# Agenda

## Solent NHS Trust In Public Board Meeting

Date: Monday 1 August 2022
Timings: 9:30 – 12:50
Meeting details: Virtual meeting

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

| Item | Time | Dur. | Title & Recommendation | Exec Lead / Presenter | Board Requirement |
|---|---|---|---|---|---|
| 1 | 09:30 | 5mins | **Chairman's Welcome & Update**<br>• **Apologies to receive** | Chair | To receive |
| | | | **Confirmation that meeting is Quorate**<br>*No business shall be transacted at meetings of the Board unless the following are present;*<br>• *a minimum of two Executive Directors*<br>• *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair* | Chair | - |
| | | | **Register of Interests & Declaration of Interests** | Chair | To receive |
| 2 | 09:35 | 30mins | **Patient Story – Joe Jenness, Story Telling Champion** | Deputy CEO & Chief Nurse | To receive |
| 3 | 10:05 | 30mins | **Staff Story - Talking Change, Psychological Services – Charmaine Wright** | Chief People Officer | To receive |
| 4 | 10:35 | 5mins | ***Previous minutes, 6 June 2022 and EO meeting on 13 June matters arising and action tracker** | Chair | To approve |
| **Quality and safety first** | | | | | |
| 5 | 10:40 | 10mins | **Safety and Quality – contemporary matters including:**<br>• **Board to Floor feedback**<br>• **Freedom to Speak Up matters** | Deputy CEO & Chief Nurse Chief of Staff | Verbal update / To receive |
| **10-minute break** | | | | | |
| **Items to receive** | | | | | |
| 6 | 11:00 | 10mins | **Six Monthly Safe Staffing Report December 2021 – May 2022** | Deputy CEO & Chief Nurse | To receive |
| 7 | 11:10 | 10mins | **Patient Safety including Learning from Deaths, Learning from incidents and SIs Annual Report** | Deputy CEO & Chief Nurse | To receive |

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| 8 | 11:20 | 20mins | **Chief Executive's Report** | CEO | To receive |
| 9 | 11:40 | 35mins | **Performance Report**<br>*Including:*<br>• *Safe*<br>• *Caring*<br>• *Effective*<br>• *Responsive*<br>• *People*<br>• *Finance*<br>• *Research and Improvement*<br>• *Self-Declaration NHS Provider Licence*<br>• *Single Oversight Framework*<br>• *System Oversight Framework* | Executive Leads | To receive |
| 10 | 12:15 | 10mins | **Information Governance Compliance Report April – June 2022** | Chief of Staff | To receive |
| **Reporting Committees and Governance matters** | | | | | |
| 11 | 12:25 | 20mins | **People Committee -** *Exception report from meeting held 14th June 2022* | Committee chair | To receive |
| 12 | | | **Engagement and Inclusion Committee –** *Exception report from meeting 23rd June 2022* | Committee chair | To receive |
| 13 | | | **Mental Health Act Scrutiny Committee-** *Exception report from meeting 23rd June 2022* | Committee chair | To receive |
| 14 | | | **Audit & Risk Committee –** *Exception report from meeting 13th June 2022*<br>• *Internal Audit Plan* | Committee chair | To receive |
| 15 | | | **Quality Assurance Committee-** *Exception report from meeting held 21st July 2022.*<br>*Supplementary papers provided:*<br>• *15.2 - Infection Prevention & Control Annual Report*<br>• *15.3 - Safeguarding Adults and Children Annual Report* | Committee chair | To receive |
| 16 | | | **Governance and Nominations Committee** – *Exception report from meeting 7th July 2022*<br>• *Terms of Reference for Remuneration and Nominations Committee -to approve* | Committee chair | To receive |

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| 17 | | | **Non-Confidential update from Finance & Infrastructure Committee–** *non confidential verbal update from meeting held 25th July 2022* | Committee chair | Verbal update |
| 18 | | | **Charitable Funds Committee –** *no meeting held to report. Next meeting 4th August 2022.* | Committee chair | To receive |
| **Any other business** | | | | | |
| 19 | 12:45 | 5mins | **Any other business and reflections including:** | Chair | - |
| 20 | | | • ***lessons learnt and living our values***<br>• ***matters for cascade and/or escalation to other board committees*** | | |
| 21 | 12:50 | --- | **Close and move to Confidential meeting**<br>The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows:<br>"that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960) | Chair | - |

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***Date of next meeting:***

- ***3rd October 2022***

Item 4.1

# Minutes

## Solent NHS Trust In Public Board Meeting

Date: Monday 6 June 2022
Timings: 9:30
Meeting details: Virtual meeting via MS Teams

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| **Chair:**<br>**Catherine Mason,** Trust Chair (CMa) | |
| **Members:**<br>**Andrew Strevens,** CEO (AS)<br>**Jackie Munro**, Deputy CEO & Chief Nurse (JM)<br>**Dan Baylis**, Chief Medical Officer (DB)<br>**Suzannah Rosenberg**, Chief Operating Officer (SR)<br>**Jas Sohal**, Chief People Officer (JS)<br>**Gordon Fowler**, Chief Finance Officer (GF)<br>**Mike Watts,** Non-Executive Director (MW)<br>**Gaurav Kumar**, Non-Executive Director (GK)<br>**Stephanie Elsy,** Non-Executive Director (SE)<br>**Calum Mercer**, Non-Executive Director (CMe)<br>**Vanessa Avlonitis,** Associate Non-Executive Director (VA) | **Attendees:**<br>**Rachel Cheal**, Chief of Staff & Corporate Affairs (RC)<br>**Jayne Jenney**, Assistant Company Secretary and Corporate Support Manager (JJ)<br>**Sandra Glaister,** Company Secretary (SG)<br>**Beccy Burgos** (Shadowing Jackie Munro)<br><br>**Apologies:**<br>No apologies to note. |
| **Patient Story (item 2)**<br>Sarah Bamford (SB), Advanced MSK Adolescent Physiotherapist | **Staff Story (item 3)**<br>Kathryn Hammond, Matron CAMHS East |
| **Judgements and decisions made in the context of a Level 3 National Incident** | |

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| **1** | **Chair's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests** |
| 1.1 | CMa welcomed members of the public to the meeting.<br>CMa confirmed AS as the new CEO for the Trust.<br>It was noted to be JS, Chief People Officer's last Board meeting before leaving the Trust at the end of June.<br>CMa also informed the Board of the planned departure of GF, Chief Finance Officer to work within the Hampshire and Isle of Wight system. CMa conveyed her congratulations to all. |
| 1.2 | The meeting was confirmed as quorate.<br>There were no declarations of interest updates to note. |
| **2** | **Patient Story – Adolescent Physiotherapy** |
| 2.1 | JM introduced Sarah Bamford (SB) to the Board.<br>SB explained her new role within the Trust that is dedicated to providing musculoskeletal treatment to teenagers aged between 12-18 yrs. SB shared the goal to provide a continuation of care from paediatrics upwards to assist with the prevention of future potential health issues.<br>SB shared via videos and photos, the transformative journey of a treatment on a young patient. SB explained initial symptoms and associated problems and the treatment provided that achieved a positive outcome. |

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| | SB informed the Board that there are many similar cases to the story shared, resulting in nonattendance at school and lack of physical activities. |
| 2.2 | The Board discussed the positive investment in young people and increasing the prevention agenda to assist children in achieving their full potential in early adulthood. |
| 2.3 | DM shared his concerns with regards to the differences in treatment provided from 18 years and shared a case example of a regular A&E visitor due to a lack of preventative treatment and physio support.<br><br>SB explained the differences in dedicated pathways in Southampton and Portsmouth and informed the Board of her intervention during lockdown via telephone that prevented presentation to A&E.<br><br>The Board discussed the future of the service and of possible working within the PCN and Primary Care strategy and aligned to the Clinical Framework. |
| 2.4 | The Board discussed in some detail, workforce challenges and resource required to provide a continuity of care. |
| 2.5 | DM highlighted conversations in progress on how to improve service delivery within the ICS system. |
| 2.6 | CMa thanked SB for the presentation.<br>*SB left the meeting at this point.* |
| **3** | **Staff Story – CAMHS East** |
| 3.1 | JS introduced Kathryn Hammond (KH) to the Board.<br>• KS briefed the Board on her experience and journey within the NHS, of her various roles as a Mental Health nurse and current role within CAMHs.<br>• Despite her lack of careers advice received at school, KS informed the Board of her confidence built over the years and of a master's degree achieved that was funded by the Trust.<br>• KS shared inspiring projects achieved during lockdown within the CAMHs team to support the wellbeing of staff that have continued such as actively encouraging breaks, 3-minute discos and mirroring positive messages to staff that are shared with patients.<br>• KS highlighted current uncertainties within the Team due to the imminent departure of the manager who has been integral in the service development and support. The team are also still recovering and catching up from the pandemic. |
| 3.2 | SR commented on the significant role KS has played in the team, particularly during lockdown and thanked KS for her excellent support to the service.<br>SR also suggested that initiatives should be shared across the organisation. |
| 3.3 | KS highlighted the successful revalidated accreditation with QNCC achieved despite the pressure during lockdown and significant IT difficulties. |
| 3.4 | MW commented on staff fragility and continuing pressures faced and asked if there is anything the Board can do to help. KS provided assurance of action plans in place and of the continued positivity held by staff that pressures will improve going forward. Mitigation measures are also in place if required.<br><br>KS reported that the long-term plan is to ensure workforce is involved in the evaluation to make things more manageable within the service. |
| 3.5 | The Board reflected on the update provided. |

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| | SR informed the Board of work being led by Mahdi Ghomi to look at what the Trust can provide to address workforce trauma. This is to be discussed further at an executive meeting.<br>CMa thanked KS for the update provided and wished her well with the CAMHs recovery plans.<br>*KS left the meeting at this point.* |
| **4** | **Minutes of the meeting held Monday 4 April 2022, matters arising and action tracker** |
| 4.1 | The minutes of the meeting held on 4 April 2022 were confirmed as an accurate record. |
| 4.2 | The following actions were confirmed as complete: AC004547 AC004548, AC004549 and AC004550. |
| **5** | **Safety and Quality – contemporary matters including:**<br>• **Board to Floor feedback including 6 monthly Board to Floor update**<br>• **Freedom to Speak Up matters** |
| 5.1 | <u>Safety</u><br>JM reported that following the easing of IPC restrictions, there has been no impact to staff covid numbers. JM reminded all to continue to follow the current IPC guidelines. |
| 5.2 | <u>Board to floor visits</u><br>JM asked that any key issues identified are shared as soon as possible after visits and in advance of the written report to ensure they are dealt with promptly.<br>JM also confirmed that visits will be reduced to 3 per month with executives and NEDs attending together.<br>There were no further matters of safety issues to raise. |
| 5.3 | <u>Freedom to Speak Up matters</u><br>There were no matters for escalation.<br>It was noted that F2SU Lead interviews are to take place this week. |
| **6** | **Proposal for Approval - Formulating a Hampshire and Isle of Wight Mental Health & Learning Disability Provider Collaborative (MHLD PC)** |
| 6.1 | RC presented the paper to the Board explaining the initial proposal remit and purpose to formulate a Hampshire and Isle of Wight Mental Health & Learning Disability Provider Collaborative (MHLD PC). RC explained that the proposal is to be presented to sovereign organisational Boards and formalised at the same time as the commencement of the ICB on 1 July 2022.<br><br>RC highlighted caveats regarding further work required to recalibrate some mental health groups within the existing infrastructure, and notably that the PC and surrounding architecture will mature, including that associated with LDS and Place, and therefore change in time.<br><br>RC explained the concept of the proposed Senior Responsible Officer (SRO) being mandated to lead identified workstreams the detail of which is described within Appendix 1, draft Terms of Reference.<br><br>The Board was informed that an initial membership of the Provider Board needs to be agreed with the view to be a representative model across Trusts. |
| 6.2 | CMe commented on the potential risk of lack of local authority and patients / carers representation that could result in potential areas of opportunities being missed. |

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| | RC confirmed that the membership of the Mental Health Programme Board does include Local Authority, Voluntary Sector and primary care as well as providers and that it is anticipated that workstream architecture aligned to place and LDS will be inclusive of all parties and users. |
| 6.3 | Members of the Board shared their respective views and discussed the paper presented.<br><br>AS reported that the proposal will be discussed further during the confidential meeting. |
| 6.4 | **The Board approved:**<br>• **The initial remit and purpose described within the proposal.**<br>• **The formation of the HIoW Provider Collaborative Board operating as a Committee in Common with delegation rights as stipulated in the summary report.**<br>• **A mandate for allocated SROs to lead and coordinate respective Mental Health& Learning Provider Collaborative workstreams as described within the draft ToRs.**<br>• **DM, JM and SR as representatives for the HIoW MHLDA Provider Collaborative Board membership.**<br><br>**The Board noted:**<br>• **The initial wiring diagram demonstrating how the HIoW MHLDA Provider Collaborative Board is positioned and its relationship with existing governance arrangements.**<br>• **The draft ToR of the Provider Collaborative Board.**<br>• **The identified priority workstreams for the collaborative.** |
| **7** | **Professional Leadership & Engagement Report (inc. professional strategic framework and nurse revalidation) (Nursing, AHPs and medical workforce)** |
| 7.1 | • JM informed the Board of the successful Nurse and Nurse Support Worker Awards presented to Natasha Baker and Jerzy Rucinski, who both work at Brooker Ward.<br>• International recruitment work continues to progress and is being progressed within the wider system. JM explained pilot sites identified that are accepting national recruits into community services.<br>• JM highlighted concerns regarding low numbers of people entering health-based careers and of the need to consider how to encourage more interest.<br>• JM informed the Board of significant work in progress on AHP job planning. |
| 7.2 | The Board discussed clinical supervision and acceptable clinical time taken from services to provide. JM acknowledged the need to consider further areas for student placement, supervision arrangements and reducing consequential staffing pressures.<br><br>AA added that work is in progress to determine supervision capacity whilst considering all other factors that have an impact on staffing pressures, in particular the ongoing recovery from the pandemic. |
| 7.3 | DB informed the Board of the recent successful Doctors and Dentist Conference held.<br>**The Board noted the report and further update.** |
| **8** | **Chief Executive's Report** |
| 8.1 | • AS echoed DBs comment regarding the success of the Doctors and Dentist conference.<br>• AS informed the Board of his recent visit to Orchards with RC where they met with Natasha Simpson and commented on her enthusiasm and well-deserved Nurse award achieved.<br>• The Board was informed of positive collaborative work in progress by Solent's Chief Pharmacist with Southern on the implementation of electronic prescribing. |

