)', Financial Reporting Standard 102 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' and the Charities Act 2011. The financial statements have been prepared under the historical cost convention.

Incoming resources
All incoming resources are recognised on a receivables basis and are reported gross of related expenditure once the charity has entitlement to the resources, it is certain that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

The specific basis used are as follows:
a) Voluntary income includes donations and legacies on a receivables basis
b) Investment income is accounted for on a receivables basis
c) Activities for generating funds includes fundraising income and is shown gross
d) NHS Charities Together Grant Awards are accounted for on a receivables basis

Resources expended
Expenditure is accounted for on an accruals basis and is recognised once there is a legal or constructive obligation to make a payment to a third party.

a) Cost of generating funds

The costs of generating funds are those costs attributable to generating income resources for the charity, other than those costs incurred in undertaking charitable activities.

b) Charitable activities

Charitable activities expenditure enables the charity to meet its charitable aims and objectives. These costs, where not directly attributable, are apportioned between the categories of the charitable expenditure in addition to the direct costs.

c) Governance

These are accounted for on an accruals basis and are the costs of managing and administering the funds of the charity.

Change in the basis of accounting
The financial statements have been prepared to give a true and fair view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a true and fair view. This departure has involved following the Charities SORP (FRS 102) issued on 16 July 2015 rather than the preceding Charities SORP (SORP 2005) which was effective from 1 April 2005 and has since been withdrawn.

Taxation
The charity is exempt from tax on its charitable activities.

Fund accounting
Unrestricted funds can be used in accordance with the charitable objectives at the discretion of the trustees.

Restricted funds can only be used for particular restricted purposes within the objects of the charity. Restrictions arise when specified by the donor or when funds are raised for particular restricted purposes.

continued...

NOTES TO THE FINANCIAL STATEMENTS - continued
FOR THE YEAR ENDED 31 MARCH 2021

1. ACCOUNTING POLICIES - continued

Fund accounting

Further explanation of the nature and purpose of each fund is included in the notes to the financial statements.

2. DONATIONS AND LEGACIES

	2021	2020
	£	£
Donations	9,234	2,469
Grants	159,500	-
	168,734	2,469

Grants received, included in the above, are as follows:

	2021	2020
	£	£
NHS Charities Together Covid-19 Appeal Grant Award	159,500	-

3. INVESTMENT INCOME

	2021	2020
	£	£
Deposit account interest	157	556

All investment income is derived from assets held in the United Kingdom.

4. CHARITABLE ACTIVITIES COSTS

	Direct Costs
	£
Patient welfare and amenities	1,098
Staff welfare and amenities	111,413
	112,511

continued...

5. SUPPORT COSTS

	Management	Governance costs	Totals
	£	£	£
Other resources expended	1,575	1,000	2,575

Support costs, included in the above, are as follows:

Management

	2021 Other resources expended	2020 Total activities
	£	£
Insurance	381	325
Management & administration co sts	1,125	1,278
Bank charges	69	60
	1,575	1,663

Governance costs

	2021 Other resources expended	2020 Total activities
	£	£
Independent examination fee	1,000	948

6. TRUSTEES' REMUNERATION AND BENEFITS

There were no trustees' remuneration or other benefits for the year ended 31 March 2021 nor for the year ended 31 March 2020.

Trustees' expenses

During the year no trustees (2020: no trustees) were reimbursed out of pocket expenses.

7. COMPARATIVES FOR THE STATEMENT OF FINANCIAL ACTIVITIES

	Unrestricted funds	Restricted funds	Total funds
	£	£	£
INCOME AND ENDOWMENTS FROM			
Donations and legacies	2,469	-	2,469
Investment income	548	8	556
Total	3,017	8	3,025
EXPENDITURE ON			
Charitable activities			
Patient welfare and amenities	150	-	150
Staff welfare and amenities	1,869	-	1,869
Medical and surgical equipment	5,346	-	5,346
Other	2,611	-	2,611

continued...

NOTES TO THE FINANCIAL STATEMENTS - continued
FOR THE YEAR ENDED 31 MARCH 2021

7. COMPARATIVES FOR THE STATEMENT OF FINANCIAL ACTIVITIES - continued

	Unrestricted funds £	Restricted funds £	Total funds £
Total	9,976	-	9,976
NET INCOME/(EXPENDITURE)	(6,959)	8	(6,951)
RECONCILIATION OF FUNDS			
Total funds brought forward	229,173	3,136	232,309
TOTAL FUNDS CARRIED FORWARD	222,214	3,144	225,358

8. DEBTORS: AMOUNTS FALLING DUE WITHIN ONE YEAR

	2021 £	2020 £
Prepayments	1,440	1,068

9. CREDITORS: AMOUNTS FALLING DUE WITHIN ONE YEAR

	2021 £	2020 £
Other creditors	111,578	2,500

10. ANALYSIS OF NET ASSETS BETWEEN FUNDS

	Unrestricted funds £	Restricted funds £	2021 Total funds £	2020 Total funds £
Current assets	339,508	51,233	390,741	227,858
Current liabilities	(111,578)	-	(111,578)	(2,500)
	227,930	51,233	279,163	225,358

continued...