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| | • AS informed the Board of the recent visit from the Chief Nurse of NHS England and Improvement to St Marys to speak with international nurses from Solent and Southern.<br>• Recruiting plans for the CFO and CPO were shared. AS also reported on plans to recruit a Strategic Transformation Director and Deputy COO.<br>**The Board noted the report.** |
| **9** | **Integrated Performance Report** |
| 9.1 | The Board were asked to raise comments on each section of the Integrated Performance Report presented.<br><br><u>Safe</u><br>CMa asked if there was any further information to note with regards to the unexpected death reported. JM confirmed significant support being provided to the team involved. There were no further comments to note. |
| 9.2 | <u>Effective</u><br>MW referred to the reported capacity and demand modelling and suggested the highlighting of flow blockages in order to understand the interactive nature of the demand reported. It was agreed to consider further at a future Board away day. |
| 9.3 | CMe commented on difficulties in understanding what a good position is with the data reported. SR confirmed discussions held with executives where the future inclusion of benchmarking against efficacies was agreed. |
| 9.4 | SR highlighted discrepancies detailed on page 47 – 71 of the report due to differences in data capturing methods in Portsmouth and Southampton. SR confirmed parallel reporting expected within future reports.<br><br>SR informed the Board that the content of the report is a working progress. Further information within the 'effective' section of the report will be available in future iterations. |
| 9.5 | CMa enquired if the Trust could be eligible for a grant to assist with capacity and demand work. SR confirmed investment already made for six months training for an individual to deliver the methodology. |
| 9.6 | SR provided a contemporary update with regards to Dental GA. It was noted that Hampshire Hospitals and Portsmouth have now offered GA sessions. Improvements on the GA waiting position are beginning to emerge. |
| 9.7 | JS suggested consideration is given on how to capture prevention effectiveness. DM agreed that the Trust is not effective in using data to provide information in this area. |
| 9.8 | <u>People</u><br>VA asked what action is being taken to address the significant level of stress related sickness reported.<br><br>JS briefed the Board on work in progress to create an Occupational Health and Wellbeing Plan to assist in shaping a solution from a health and wellbeing perspective. Medium and long term solutions are being considered.<br>The Board shared their thoughts on factors contributing to staff stress including the impact of the pandemic and cost of living. |
| 9.9 | CMa asked if the post pandemic sickness trend is replicated across other trusts. JS confirmed similar trends however the Trust turnover trend is higher elsewhere. |

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| 9.10 | Research<br>DB highlighted the successful year achieved following the focus on Covid and commented on being proud of the research undertaken to date. |
| 9.11 | System Oversight Framework<br>VA asked if the increased waiting list threshold is mandated or based on an assumption of expectations. AS to enquire further and feedback. **Action: AS**<br>VA queried the decrease in psychosis treatment. SR explained significant differences in figures reported due to the small cohort of staff reported on. SR confirmed no matters of concern to raise. |
| 9.12 | The figures reported for the out of area placement (OAP) bed days were queried. AS provided clarity that the data report illustrates the number of occupied bed days and not number of beds. AS reported that Solent are leading in this area. It was agreed that AS provide clarification on the data reported if there is further information to share. **Action: AS** |
| **10** | **People Committee** |
| 10.1 | • MW informed the Board of work in progress to increase predictive reporting.<br>• The committee discussed operational risks and the possibility of looking at different scoring metrics in different areas.<br>• Significant estates issues were discussed, and it was suggested to discuss further at a future Board workshop.<br>• A retention deep dive is to report back to the August committee. |
| 10.2 | RC enquired as to when the Agile Working pilot is expected to conclude, and outcomes reported. JS to make enquiries and feedback. **Action: JS**<br>**The Board noted the exception report and further update**. |
| **11** | **Engagement and Inclusion Committee** |
| 11.1 | No meeting held to report. |
| **12** | **Mental Health Act Scrutiny Committee** |
| 12.1 | No meeting held to report. |
| **13** | **Audit & Risk Committee** |
| 13.1 | No meeting held to report. |
| **14** | **Quality Assurance Committee** |
| 14.1 | • VA reported that the committee received a deep dive on the Patient Safety Strategy. The role of champions and how they can support the quality of care and be a voice for service users was discussed.<br>• The committee received Experience of Care, Freedom to Speak Up and Research & Development annual reports which are provided as supplementary papers for the Board.<br>• The final draft of the Quality Accounts and Annual Governance Statement were approved and will be presented to the Audit and Risk Committee and EO In-Public Board meetings for approval next week.<br>JM confirmed that the Quality Accounts are to be streamlined next year to remove duplicated information that is provided within the Annual Report.<br>• The committee also received a document reviewing the Ockenden (and other Government) patient safety reports and two planned actions were noted. |

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| 14.2 | **The Board noted the exception report, two planned actions for the patient safety reports and supplementary papers provided.** |
| **15** | **Governance and Nominations Committee** |
| 15.1 | CMa provided a verbal update of the meeting held on 27 May 2022. It was noted that the committee approved the appointment of a Director of Strategic Transformation and Deputy COO.<br>The committee also discussed that with the increasing governance demands within the ICB, it would be of benefit to introduce a non-voting member of the Board with expertise in this area.<br>**The Board noted the update provided and approved the proposal to change the status of the Chief of Staff to become a non-voting member of the Board.** |
| **16** | **Non-Confidential update from Finance & Infrastructure Committee** |
| 16.1 | SE drew the Board's attention to the updated Green Plan presented for information. |
| 16.2 | There were no further matters to report. |
| **17** | **Charitable Funds Committee** |
| 17.1 | GK briefed the Board on business conducted at the meeting held on 27 May 2022.<br>• The committee received the financial report for period 01 January 2022 to 31 March 2022 and noted a deficit due to the Multi Use Games Area (MUGA) purchase at St James' Hospital.<br>• It was noted that due to the volume of requests, the application for the stage 3 recovery grant has been suspended.<br>• The committee approved in principle a bid for a Motion Activated Magic Table for Dementia care.<br>• Committee objectives were agreed for the year.<br>• It was agreed that staff would be contacted to be involved in a poll relating to the rebranding of the Charity and associated logos.<br>**The Board noted the exception report.** |
| **18** | **Any other Business** |
| 23.1 | There was no further business discussed. |
| **19** | **Lessons learnt and living our values**<br>**Matters for cascade and/or escalation to other board committees** |
| 19.1 | There were no matters for cascade or escalation.<br>Members of the Board reflected on discussions held. AS commented on the excellent patient story presented. JM confirmed that services are contacted and thanked for sharing stories following meetings. |
| **20** | **Meeting closed** |

***Date of next meeting:*** EO meeting 13th June 2022 then 1st August 2022

Item 4.2

# Minutes

## Solent NHS Trust Extra Ordinary In Public Board Meeting

Date: Monday 13 June 2022
Timings: 13:30
Meeting details: Hybrid (Condor and via MS Teams)

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| **Chair:**<br>**Stephanie Elsy,** Non-Executive Director (SE) | |
| **Members:**<br>**Andrew Strevens,** CEO (AS)<br>**Jackie Munro**, Deputy CEO & Chief Nurse (JM)<br>**Dan Baylis**, Chief Medical Officer (DB)<br>**Suzannah Rosenberg**, Chief Operating Officer (SR) – via MS Teams<br>**Jas Sohal**, Chief People Officer (JS)<br>**Gordon Fowler**, Chief Finance Officer (GF)<br>**Gaurav Kumar**, Non-Executive Director (GK)<br>**Calum Mercer**, Non-Executive Director (CMe)<br>**Vanessa Avlonitis,** Associate Non-Executive Director (VA) – via MS Teams<br>**Rachel Cheal**, Chief of Staff & Corporate Affairs (RC) | **Attendees:**<br>**Jayne Jenney**, Assistant Company Secretary and Corporate Support Manager (JJ)<br>**Sandra Glaister,** Company Secretary (SG)<br><br>**Apologies:**<br>**Catherine Mason,** Trust Chair (CMa)<br>**Mike Watts,** Non-Executive Director (MW) |

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

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| **1** | **Chair's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests** |
| 1.1 | SE chaired the meeting on behalf of CMa, as previously agreed by the Board. SE welcomed Board members to the Extra Ordinary In-Public Board meeting. |
| **2** | **Audit Results Report for the year ended March 2022** |
| 2.1 | GF reported that the Audit Results Report remains in draft format due to an issue identified late on Friday in relation to a sample test on 'Goods Received Not Invoiced' (GRNI). GF confirmed that material changes are not expected. |
| 2.2 | Annual Audit Letter of Representation 21/22<br>GF informed the Board that the letter of representation cannot be finalised until accounts are agreed.<br>(See below note 6.3 regarding Letter of Representation delegation) |
| **3** | **Annual Accounts 2021/22** |
| 3.1 | GF highlighted the main difference from previous accounts is due to a growth in workforce including investment schemes of hospital discharge to support operational assistance within the system. |
| 3.2 | **The Board approved the accounts for FY21/22 subject to:**<br>• **Confirmation from external auditors that they have finalised the outstanding piece of work on Good Received Not Invoiced which may impact on Income & Expenditure and therefore needs reflecting in the Trust's Annual Accounts and summary accounts within the Annual Report. Confirmation of the figures will be shared and approved by the CEO, CFO and Chair of** |

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| | **Audit Committee prior to submission on or before 22nd June (with the Trust Chair following return from Annual Leave and prior to 22 June)**<br>• **If the materiality of the difference is more than a £1m change to the I&E then an extra-ordinary Board will need to be convened to approve the accounts prior to 22nd June.**<br>• |
| **4** | **Annual Report 2021/22 including Annual Governance Statement** |
| 4.1 | Following discussion at the Audit Committee earlier, and minor amendments completed, RC explained that the Annual Report and Annual Governance statement is presented for approval, subject to continued enquiries being conducted on the accounts as explained by GF, in relation to GRNI.<br><br>RC also informed the Board that external auditors are conducting their consistency checks and reviewing 'staff numbers' within the Annual Report, which are expected to be immaterial, but have confirmed that the Annual Governance Statement (AGS) is finalised with no further queries.<br>RC stated that the draft AGS had previously been presented to the May 2022 Quality Assurance Committee.<br><br>**The Board approved the Annual Report subject to finalisation of the Accounts (and therefore Summary Accounts)**<br><br>**The Board approved the Annual Governance Statement.** |
| **5** | **Quality Account 2021/22** |
| 5.1 | JA introduced the Quality Account, which had previously been presented to the May 2022 Quality Assurance Committee. There were no changes to highlight.<br>**The Board approved the Quality Account 2021/22** |
| **6.** | **Any Other Business** |
| 6.1 | On behalf of the Board, RC thanked members of the wider support team for the hard administrative work conducted behind the scenes to coordinate the proceedings of the day and production of the various reports. |
| 6.2 | AS introduced Shahana Ramsden to the Board and explained her role as CPO from 30th June. |
| 6.3 | **Letter of Representation Delegation**<br>**The Board agreed to delegate approval and signature of the Letter of Representation to the Chief Finance Officer and Chair of the Audit & Risk Committee outside of the meeting, following finalisation of the accounts** |
| **6** | **Close** |

***Date of next meeting:*** 1st August 2022

# Action Tracker

| Overall Status | Source Of Action | Department | Date Action Generated | Minute Reference/ Additional URN | Action Number | Title/Concerning | Action Detail/ Management Response | Action Accountable Lead | Latest Progress Update |
|---|---|---|---|---|---|---|---|---|---|
| On Target | Board meeting - In Public | Executive | 06/06/2022 | 9.11 | AC004630 | BOD 1 - Integrated Performance Report | System Oversight Framework - VA asked if the increased waiting list threshold is mandated or based on an assumption of expectations. AS to enquire further and feedback. | Andrew Strevens | 13/06/2022 - The value shown is the ICS trajectory, which will need to change now given the break-even plan. |
| On Target | Board meeting - In Public | Executive | 06/06/2022 | 9.12 | AC004631 | BOD 1 - Integrated Performance Report | The figures reported for the out of area place (OA) bed days were queried. AS provided clarity that the data report illustrates the number of occupied bed days and not number of beds. AS reported that Solent are leading in this area. It was agreed that AS provide clarification on the data raeport if there is further information to share. | Andrew Strevens | 13/06/2022 - The numbers shown are occupied bed days. |

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| Item No. | 6 | Presentation to | Trust In Public Board | | |
| Title of paper | Six Monthly Safe Staffing Report December 2021 – May 2022 | | | | |
| Purpose of the paper | This report provides an overview of the Nursing & AHP safe staffing status for the period December 2021 to May 2022 and is set out in line with the National Quality Board (NQB) standards | | | | |
| Committees /Groups previous presented and outputs | Quality Improvement and Risk Group<br>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 | | For assurance | X | |
| Summary of Recommendations and actions required by the author | The Trust Board is asked to:<br>• Note the outcome of the six-monthly safe staffing report and the impact of the COVID-19 pandemic on the workforce.<br>• Note the ongoing work to improve the approach to safe staffing | | | | |

| To be completed by Exec Sponsor - Level of assurance this report provides: | | | | | | | |
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| Significant | | Sufficient | X | Limited | | None | |
| Exec Sponsor name: | Jackie Munro, Deputy CEO & Chief of Nursing and Allied Health Professionals | | Exec Sponsor signature: | JAMunro | | | |

**Executive Summary**

This report provides Trust Board an overview of the Nursing & AHP safe staffing status for the period December 2021 to May 2022. It provides assurance that arrangements are in place to safely staff the services in line with the National Quality Board (NQB) (2016) safe staffing guidance.

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

The Board is asked to note the current reported position, including the actions taken in response to Covid-19 pandemic and to endorse the action being taken to maintain and monitor safe staffing levels across the organisation.

**Key highlights**

- NHSEI produced guidance regarding Staffing Assurance Framework for Winter Preparedness December 2021. Because of our benchmarking against the framework safe staffing escalation weekly meetings were introduced. As the position has stabilised these have reverted to the monthly meetings and specifically focus on our inpatient wards and community nursing teams.
- In addition, services were asked to submit a daily situation report to rate their compliance against their safe staffing levels and this was reviewed by the executive team. As the situation improved in the spring this daily reporting was stood down.
- A position paper in respect of Safe Staffing was presented at People forum with a set of recommendations for the future and a workshop, led by Deputy Chief Nurse was held in March 2022, with representation from HR including Healthroster, Finance, Performance, Clinical

Workforce Development, HQP and Head of Nursing (Professional Leadership). The workshop reviewed the current state and set a vision for the future to enhance our approach to safe staffing and workforce planning to ensure the trust has a workforce fit for the future.

- Following this meeting a workforce planning programme board was established and had its first meeting in May 2022. The aim is to develop a robust Workforce Planning Programme with defined work streams. These will be developed further and will be monitored within the programme board. Representation from service line Operational Directors was also present, acknowledging the challenges of service change and financial probity
- A further national bid supported the successful recruitment of three Band 4 Practice Educators to support the Educator in Practice (EiP) team. They can now ensure that our HCSW colleagues, whether new to care or existing staff have pastoral and career development support. There is anecdotal evidence that this is having a positive impact on retention at three months of employment; however, this will be an area we continue to monitor.
- International Recruitment has continued throughout the period across adult community and mental health inpatient areas. Of our MH Nurse cohort 33% have been successful in securing senior roles and / or development opportunities within both inpatient and community teams.
- The first cohort of International Educated Nurses (IENs) commenced in Q1 following successful national bid to design, develop and deliver a community nursing transition programme.
- Uncertainty regarding the future provision of rehabilitation bed capacity within the Portsmouth system continues to cause concern has had an impact on staff turnover, recruitment, and retention.

## 1. Introduction

1.1 This report provides the Trust Board with an overview of the Nursing & AHP staffing status and linked quality metrics for the period December 2021 to May 2022. It is set out in line with the NQB (2016) safe staffing guidance and expectations to provide assurance that arrangements are in place to safely staff our services with the right number of nurses and midwives with the right skills at the right time and provides an explanation about how this was achieved.

## 2. Background

2.1 Solent NHS Trust have a duty to ensure staffing levels are adequate so that our patients are cared for by appropriately registered and experienced staff in safe environments. This right is enshrined within the NHS constitution (2015) and Health Act (2009) which make explicit the Board's corporate accountability for quality. Demonstrating sufficient staffing is one of the quality and safety standards as set out in 'Hard Truths' (2014) a publication from the Care Quality Commission (CQC).

2.2 In its guidance the NQB (2016), sets out a series of expectations and a framework within which organisations and staff should make decisions about safe staffing and emphasises the requirement for NHS provider Boards to be accountable for ensuring that their organisation has the right skills in place for safe, sustainable and productive staffing. The key expectations are set out below:

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

2.3 This report provides in-patient data published via an upload to Unify each month and now includes Care Hours Per Day (CHPPD) data.

2.4 Whilst Solent NHS Trust recognises that the national mandate for reporting relates to in-patient nurse staffing levels the Trust continues to include and acknowledge the contribution other disciplines make to ensure that clinical teams deliver safe, effective and high-quality care in an increasingly complex environment.

2.5 In line with the most recent NQB guidance in relation to CHPPD, the Trust has not identified any clinical inpatient teams where Allied Health Professionals should be included in the planned staffing levels, the criteria being that they are permanently part of the ward roster. This position is reviewed at the safe staffing meetings and will be amended should models of service delivery change.

## 3. Overview of Period December 2021 to May 2022

### 3.1 Safe Staffing Meetings: to include improvements in last 6 months

Safe staffing meetings have continued during this reporting period and were a critical component of our continued response to the Covid-19 pandemic. Within the reporting period particular attention was paid to the recovery of services and to the well-being of our teams. The safe staffing meetings enabled our Ward / Service Leaders and Matrons to escalate their successes and challenges to the Chief Nurse and / or their delegate.

It was escalated within safe staffing meetings, the Omicron variant had been particularly challenging for our teams, irrespective of the service and during January 2022 services were challenged by the increase in staff being contacted and required to isolate. This is noted as a difficult period for all services. The impact also affected the number of temporary staff available due to the impact on school age children. Between December and February 2022 both Portsmouth and Southampton services increased bed capacity and increased staffing levels proportionally. All decisions were taken through the QIA process.

In December 2022 there was a request to respond to a requirement to increase the capacity of our Mass Vaccination Centres (MVC) to respond to a surge delivery of the Covid 19 booster programme. This required the redeployment of staff from across the Trust as well as from the system and required key staff to cancel planned leave over the Christmas period. All involved responded well and the scale of redeployment was kept to a minimum in recognition of wider system pressures and in response to feedback from previous redeployment experiences by staff.

A constant review of the safe staffing meeting format is undertaken to ascertain the appropriateness of the agenda, with the aim to reduce duplication of information between service line assurance frameworks and operational / performance reviews. Within the reporting period the safe staffing escalation meetings moved from weekly to a monthly schedule.

Individual teams (whether inpatient or community) have an "timeslot" with 30 minutes to discuss current state, future challenges (for the roster period) and high-level HR, including roster management and well- being of staff. Specialist services such as Dentistry, Sexual Health and Primary Care continue to have a rolling programme of quarterly meetings. The meetings are chaired by the Chief Nurse, Deputy Chief Nurse, or their delegated deputy.

With the development of the workforce planning Programme Board, the safe staffing meetings will continue to evolve further. The development of a Safe Staffing Dashboard continues and was due to be piloted in Q4. However, it has presented an opportunity to utilise a product within Health Roster; Safe Care, that could support and enhance the information and forecasting available to us. This was explored however significant investment would be required. A review of the dashboard in its current state will be undertaken alongside other examples both internally and nationally.

3.2 Within the reporting period with reference to Covid-19, the following challenges that impacted on safe staffing provision were discussed and strategies to address were explored:

- Acknowledging that less staff had been redeployed within the previous reporting period, staff who remained redeployed did so through personal choice and in support of their line manager and the receiving area. This remained predominately within the vaccine centres.
- Throughout the reporting period services continued to return to a combination of business as usual and adopting new ways of working (in response to lessons learnt / digital capacity during the pandemic) and developing a mixed model of remote and face to face consultations. Whilst this did not impact upon staff requirement i.e. a reduction of wte, it enabled staff to work flexibly and address concerns regarding morale and well-being.
- Services noted that the support from the Occupational Health team and Health & Well-Being Team was much appreciated and services took opportunities within the reporting period to host "away days" for staff to re-engage and connect.
- Throughout the period, there continued to be concern regarding further waves requiring additional bed capacity and how in future this could be facilitated. However, as the national situation improved during the latter part of reporting period, alongside changes to national guidance and Infection Prevent and Control (IPC) advice, there has been a planned reduction in additional capacity. At the time of report, only one inpatient environment within Portsmouth had additional capacity however acknowledged that this has reduced from peak capacity during pandemic.
- It is noted that during May's safe staffing meetings all inpatient services anecdotally reported an uplift in staff morale, a combination of reducing IPC restrictions, reducing inpatient bed capacity, and pending Jubilee Celebrations. Unfortunately, this was not reflected within our adult community services, who continue to be challenged by the consequence of the pandemic on our vulnerable patients and high levels of vacancies.
- Throughout the period there had been a notable challenge to fill bank & agency shifts. This was predominately attributed to the availability of shifts within vaccine centres, staff having to isolate / care for school aged children and bank / agency unavailability due to school holiday periods.

3.3 During this reporting period the position in relation to reliance on temporary staffing in some service areas, particularly across mental health services, remained a concern and continued to be monitored and strategies planned to reduce reliance on bank and agency solutions.

In April 2022 senior leads in the mental Health (MH) services escalated concerns regarding the Crisis Resolution Home Treatment (CRHT) team, an element of which related to safe staffing due to staff sickness/absence, turnover and recruitment. Additional leadership support was provided and a number of 'Safety Chats' were help with people from the team. As a result, a programme of support was put in place and weekly safe staffing meetings commenced with the deputy chief Nurse in June 2022. The team have developed a safe staffing dashboard and have made good progress with improving staff morale and have had some success in recruitment. Although we are in the early stages of this support programme the impact appears positive currently.

Following a period of focused HCSW recruitment there has been a reduction in HCSW vacancies. The focus will continue across all and as a direct consequence of a national Chief Nurse Office directive Solent NHS Trust participated in a HIOW Mass Recruitment Event in which 27 individuals were offered HSCW roles across a variety of teams, 10 offered bank contracts and 10 offered second interviews. At time of reporting some are still undertaking HR pre employment checks.

Within the current safe staffing format there has been less focus on the compliance and effectiveness of roster management across all teams. This will be considered as part of the Workforce Planning programme and safe staffing meeting review, and is likely to focus on five key elements:

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

3.4 Within the reporting period there has been a pause on collecting the acuity and dependency data within the Mental Health inpatient wards. As reported previously, the mental health inpatient wards aim to utilise the Mental Health Optimal Staffing Tool (MHOST), recording and reviewing the acuity and dependency of the patient cohort against an established criterion. This enables benchmarking and to set evidence based, patient need driven staffing levels, alongside professional judgement and CHPPD. Initially the data was being recorded however, it transpired that further training and education was required to enable accurate recording and reporting. The national team will be supporting delivery of this training.

As noted above, acuity & dependency tools are critical within workforce planning and safe staffing. There has been national development of a Community Nursing Safer Care Nursing Tool, which we are pending licence and will commence a review of the tool, with view to implement across our community services.

In addition, there is a national acuity and dependency tool for adult inpatient, which is acute focused. It is noted nationally that community trusts with similar patient cohort have utilised the tool and therefore we are pending licence and training sessions with the view to implement.

**4.0 Vacancy and recruitment**

4.1 Successful International Recruitment (IR) continued throughout the reporting period with the Trust target of 51 nurses within 21/22 successfully completed within June 2022.

4.2 For 22/23 the international recruitment target agreed upon is 20 MH nurses and 24 Community Nurses. We have successfully recruited to our full complement of MH nurses between January and May 2022 and are therefore in a good position pending recruitment processes and onboarding aim to have new recruits in post by 31 March 2023.

4.3 Our community nursing teams are currently supporting 7 international nurses. This is supported by Educators in Practice and a robust transition to community nursing programme. An evaluation of the Transition programme will be undertaken prior to the new 22/23 cohorts arriving to ensure that the programme remains relevant to the knowledge and skills required. This will be completed with feedback from the nurses undertaking the programme, Community Nurses, and the Educators in Practice.

## 5 Absence Rates & Temporary Staffing

5.1 Annual leave is managed well and remains within the expected 11-17% range with a focus on encouraging staff to take leave regularly to support their health and wellbeing and to avoid the need for carry over of leave into 2023/24.

5.2 The table below illustrate the agency and bank request rate and fill rate across the reporting period. This supports monitoring and review of agency and bank usage and progress in relation to total establishment, vacancy, additional posts, headroom utilisation, agency reduction and overall nursing productivity.

| December 2021 - May 2022 | Req | Bank | % | Agency | % | Unfilled | % |
|---|---|---|---|---|---|---|---|
| MHS SERVICES | 4817 | 2737 | 57% | 1791 | 37% | 289 | 6% |
| PORTSMOUTH ADULT SVS | 5142 | 2996 | 58% | 1034 | 20% | 1112 | 22% |
| PORTSMOUTH CHILDREN SVS | 1016 | 1015 | 100% | 0 | 0% | 1 | 0% |
| SOUTHAMPTON ADULT SVS | 5368 | 3433 | 64% | 1507 | 28% | 428 | 8% |
| PRIMARY CARE | 986 | 984 | 100% | 0 | 0% | 2 | 0% |
| SOUTHAMPTON CHILDREN SVS | 952 | 951 | 100% | 0 | 0% | 1 | 0% |
| SPEC DENTAL SERVICES | 112 | 112 | 100% | 0 | 0% | 0 | 0% |
| SEXUAL HEALTH SERVICES | 716 | 710 | 99% | 0 | 0% | 6 | 1% |
| TOTALS | 19109 | 12938 | 68% | 4332 | 23% | 1839 | 10% |

## 6 Shift Fill Rates

6.1 The table below provides an overview of planned & actual staffing levels and ratios for the reporting period. It is noted that all areas are in the main working above plan for both registered and unregistered staff. This reflects the level of acuity and dependency of patients as well as reflecting the additional staffing required to support the increased bed capacity in some areas. In the small number of cases where wards were under plan it is noted the corresponding role was significantly over plan to ensure the wards remained safe and patients received the appropriate care. On these occasions the senior clinical team use professional judgement to take safe decisions.