NOTES TO THE FINANCIAL STATEMENTS - continued FOR THE YEAR ENDED 31 MARCH 2021

11. MOVEMENT IN FUNDS

	At 1.4.20 £	Net movement in funds £	At 31.3.21 £
Unrestricted funds			
General fund	173,109	3,396	176,505
Staff welfare fund	48,131	-	48,131
ADS Southampton Wards fund	-	600	600
Cardiac - Adults Southampton fund	-	300	300
Community Nursing - Adults Portsmouth fund	450	620	1,070
Primary Care - Hydrotherapy fund	170	-	170
Primary Care - Homeless Healthcare fund	-	300	300
Childrens community nursing fund	354	500	854
	222,214	5,716	227,930
Restricted funds			
Chapel fund	3,144	2	3,146
NHS Charities Together Covid-19 Appeal fund	-	48,087	48,087
	3,144	48,089	51,233
TOTAL FUNDS	225,358	53,805	279,163

Net movement in funds, included in the above are as follows:

	Incoming resources £	Resources expended £	Movement in funds £
Unrestricted funds			
General fund	7,069	(3,673)	3,396
ADS Southampton Wards fund	600	-	600
Cardiac - Adults Southampton fund	300	-	300
Community Nursing - Adults Portsmouth fund	620	-	620
Primary Care - Homeless Healthcare fund	300	-	300
Childrens community nursing fund	500	-	500
	9,389	(3,673)	5,716
Restricted funds			
Chapel fund	2	-	2
NHS Charities Together Covid-19 Appeal fund	159,500	(111,413)	48,087
	159,502	(111,413)	48,089
TOTAL FUNDS	168,891	(115,086)	53,805

continued...

11. MOVEMENT IN FUNDS - continued

Comparatives for movement in funds

	At 1.4.19 £	Net movement in funds £	At 31.3.20 £
Unrestricted funds			
General fund	179,173	(6,064)	173,109
Staff welfare fund	50,000	(1,869)	48,131
Community Nursing - Adults Portsmouth fund	-	450	450
Primary Care - Hydrotherapy fund	-	170	170
Childrens community nursing fund	-	354	354
	229,173	(6,959)	222,214
Restricted funds			
Chapel fund	3,136	8	3,144
TOTAL FUNDS	232,309	(6,951)	225,358

Comparative net movement in funds, included in the above are as follows:

	Incoming resources £	Resources expended £	Movement in funds £
Unrestricted funds			
General fund	2,043	(8,107)	(6,064)
Staff welfare fund	-	(1,869)	(1,869)
Community Nursing - Adults Portsmouth fund	450	-	450
Primary Care - Hydrotherapy fund	170	-	170
Childrens community nursing fund	354	-	354
	3,017	(9,976)	(6,959)
Restricted funds			
Chapel fund	8	-	8
TOTAL FUNDS	3,025	(9,976)	(6,951)

Unrestricted funds (designated):

Staff Welfare fund
Being donations received to be specifically spent on the Staff Welfare service line.

Community Nursing - Adults Portsmouth fund
Being donations received to be specifically spent on the Community Nursing - Adults Portsmouth service line.

Primary Care - Hydrotherapy fund
Being donations received to be specifically spent on the Primary Care - Hydrotherapy service line.

Primary Care - Homeless Healthcare fund

continued...

11. MOVEMENT IN FUNDS - continued

Being donations received to be specifically spent on the Primary Care - Homeless Healthcare service line.

Children's Community Nursing fund
Being donations received to be specifically spent on the Children's Community Nursing service line.

Cardiac - Adults Southampton fund:
Being donations received to be specifically spent on the Cardiac - Adults Southampton service line.

ADS Southampton Wards fund
Being donations received to be specifically spent on the ADS Southampton Wards service line.

Restricted funds:

Chapel fund
Being donations received to be specifically spent on the pastoral service line.

NHS Charities Together Covid-19 Appeal fund
Being grant income received to be specifically spent on urgent and immediate needs of staff, patients and volunteers, and their physical health.

12. RELATED PARTY DISCLOSURES

During the year certain members of the Charitable Funds Committee, which have been delegated authority by the trustee to act on its behalf in the day to day administration of all funds held on trust, were also Board members of Solent NHS Trust.

Solent NHS Trust has also received revenue from Solent NHS Charity of which the NHS Trust Board is the corporate trustee.

At the end of the year Solent NHS Trust was owed £110,522 by Solent NHS Charity.

Board members of Solent NHS Trust, the corporate trustee, and members of the Charitable Funds Committee ensure that the business of the charity is dealt with separately from that associated with exchequer funds for which they are also responsible. Declarations of personal interest are made, where appropriate, and those declarations pertaining to the funds held on trust are available for public inspection by application through Solent NHS Trust.