Dec-21

| | Day Fill Rate | | Night Fill Rate | |
|---|---|---|---|---|
| | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthor | 108.1% | 121.5% | 101.6% | 103.2% |
| AMH Orchards - Maples | 153.2% | 109.7% | 156.5% | 121.2% |
| The Limes | 97.3% | 97.0% | 103.2% | 103.2% |
| Jubilee House | 125.8% | 121.0% | 146.8% | 117.7% |
| Spinnaker | 94.2% | 118.1% | 100.0% | 100.0% |
| Lower Brambles | 97.4% | 97.1% | 100.0% | 96.8% |
| Fanshawe | 97.4% | 101.1% | 98.4% | 95.7% |
| Snowdon Ward | 103.2% | 102.3% | 98.4% | 98.4% |
| Kite | 101.6% | 115.7% | 100.0% | 150.0% |

Jan-22

| | Day Fill Rate | | Night Fill Rate | |
|---|---|---|---|---|
| | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthor | 101.6% | 144.1% | 104.8% | 118.3% |
| AMH Orchards - Maples | 143.5% | 97.4% | 162.9% | 98.6% |
| The Limes | 105.4% | 98.4% | 104.3% | 102.4% |
| Jubilee House | 125.2% | 142.7% | 159.7% | 132.3% |
| Spinnaker | 103.2% | 111.6% | 104.8% | 106.5% |
| Lower Brambles | 100.0% | 146.8% | 98.4% | 145.2% |
| Fanshawe | 102.6% | 112.4% | 98.4% | 151.6% |
| Snowdon Ward | 109.7% | 153.5% | 96.8% | 100.0% |
| Kite | 102.4% | 116.9% | 125.8% | 141.9% |

Feb-22

| | Day Fill Rate | | Night Fill Rate | |
|---|---|---|---|---|
| | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthor | 92.9% | 133.3% | 94.6% | 113.1% |
| AMH Orchards - Maples | 140.2% | 100.4% | 160.7% | 100.5% |
| The Limes | 99.4% | 95.2% | 101.2% | 97.3% |
| Jubilee House | 112.9% | 120.5% | 146.4% | 125.0% |
| Spinnaker | 93.6% | 115.0% | 91.1% | 107.1% |
| Lower Brambles | 100.0% | 144.6% | 98.2% | 142.9% |
| Fanshawe | 100.0% | 97.0% | 94.6% | 146.4% |
| Snowdon Ward | 99.1% | 147.1% | 101.8% | 98.2% |
| Kite | 102.7% | 88.4% | 153.6% | 101.8% |

Mar-22

| | Day Fill Rate | | Night Fill Rate | |
|---|---|---|---|---|
| | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthor | 97.6% | 130.1% | 98.4% | 106.5% |
| AMH Orchards - Maples | 143.5% | 98.2% | 153.2% | 102.3% |
| The Limes | 98.4% | 92.7% | 103.2% | 119.4% |
| Jubilee House | 123.9% | 121.0% | 148.4% | 141.9% |
| Spinnaker | 92.9% | 112.3% | 100.0% | 96.8% |
| Lower Brambles | 97.4% | 142.5% | 101.6% | 151.6% |
| Fanshawe | 96.8% | 96.2% | 96.8% | 143.5% |
| Snowdon Ward | 101.6% | 152.3% | 98.4% | 100.0% |
| Kite | 100.8% | 105.6% | 190.3% | 100.0% |

| | Apr-22 | | | |
|---|---|---|---|---|
| | Day | | Night | |
| | Fill Rate | | Fill Rate | |
| | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthor | 100.0% | 162.2% | 103.3% | 136.7% |
| AMH Orchards - Maples | 146.7% | 99.4% | 163.3% | 101.0% |
| The Limes | 100.0% | 91.9% | 96.7% | 106.7% |
| Jubilee House | 140.7% | 193.3% | 146.7% | 186.7% |
| Spinnaker | 92.7% | 108.7% | 100.0% | 96.7% |
| Lower Brambles | 98.0% | 151.1% | 98.3% | 143.3% |
| Fanshawe | 98.7% | 102.2% | 98.3% | 141.7% |
| Snowdon Ward | 105.0% | 150.0% | 98.3% | 100.0% |
| Kite | 100.0% | 86.7% | 196.7% | 101.7% |

| | May-22 | | | |
|---|---|---|---|---|
| | Day | | Night | |
| | Fill Rate | | Fill Rate | |
| | Registered | Care Staff | Registered | Care Staff |
| AMH Orchards - Hawthor | 96.0% | 152.2% | 109.7% | 115.1% |
| AMH Orchards - Maples | 144.4% | 97.8% | 153.2% | 99.5% |
| The Limes | 95.2% | 93.0% | 94.6% | 106.5% |
| Jubilee House | 156.8% | 204.0% | 148.4% | 195.2% |
| Spinnaker | 95.5% | 113.5% | 98.4% | 100.0% |
| Lower Brambles | 99.4% | 96.8% | 100.0% | 151.6% |
| Fanshawe | 99.4% | 102.2% | 100.0% | 146.8% |
| Snowdon Ward | 111.3% | 158.1% | 100.0% | 104.8% |
| Kite | 96.0% | 107.3% | 93.5% | 103.2% |

6.2 With reference to CHPPD, daily staffing numbers and the daily patient count at midnight are aggregated for the month. Whilst this method does not represent the total and fluctuating daily activity, turnover or the peak bed occupancy it provides reliable and consistent information and a common basis for comparisons to measure, review and reduce variation at ward level within organisations and within similar specialties across different trusts. CHPPD data should **not** be considered in isolation but should be viewed with additional data sources as changes in speciality, staffing levels and service moves occur. Reviewing it in isolation could demonstrate a misleading picture in terms of safe staffing levels.

6.3 Additional work is required to ensure CHPPD for each clinical environment is reviewed. This will be considered as part of the revised format of reporting on safe staffing from July 2022.

**7.Safety and Quality Incidents**

7.1 When considering safe staffing it is essential to triangulate with other indicators to identify if there has been any adverse impact because of below planned staffing numbers.

There have been increases in reporting of some indicators which may be symptomatic of the pressures in the clinical areas and the impact of Covid reset on people's behaviours. These are areas that will be monitored closely through normal governance processes. The areas specifically are outlined below:

| Incident type | Number June/Nov 2021 | Number December/May 2021/22 |
|---|---|---|
| Assault Verbal / bullying | 45 | 89 |
| HR & Staffing | 24 | 65 |
| Pressure Ulcers | 69 | 156 |
| Slips, trips & falls | 124 | 144 |

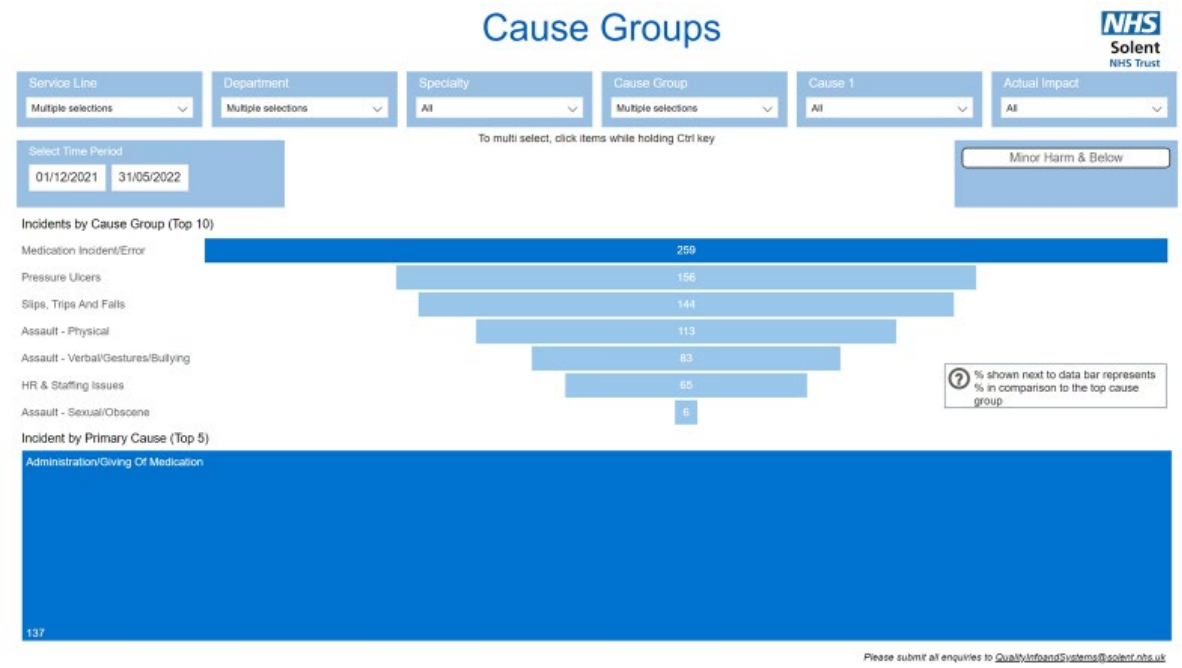
7.2 The review of incident data shows an increase in the number of incidents to 826 in comparison to the previous period where 621 incidents were reported. There has been a decrease in reported physical assaults from 141 to 113 from the previous reporting period.

The highest levels of medications errors continue to be in the acute metal health wards at 142 incidents for the reporting period, however these are reported as minor and / or no harm, which would indicate that good reporting is ongoing.

It is concluded that the increase is not related to low staffing levels but may have a correlation to the continued reliance in these areas on temporary staffing, skill mix, number of Registered Mental Nurse (RMN) vacancies and the number of staff who require support as they are a IEN or a Newly Qualified Nurse (NQN). As previously highlighted, this will be explored in more detail in the MH Safe staffing meeting.

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

Table 1 below shows Incidents, by cause group across all Solent NHS Trust Inpatient Wards



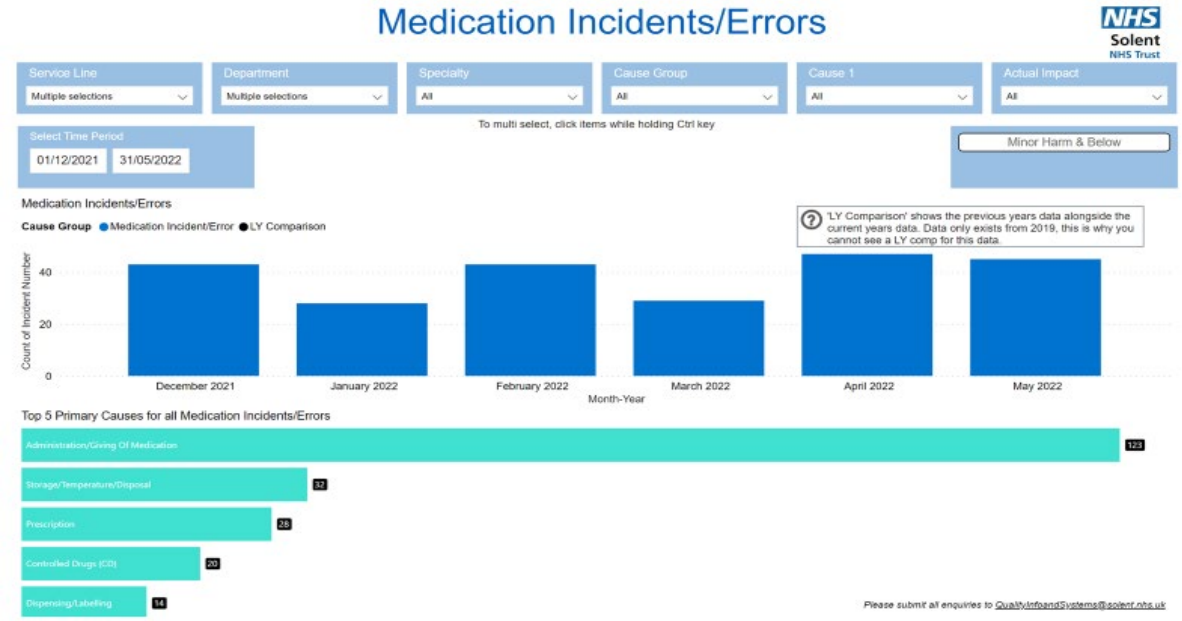
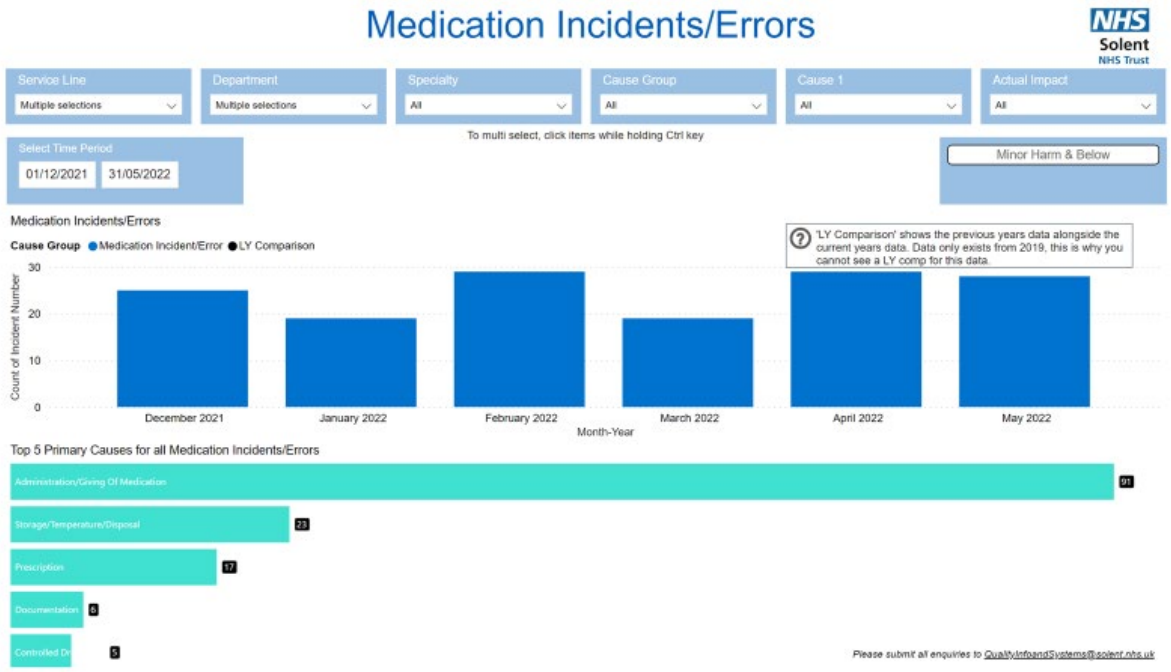




Table 2 above shows Medication incidents across all Solent NHS Trust Inpatient Wards

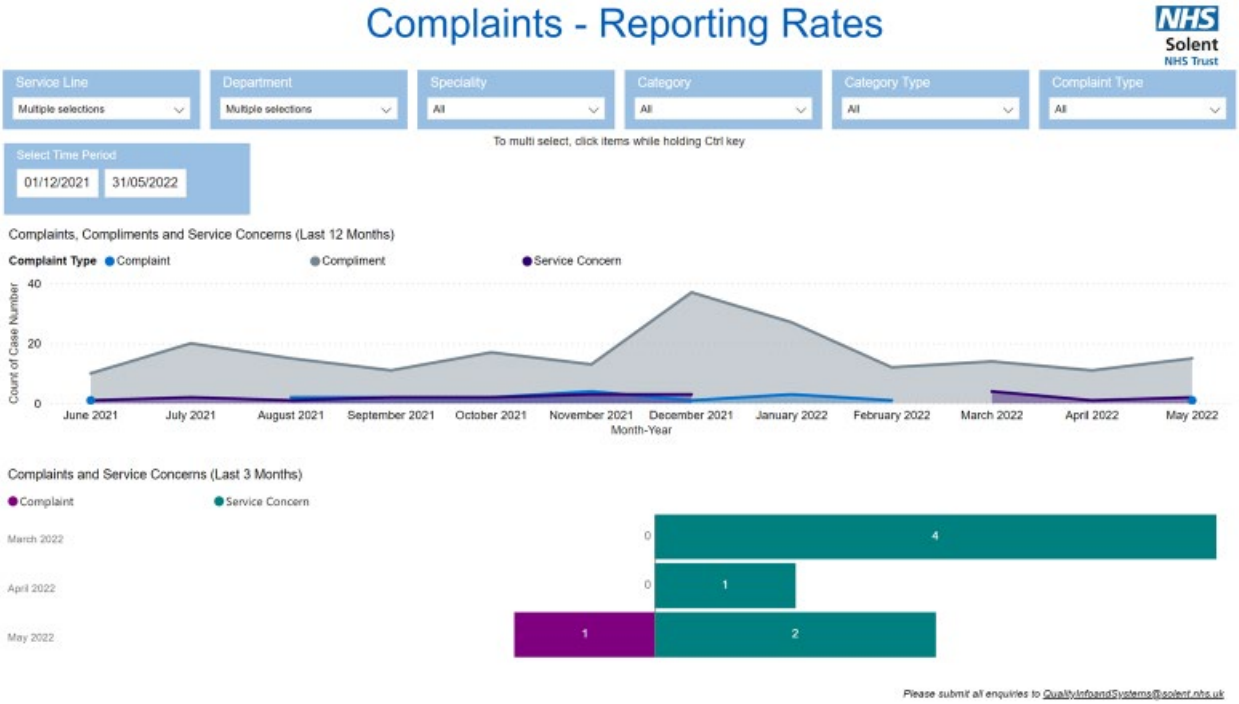
Table 3 below shows Mental Health Inpatient wards medication errors

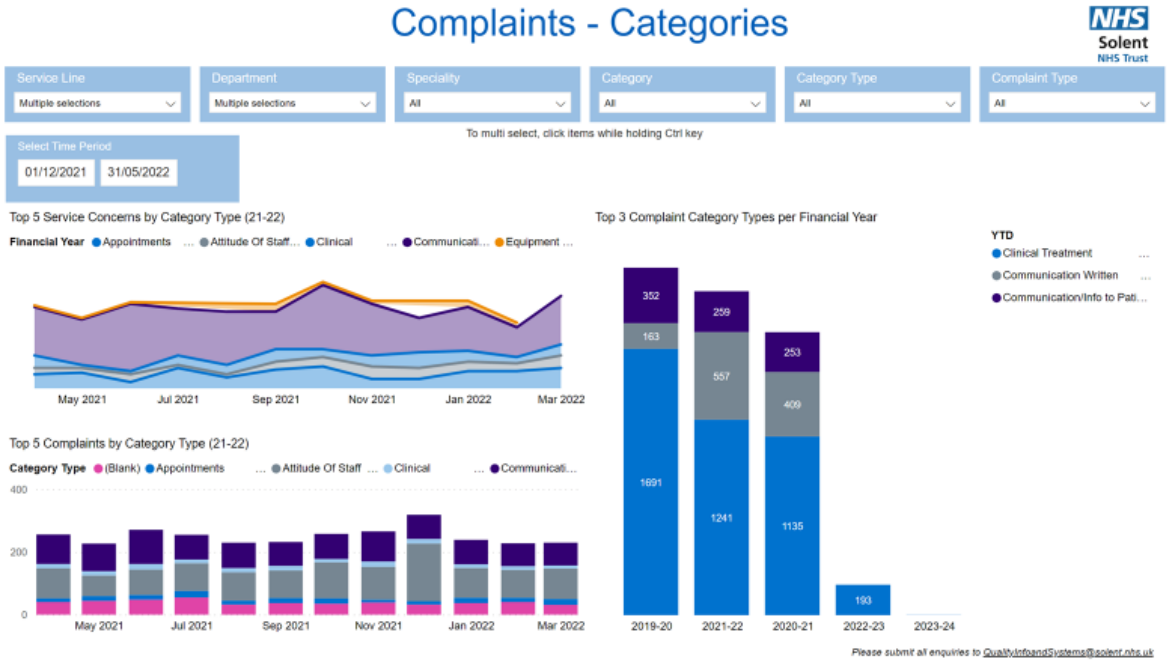


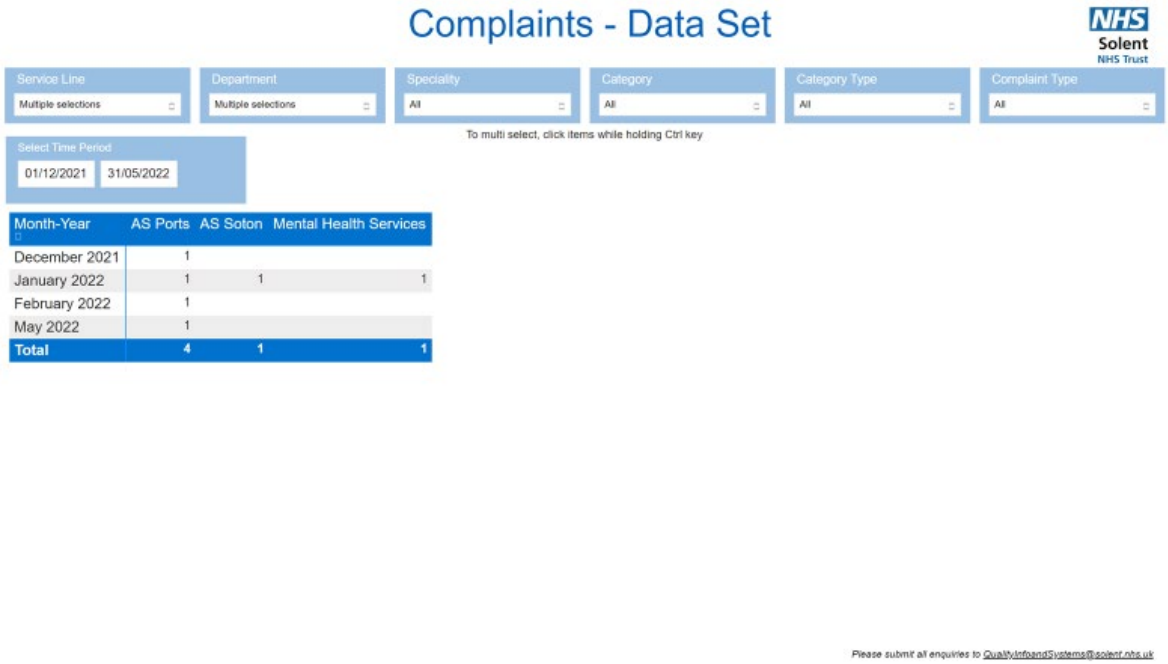

## 8. Complaints

8.1 During the reporting period there has been a decrease in the number of formal complaints and service concerns raised relating to care within the Adult Inpatient Wards. From 12 in the previous period to 6 in this reporting period. Portsmouth Inpatient have received 4 and MH and Adults Southampton both receiving one complaint. The number of service concerns continues to decrease from 11 to 10 in this reporting period.

8.2 The recurring theme in both complaints and service concerns continues to be staff attitude and communication in relation to clinical treatment and/or care provided and therefore it is concluded that there is not a causal link between complaints and safe staffing levels.






## 9. Service Line Commentaries

### 9.1 **Adult Southampton Inpatient**

| | |
|---|---|
| **Key successes** | December to May continued to be a busy period within the Adults Southampton Inpatient teams. Operational challenges continued and increasing acuity and dependency enabled inpatient teams to consider the admission criteria and clinical skills required in response to the increasing acuity. Within the period there has been new nursing leadership, which is embedding into practice alongside a new Matron Structure across the 4 adult inpatient wards. |

| | |
|---|---|
| **Key challenges** | In response to the pandemic there has been continual flex of the bed capacity within all inpatient areas. This has created uncertainty and demand to increase workforce to support additional capacity.<br><br>A high incidence of staff (whether permanent or temporary staff) were required to isolate, this had a significant impact on absence from work and availability of bank / agency staff impacting upon staff morale.<br><br>Management of IENs, NQN and new starters increases challenges for supervisors<br><br>Following HCSW Mass recruitment event – a period of communication challenges between service line and HR teams re new starters. Lessons learnt have been shared. |
| **Key initiatives** | Consideration of HCSWs "batch" recruitment for inpatient and community areas. |

**Adults Southampton Community**

| | |
|---|---|
| **Key successes** | The community teams have introduced Auto Allocate. A tool to assist the allocation of clinical caseload. Whilst intensive in the initial phase, it supports the ability of senior leaders to effectively allocate and supports the allocation of skill mix. |
| **Key challenges** | The service continues to have a high level of RN vacancies and acknowledge a high number of mature staff who may be considering their future career.<br><br>This has been escalated via the Service leads to Chief Nurse and a focused community safe staffing meeting has been held. The presentation highlighting key areas of challenge will be shared with other teams as a potential way to present their individual data. As a consequence of the focused meeting, the aim to identify key challenges and opportunities to consider marketing and recruitment, in addition to liaising with International Recruitment Leads and reviewing how the Transition Programme can be utilised to support "new to community".<br><br>The vacancy factor is having a significant impact on the workforce and much work regarding ensuring the patient cohort receives safe, compassionate care at the right time and right place. |
| **Key initiatives** | IEN Community Nurse Pilot has seen a robust marketing and recruitment process undertaken and 4 nurses currently within the transition programme. A further 8 nurses to be recruited within 22/23, alongside traditional UK based recruitment.<br><br>Implementation of Safe Care Community Nursing tool once received to support assessment of case load and workforce requirements. |

9.2 **Adult Portsmouth Inpatients & Community**
**Inpatient**

| | |
|---|---|
| **Key successes** | Wards continue to flex their capacity to support Portsmouth System. |

| | |
|---|---|
| **Key challenges** | Decision relating to future of Jubilee House has significantly impacted upon morale of team and decreased stability with RNs considering leaving the Trust.<br><br>Due to system pressures there has been additional bed capacity within both inpatient areas. This has created challenges to staffing and reliance on temporary staffing. This has also had a significant impact on the morale of the teams. |
| **Key initiatives** | Review of inpatient capacity post Jubilee closure. |

**Adults Portsmouth Community**

| | |
|---|---|
| **Key successes** | Community services continue to and align the community teams to the City PCN's. This supports continuity of medical and community care. |
| **Key challenges** | Number of vacancies at B5 & B6, impacting upon staff morale.<br><br>Focus review with Chief Nurse held in partnership with Adults Southampton re solutions |
| **Key initiatives** | Implementation of Safe Care Community Nursing tool once received to support assessment of case load and workforce requirements. |

**9.3 Mental Health**

**Inpatient**

| | |
|---|---|
| **Key successes** | Throughout reporting period planned recruitment of IENs continues and robust support in place to support to undertake OSCE and join UK NMC Register. Ongoing recruitment anticipated throughout 2022/ 23. This has reduced number of B5 vacancies.<br><br>Recruitment of HCSWs across all MH wards – has occurred with supported induction and onboarding. This remains under review quarterly to ensure that vacancies are identified at earliest opportunity to ensure that previous high levels are not repeated, in turn reducing reliance on temporary staffing |
| **Key challenges** | Numbers of IENs, HCSW and new starters having impact on skill mix within inpatient areas and resulting in a junior workforce. Development posts are in place to support career progression from B5 to B6.<br><br>Changes within leadership teams across all inpatient areas which is being supported by the senior leadership team. |
| **Key initiatives** | HCSW recruitment, Continued IEN recruitment.<br><br>Development programmes to be reviewed by Head of Clinical Education to ensure key elements and focus identified. |

**9.4 Child and Families**

There has been a re- introduction of safe staffing meetings during the reporting period. The continued increase in safeguarding activity is having an impact particularly on the community paediatric medical and nursing teams who provide the child protection medical examination service.
Challenges to recruit to CAMHS, Health Visiting, School Nursing and Hospital@ Home remain.

A focused initiative to attract international nurses to CAMHs services is currently under development, following successful completion of ICS bid to develop a CAMHs Academy. This is being led within service and HR. Progress is being monitored via NHSEI scheduled updates.

It is acknowledged that the development of the CAMHs Academy will take a significant period to increase the number of skilled practitioners into practice and acknowledged that supervision and clinical support is paramount to its success.

**9.5 Sexual Health**

Meetings continue to occur every 3 months and the service continues to review ways of working post pandemic and report increase in demand for services. The major challenge for the service is to recruit experienced sexual health nurses and whilst there is a robust development programme in place, this has impact upon experienced staff who are constantly in demand to supervise junior staff. This has impacted upon the morale of the experienced nursing team.

Success during the period has seen the appointment of a Matron to the Southampton region, with interviews pending in June for Portsmouth & IOW region.

**9.6 Specialist Dentistry**

One meeting was held during the reporting period with escalation regarding capacity and demand. However, the teams continue to flex to safely accommodate clinics and staff are requested to move sites to ensure safe staffing.

**9.7 Primary Care**

**Podiatry** – continued challenges to recruit to senior podiatry posts (B6 & B7). The team have explored international recruitment, which is supported via a national bid to recruit OTs, Radiographers and Podiatrists.

Successful recruitment for newly qualified Podiatrists will see 5 podiatrists starting later in the year. A robust induction and mentorship programme have been developed.

**MSK** – returning to BAU and reviewing new ways of working, alongside additional clinics have been introduced to support the reduction of waiting list pressures.

Successful interviews for the B5 rotation posts has been completed.

**Solent GP Surgery & HHT -** There has been successful recruitment to key operational roles within the GP Surgery and primary care nursing team during this period. This will take a period of adjustment and adapting to new ways of working and continued pressure on delivering face to face appointments.

Successful interviews to recruit to the Practice Nurse Team completed (including Newly Registered Nurses) in addition to new roles to triage telephone consultations.

## 10.0 Conclusion and recommendation

The pressures and challenges to our workforce continue and there is a need for a focus on the short term support as well as having a clear workforce plan to ensure we have the resources available for the future to ensure sustainability of NHS services and delivery of safe care to our communities. In the coming months work will eb completed to refocus the safe staffing agenda including developing and implementing a more planned and pro-active approach to workforce planning. This will include changes to the safe staffing reporting process through to Board. The Group and Board are asked to note:

- The six-monthly safe staffing report and the impact of the COVID-19 pandemic on our people and services.
- The ongoing work to improve the approach to safe staffing and work force planning throughout 2022 / 23.
- A change to the reporting schedule with the introduction of quarterly safe staffing reports with the Q1, 2022/23 report being presented in September 2022 and quarterly thereafter

# Report template- Board and Committees

Item 7

NHS Solent NHS Trust

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Item No. | 7 | | | Presentation to | Trust In Public Board | | |
| Date of paper | 06/06/2022 | | | Author | Pauline Jeffrey Head of Quality and Safety<br>Mark Hopkinson, Quality and Safety Manager<br>Teresa Power, Patient Safety Operational Lead | | |
| Title of paper | Patient Safety Annual Report 2021/22 | | | | | | |
| Purpose of the paper | To provide an overview of activity and improvements in patient safety, learning from incidents and deaths and implementation of the patient safety strategy over the year 2021/22 | | | | | | |
| Committees /Groups previous presented and outputs | Quality Improvement and Risk Group<br>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 | | For assurance | X | | | |
| Summary of Recommendations and actions required by the author | The Trust In Public Board is asked to note the following:<br>• The number of incidents reported continues to steadily increase whilst levels of harm to patients and staff are reducing. This provides evidence of a strong reporting culture.<br>• The number of Serious Incidents reported is reducing year on year and our approach to Investigations is evolving with a more supportive, case review type methodology.<br>• Incidences of Assault against staff peaked during the year but has slowly reduced. A collaborative approach to the response for staff has been implemented between Quality & Safety, Health & Safety and the Trust Security Specialist.<br>• Support for our staff has and will continue to be a key focus for the team with the implementation of the RIPPLE Model and Safety Chats.<br>• We have appointed our first Patient Safety Partner with further recruitment planned over the coming year.<br>• Essentials of Patient safety Training has been completed by 3157 or 74% of staff. | | | | | | |

| To be completed by Exec Sponsor - Level of assurance this report provides : | | | | | | | |
|---|---|---|---|---|---|---|---|
| Significant | | Sufficient | X | Limited | | None | |
| Exec Sponsor name: | Jackie Munro, Deputy CEO & Chief of Nursing and Allied Health Professionals | | | Exec Sponsor signature: | JAMunro | | |

NHS Solent NHS Trust

**“How do we make it easy for our staff to do the right thing for our patients every time?”**

# Patient Safety Annual Report 2021/22

**Quality & Safety Team**

## *Insight and evidence*

## INCIDENT DATA

The Quality and Safety Team continuously monitor incident data for themes and trends and analyse it to understand overall numbers and how this relates to the safety culture of the Trust. We also look at harm levels and establish the types of incidents that cause harm to our patients, both of which are covered in more detail below. This helps us to identify where further analysis is required and potential areas for quality improvement. ***Figure 1.1*** shows the numbers of incidents reported by month from April 2019.

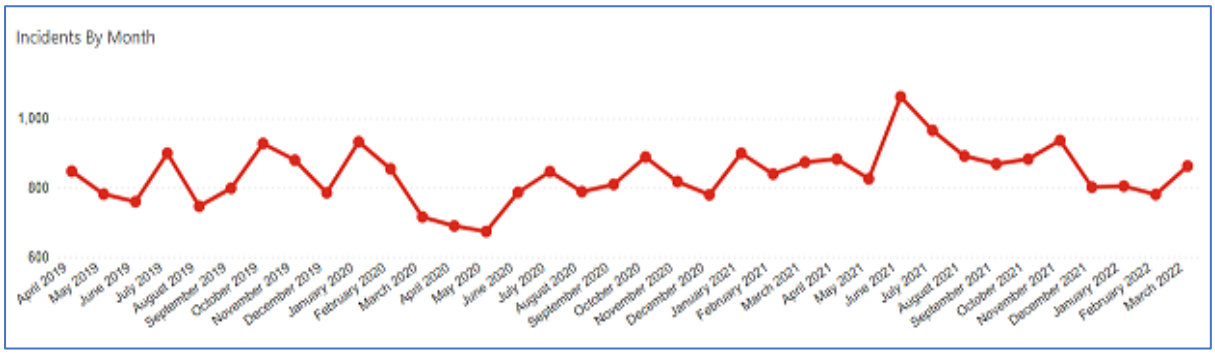



***Figure 1.1***

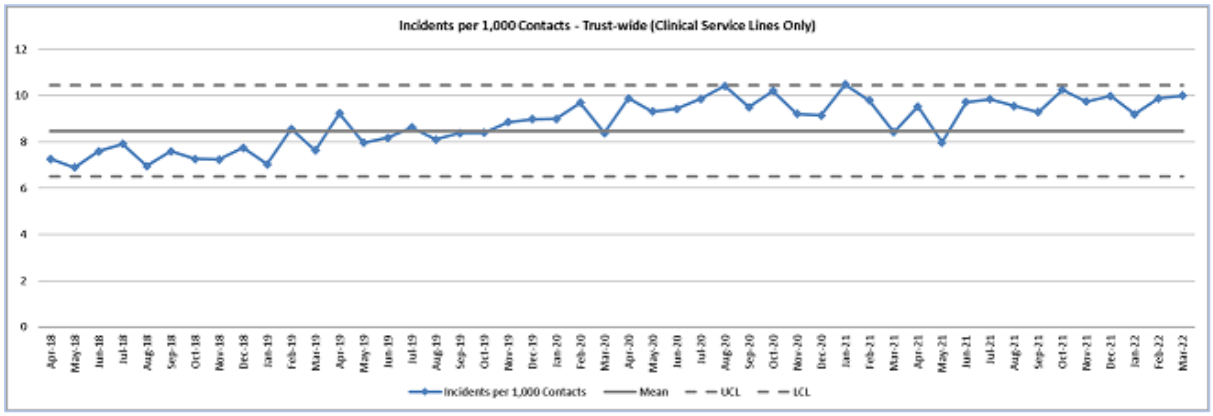



***Figure 1.2***

After a drop in the number of incidents reported during the first wave of the COVID-19 pandemic, numbers have increased in 2021/22 and the end of year total exceeds the number reported in both 2019/20 and 2020/21. This overall increasing trend in numbers of incidents reported was expected as the demand on services increases and with an improving reporting culture. The Incidents reported per 1,000 contacts (***Figure 1.2***) also continues to show a gradual increase year on year. This reflects the development of our safety culture.

## Levels of Harm

Analysis of the impact/harm of incidents over 2021/22 shows that near miss incidents and incidents of no harm are also gradually increasing which again provides evidence that staff recognise the value of incident reporting as part of Solent's culture. This can be seen in ***Figure 1.3*** below.

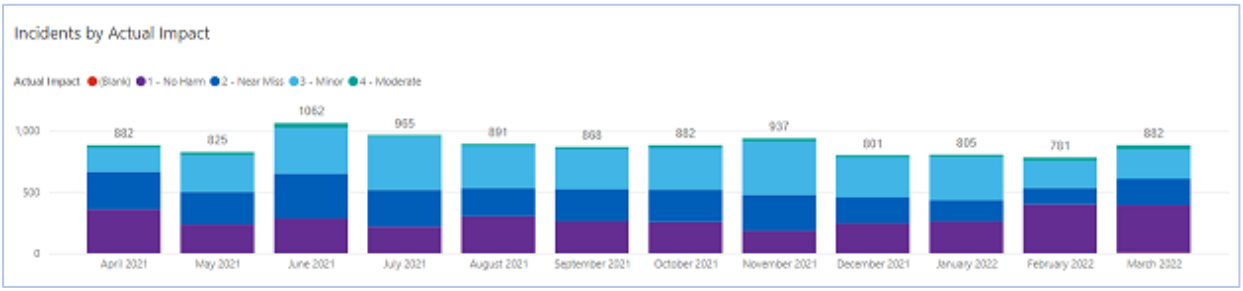



***Figure 1.3***

Further analysis of harm has identified that most incidents where moderate harm has been reported are related to pressure ulcers as can be seen in ***Figure 1.4***. Reducing the number of patients developing pressure ulcers while in Solent's care is important and will form part of the Patient Safety Incident Response plan, to be developed by April 2023. This will be progressed in collaboration with the Tissue Viability Team. More information on this plan is in the section headed **Patient Safety Incident Response Framework (PSIRF)**

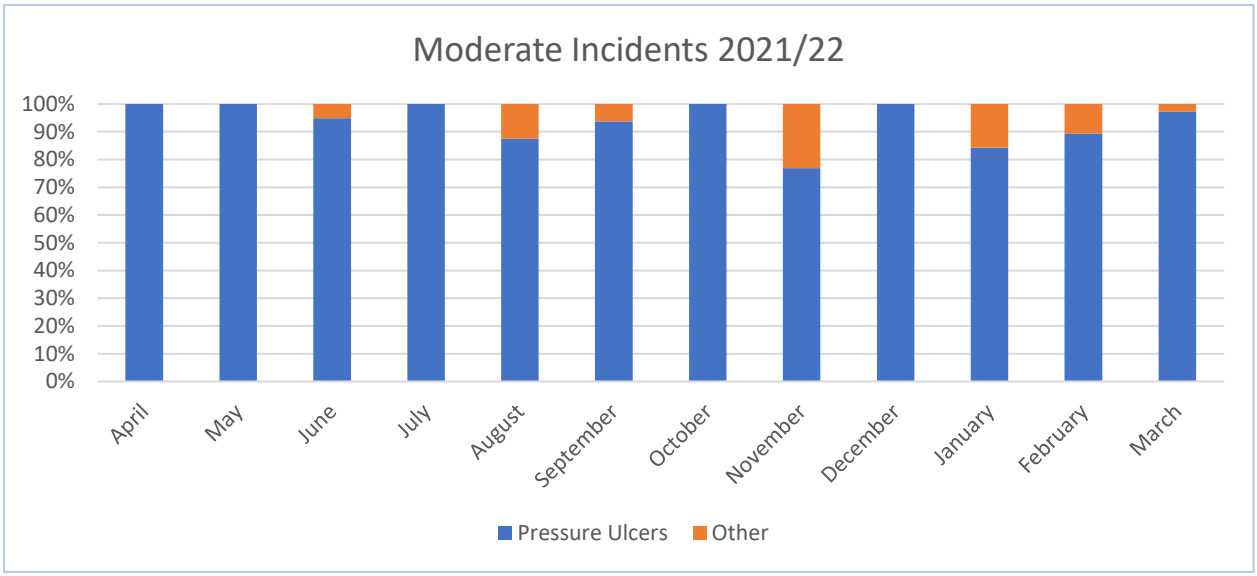



***Figure 1.4***

A review of incidents where minor harm has been reported has established that most of these relate to pressure ulcers or the death of a patient whilst receiving care from Solent NHS Trust. However, there are several other cause groups where minor harm is reported. The breakdown of incidents of minor harm is shown in ***Figure 1.5***. More information on the **CAUSE GROUPS** can be found in the section below.

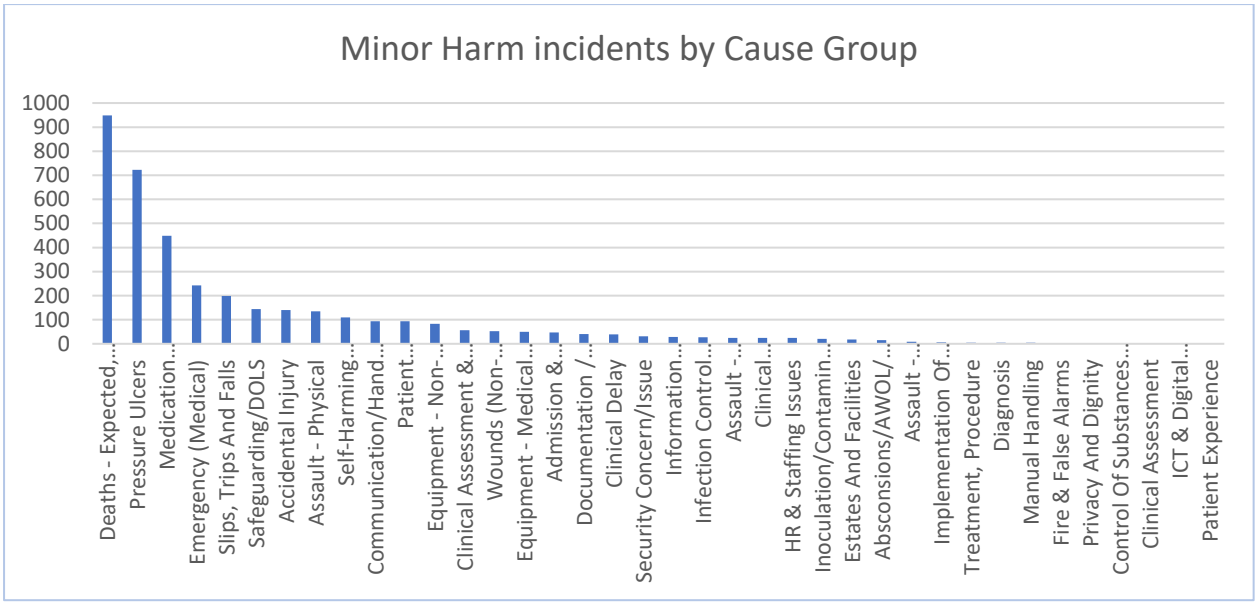



***Figure 1.5***

## CAUSE GROUPS

Understanding the cause groups of all incidents reported provides information on areas for learning across the Trust whether harm has occurred or not. The Quality and Safety Team review this on a quarterly basis to understand themes that may be emerging. Analysis of incidents as per ***Figure 1.6*** shows that medication related incidents in addition to the death of a patient receiving care (see **LEARNING FROM DEATHS** below) and pressure ulcer related incidents (see **LEVELS OF HARM**), were the largest cause groups for all incidents reported in Quarter 4 of 2021/22.

The Quality & Safety Team have also been monitoring incidents relating to Assaults against staff, as seen in Quarters 1, 2 and 3. Senior representatives from Quality and Safety, Health and Safety and the Security Management Specialist are completing several joint site visits, enabling the review of safety and security of our staff as a collaborative approach, combining clinical, security and environmental expertise. This is discussed in more detail under **ASSAULTS AGAINST STAFF.**

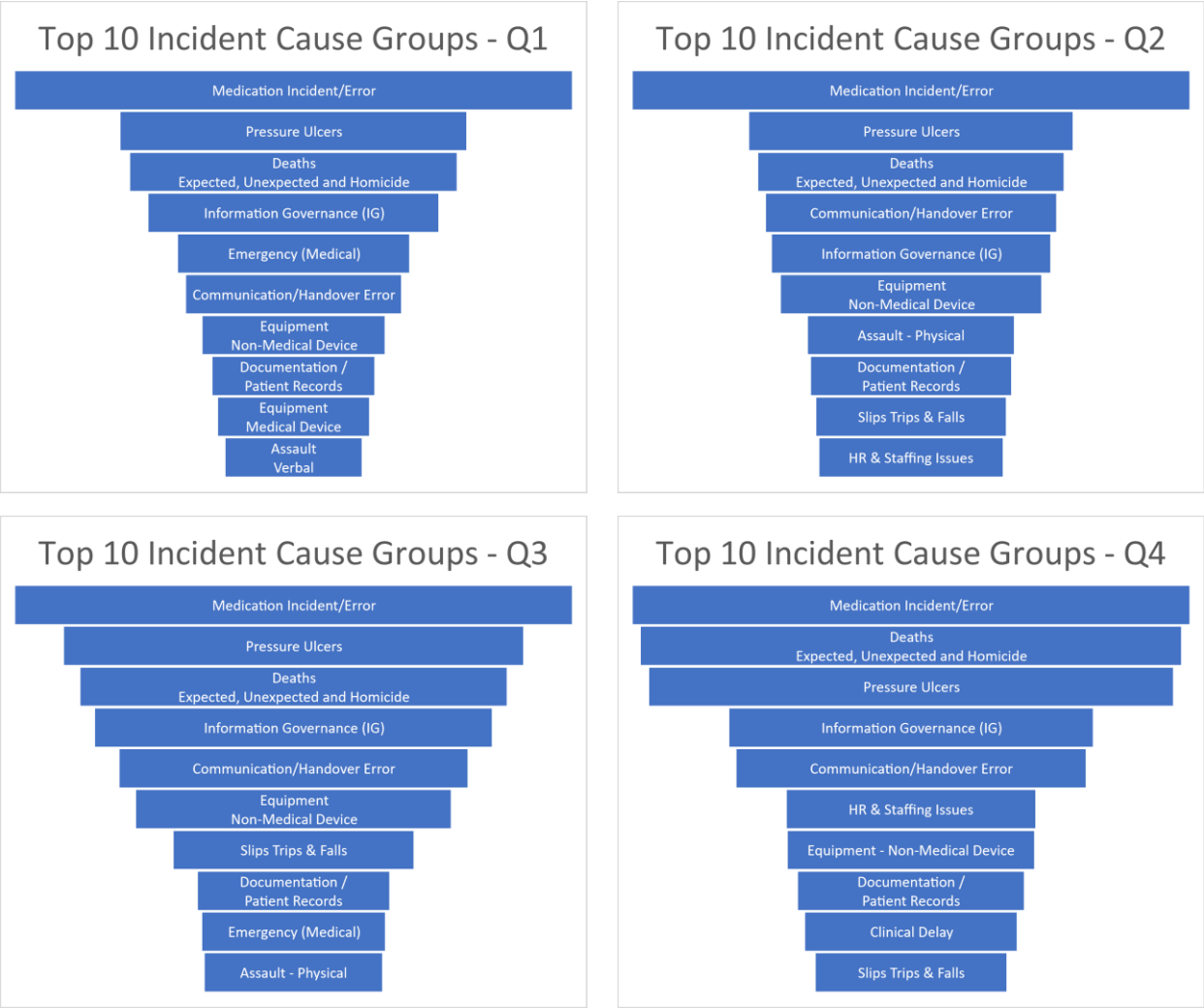



***Figure 1.6***

Trend analysis of the top three cause groups (***Figure 1.7***) has shown that, although they remain the same themes over the year, the numbers of medication errors is reducing gradually. This will be monitored by the Quality and Safety Team in collaboration with the Pharmacy Service. The Quality and Safety team are also organising a Medication without Harm conference in September 2022 to mark World Patient Safety Day.

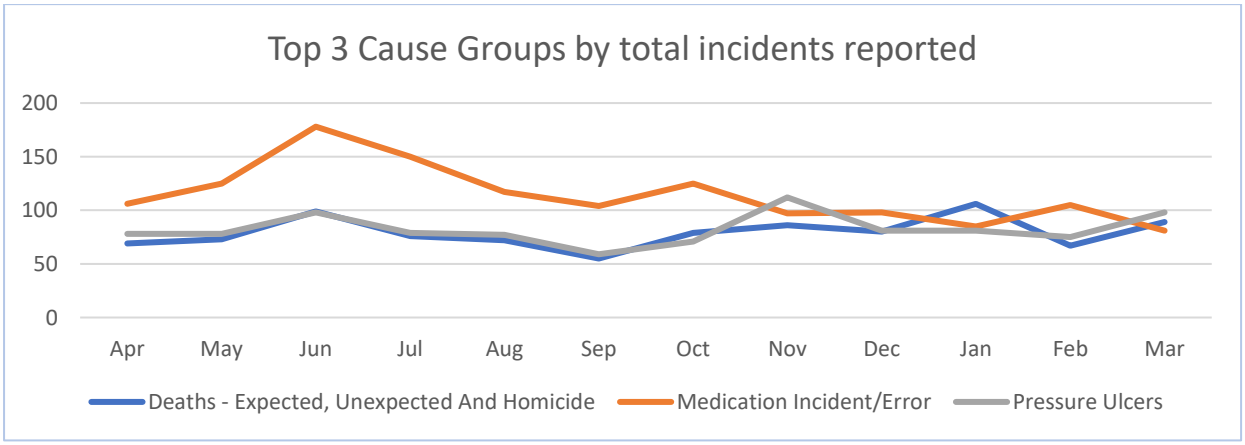



***Figure 1.7***

## Serious Incidents

The number of Serious Incidents declared is showing an overall downward trend over the last three years with 15 declared in 2021/22, 24 in 2020/21 and 49 in 2019/20. However, in 2021/22 five Serious Incidents have been downgraded following investigation and review, with the agreement of the relevant Clinical Commissioning Group, as they no longer met the threshold under the Serious Incident Framework.

### Case Review Methodology

The implementation of the Patient Safety Incident Response Framework in 2023/24 will change the response to incidents and the way they are investigated. In preparation, we adopted a Case Review Methodology for three Serious Incident Investigations in 2021/22.

The case review methodology involves asking staff who cared for the patient to participate in a group discussion to review the care provided. In advance of the meeting, staff prepare a chronology which will be used to agree a timeline of events. Staff are encouraged to participate in an open and transparent way, and it is made clear that the review will not apportion blame.

The review itself is led by an experienced Investigation Officer who prompts the group with a series of questions designed to explore the events in detail. The resulting discussion is noted by a member of the Quality & Safety Team. This allows the group to agree on any learning and immediate actions, if required, and is also an opportunity for the staff involved to provide support to each other. If a more involved peer support session is required post meeting, this can be facilitated by a member of the Quality and Safety Team. Sections on **Supporting our staff** and **Caring for and valuing our Staff** follow later in this report.

This methodology provides better outcomes in terms of analysing the quality of care, generating timely and informed improvements and increased Patient Safety. The three case reviews completed have met with a positive response from staff who have expressed how much better the experience was for them. We will continue to apply this methodology for Serious Incidents wherever appropriate.

Patients and their relatives are currently involved separately from the process described above, but they remain key to developing the terms of reference and can ask questions about the care they received. We also endeavor to provide the patients with a copy of the final report and offer to meet in person to discuss the findings. In the future we will work with our patients throughout the process, so they have the opportunity to contribute to the review throughout.

An example of how we have shared the learning from a Serious Incident review using a case review methodology can be found below:

## To ensure emergency events are accurately documented


- Develop emergency scenarios to simulate safe and effective responses within clinical areas
- Clocks/time pieces to ensure accurate timing is recorded during emergency events.
- Significant event free scribe document.
- PLACE compliant wall clocks with date display
- Digital clock located on emergency trolley.
- Use of Fob watches/ mobile phones for time keeping – wider discussion across inpatient areas and current practise.



## Storage and Communication

- Portable oxygen cylinders present in the identified storage location, are full and replaced as required.
- All equipment needs to be clearly identifiable, particularly for new members of staff.
- Areas of recording keeping that were fair to good however could be improved to excellent.
- Healthcare Professional Line
  - Default to 999 previously agreed if challenges with HCP line.
  - SCAS triage levels poster on display by nurses station
  - All staff received a copy to support effective handover of information.

**FANSHAWE WARD DAILY OXYGEN CANISTER CHECK**

Month _____

| Date | O2 bottle on emergency trolley Y/N | How many bottles in wall mounts | Any O2 cannisters in patient rooms Y/N | Are bottles full? Y/N | Signature/comments |
|---|---|---|---|---|---|
| 1st | | | | | |
| 2nd | | | | | |
| 3rd | | | | | |
| 4th | | | | | |
| 5th | | | | | |
| 6th | | | | | |
| 7th | | | | | |

## Reflection and Case Review

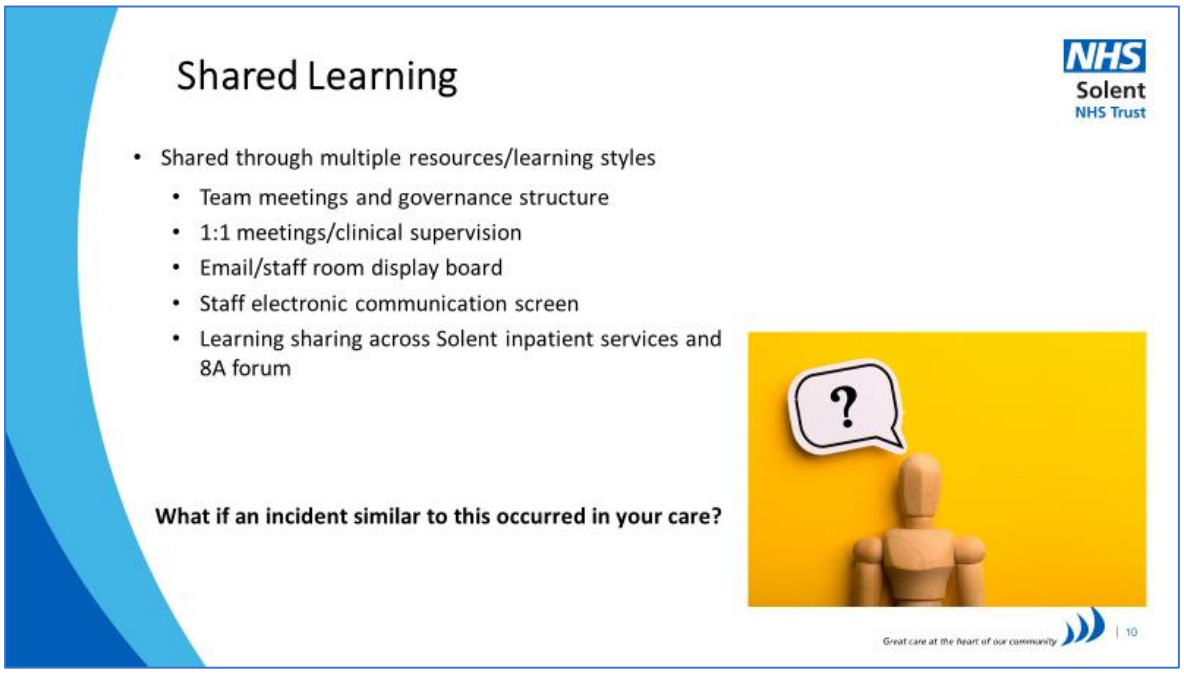


Great care at the heart of our community

## Report Conclusion

- Demonstration of a high calibre of teamwork
- Service recognised the full extent of the patient's healthcare needs with particular reference to but not exclusively the patient's postural hypotension, balance and mobility.
- The interventions in place were in line with the clinical assessments and agreed management plan and that there were no omissions in care, and practice was in line with trust and national policies and procedures.
- The response and clinical management following the patient fall was appropriate and in line with guidelines and policies and equipment including oxygen was readily available

Great care at the heart of our community




The slides above were shared at Solent's Learning from Incidents & Deaths Panel and subsequently at a Safety, Excellence, and Improvement Forum. See section on **SAFETY, EXCELLENCE, AND IMPROVEMENT FORUM.**

## THEMATIC LEARNING

We have also trialed the presentation of thematic learning from Serious Incident investigations twice in the form of COVID-19 specific Learning from Incidents & Deaths panels and once by the Special Care Dental Service. This format allows us to consider improvements which span several investigations and identify the most effective way to translate or share the learning with other areas or providers.

Thematic Learning and Case Reviews will become more embedded as we implement the **PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)** over the coming year.

## Never Events

In 2021/22 two Serious Incident investigations were carried out which met the criteria of a Never Event under the Never Events Policy and Framework. Details of these are shown in ***Table 1.1*** below:

| Service | Description |
|---|---|
| **Special Care Dental Service** | A dental prop was left in the mouth of a 10 year old patient after surgery. |
| **Sexual Health Service** | An error in the transcribing of a patient's details resulted in the wrong patient being referred for a Colposcopy. This incident meets the criteria of a Never Event under the definition of 'wrong site surgery'. |

***Table 1.1***

These incidents have been fully reviewed with Clinical Commissioning Group, NHS England Commissioning and Public Health colleagues and the learning shared.

See Appendix 1 for a full summary of the Serious Incident Investigations completed by Solent in 2021/22.

## Learning from Deaths

Some patients die whilst receiving care from one of the services that Solent NHS Trust provides. Many of these patients are on a palliative pathway or die from a pre-existing condition, as shown in ***Figure 1.8***. A smaller number die unexpectedly, and each of these is reported on the Trusts Incident Reporting System, Ulysses. We carry out regular reviews into patient deaths, whether expected or not, so that we can continually learn and improve services for patients and their relatives. Specific concerns about the provision of end-of-life care to individual patients, and improvements for future patients, are discussed at Solent's End of Life Steering Group.

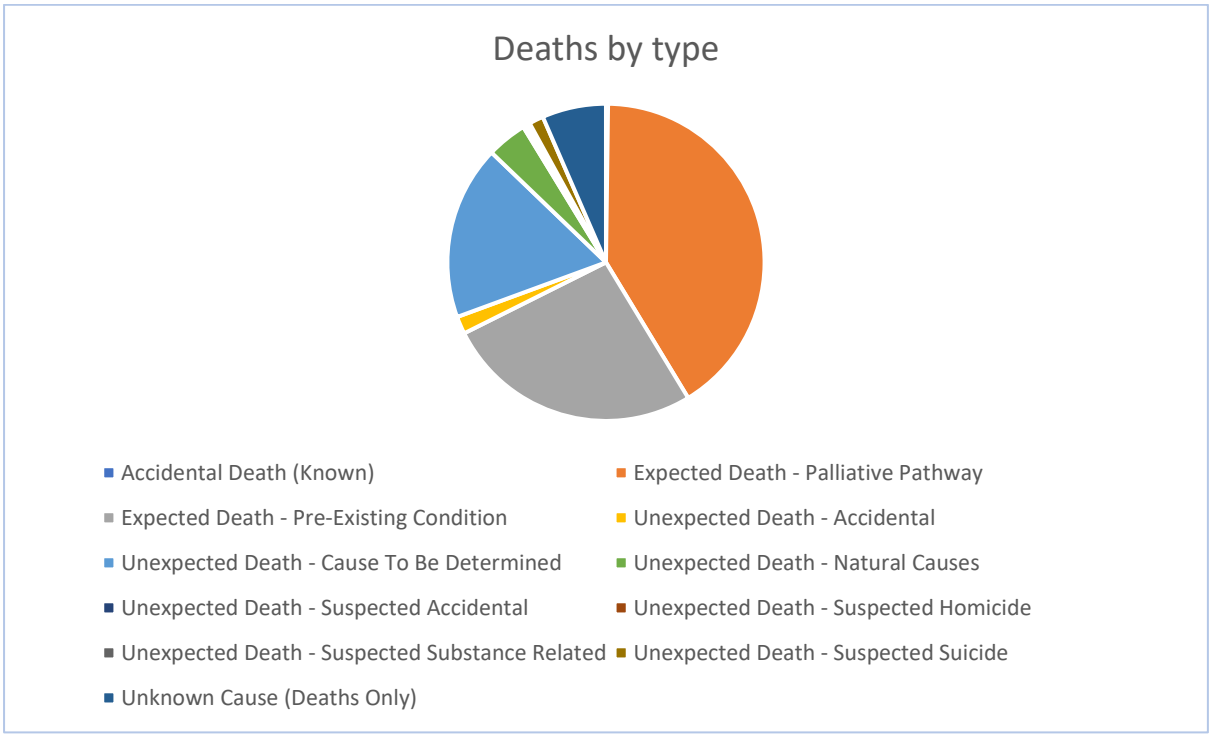



***Figure 1.8***

In 2021/22 1670 people who have been in receipt of services provided by Solent NHS Trust died. This comprised of the following number of deaths having occurred within each quarter of that reporting period:

- 365 in the first quarter
- 433 in the second quarter
- 388 in the third quarter
- 484 in the fourth quarter

During this period, a total of 4 Serious Incident investigations have been carried out in relation to 4 of the deaths included above.

In 390 cases, a death was subjected to a structured judgement review and/or an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out by Solent was:

- 90 in the first quarter; (118 including other providers)
- 111 in the second quarter; (124 including other providers)
- 72 in the third quarter; (87 including other providers)
- 117 in the fourth quarter (138 including other providers)

The Learning from Deaths process across the Trust continues to develop and we are continually looking at new ways to share the learning across all areas of the Trust. When reporting on deaths at the Learning from Incidents and Deaths Panel, Service Lines now focus on specific cases, or key points, which can be used to improve outcomes for patients across all Service Lines.

In July, a thematic review of four Serious Incident Investigations, carried out following the COVID-19 outbreak on Brooker Ward, was completed. The learning was shared with colleagues across the Trust and local CCG's. This format has been successful in generating discussion around the wider themes and actions resulting from Serious Incident reviews.

A summary of the learning we have identified by undertaking reviews of deaths, and the subsequent actions taken, can be found in **Appendix 2**. Delivery of actions has been monitored through the Trust Learning Database, the Learning from Incidents and Deaths panel and the monthly Quality Review Meetings.

## Medical Examiner

Medical examiners (ME) provide independent scrutiny of the causes of death in cases not investigated by a coroner and give the bereaved a voice by asking them whether they have questions or concerns about the care of a patient before they died. They have been reviewing deaths in Acute hospitals for some time. The established Medical Examiner Offices (MEO) used by Solent are at Portsmouth Hospitals University Foundation Trust and University Hospital Southampton Foundation Trust. The national target date for community inpatient wards to begin referring deaths to Medical Examiners was 1st April 2022. This is limited to deaths for which the Community Trust clinician writes the Medical Certificate of Cause of Death (MCCD).

Solent has met this target for community inpatient and the draft Medical Examiner Standard Operating Procedure (SOP) is now live. The SOP will remain a draft as it is likely to need updating as the inpatient process embeds over the next couple of months, and whilst the process is rolled out to primary care.

There is a national requirement for all primary care certificated deaths to be included within the ME process. We have been discussing with our GP practices how we can get over the practical challenges of face to face ME meetings. Our local MEO have a suggested go-live live date for our GP practices of 20th June 2022, and we are using that as our target date.

## *Involvement*

The Quality and Safety Team aspire to connect with the service lines by providing support and information on areas of concern, themes and trends from incidents and deaths. We meet with each service line's Head of Quality and Professions at a Quality Review Meeting monthly to discuss quality and safety within their service. In addition to this regular support, we also aim to provide an approachable and visible presence within the organisation and are available to discuss any additional support that could help with quality, safety, or safety culture.

The Quality and Safety Team are proud to have been nominated for an Annual Solent Award for Excellence demonstrating the effort that all the team have made to improve our support to staff across the organisation.

> The Quality & Safety Team have made an exceptional contribution to patient care. Their work affects every aspect of delivery of care and clinical standards across the organisation. They are exceptional in the work they do and want to `get it right' so that staff and patients benefit. The team work extremely hard and often this is `behind the scenes'. When the team do work with colleagues in services they are always conscious of the pressures that are being felt due to post-covid challenges and able to communicate in a respectful, but effective way. Pauline and Gina lead the team and demonstrate the Trust's values in all they do. An example of this is they organise a weekly team `check-in', so that people can regularly support each other to make sure everybody is okay. I have seen other examples where people are genuinely supported on an individual basis. I feel that the Quality and Safety Team deserve the `Excellence Award' as an example of delivering high levels of care in a supportive and values led approach.

### SUPPORTING OUR STAFF

The Quality and Safety team provided clinical support to the vaccination centres during the booster vaccination programme in December 2021. This has been valuable to the clinicians involved as it provided an opportunity to connect with the staff in the vaccination service and to update clinically.

Solent NHS Trust recognises the impact that being involved in an event at work can have on staff members. The Covid-19 pandemic has added additional challenges which may have reduced the resilience of our staff. The Head of Quality and Safety held a workshop at the Quality Improvement and Risk Group to understand current support available for staff following events. This established that a wide range of supportive measures are available, but this is inconsistent across the Trust and staff awareness is variable. In response to this the Head of Quality and Safety has developed a model for all staff to be able to access relevant support following events, if required. The Head of Quality and Safety has provided facilitated peer support sessions to teams following incidents that have had an impact on them and has met with individuals who have required additional support. This has been rolled out as a part of the RIPPLE model which is described under **CARING FOR AND VALUING OUR STAFF**.

## TRAINING

A new training package for both Incident Reporting and Incident Reviewing has been developed, with monthly sessions now available on the Learning Management System for all staff to book. Since the launch, 129 staff members have attended Incident Management for Reporters and 49 have attended Incident Management for Reviewers. Further developments including an online package and recordings of previous sessions are planned. In teams where the new package of training has already been delivered, we have seen incident numbers start to increase. This has been particularly evident in Child and Family services where 65 members of staff have completed the training.

Level One Essentials of Patient Safety Training has also been produced and made available for all staff to complete. By the end of March 2022, 3157 Staff had completed the training. The Special Care Dental Service have championed the Essentials of Patient Safety Training and have an overall completion rate of 93.5%.

The Head of Quality & Safety and Patient Safety Specialist – Operational Lead also completed a bespoke piece of training for the Special Care Dental Service covering patient safety, psychological safety and kindness and civility. In Primary Care, training was delivered to key individuals within the Solent GP (General Practice) Service in November & December 2021 about the value of incident reporting. The number of incidents reported within this area increased by 27% compared to the same period last year. We will continue to encourage this at the monthly Service Line Quality Review Meetings.

## JUST CULTURE

All staff should feel safe to report incidents without fear of blame or repercussions. If staff do not feel safe to report when things go wrong, incidents will go unreported leading to missed opportunities for learning. It is key that Solent staff feel a sense of belonging, inclusion, and psychologically safe so they are confident in reporting incidents. The Head of Quality and Safety has worked with the Trust People Services Team to provide a joint approach to the development of a culture of belonging and safety. A dignity and civility framework is being developed to ensure that this is embedded across the organisation. This has led to the development and delivery of sessions on 'Just Culture,' psychological safety and kindness and civility.

## VETERANS HIGH INTENSITY SERVICE

Four patients under the care of the Service died between November 2021 and January 2022. A case review will be carried out into two of the deaths, by the Senior Serious Incident Investigator, to identify any learning which can be applied to future care. A third case is being investigated by Kent NHS Trust under the Serious Incident Framework and Solent will contribute as appropriate. The importance of providing support for the staff involved in these cases was recognised at an early stage and the Head of Quality & Safety has provided facilitated peer support sessions using the new RIPPLE Model.

## *Improvements*

### THE TEAM

The Quality and Safety Team endeavour to improve the service that we provide for our colleagues across the trust by continuing to champion the goal of 'making it easier for our staff to do the right thing for our patients every time.' We apply our key foundations for incident review in all our work and have reviewed and refreshed our processes to fully align with these. Our five foundations are:

- Involvement of Patients and Families
- Support for our staff
- Proportionate and appropriate review
- Ownership from board to floor
- Focus on learning

### ASSAULTS AGAINST STAFF

The Quality and Safety Team noticed an increase in the number of incidents reported which involved Assault against staff, Verbal or Physical, between July and November 2021 (see ***Figure 1.9***). This was an emerging theme across three key services, Primary Care, Adult Services Southampton, and the Vaccination Centres. In September 2021 Primary Care (13) and Adult Services Southampton (22) recorded their highest totals.

The review of incidents in the vaccination centres established a spike in incidents of assaults/security concerns in August 2021. It is already an established theme in Adult Mental Health although numbers peaked between August and October 2021 before overall numbers decreased again from November and December. Numbers in January and February 2022 are comparable to the same period in 2021 and are below 2020 levels. Whilst it is pleasing to see a reduction, the collaborative work between the Quality & Safety Team, Health and Safety and the Security Management Specialist will continue to ensure staff are fully supported following an incident.

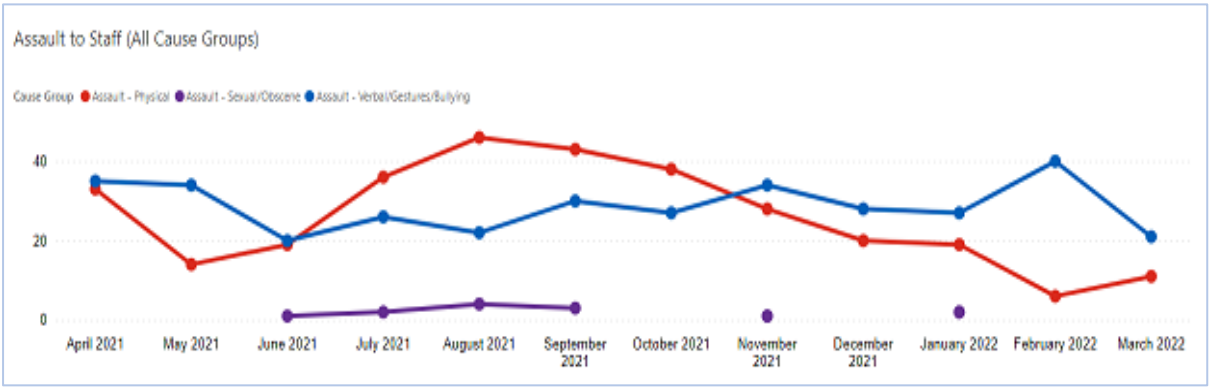


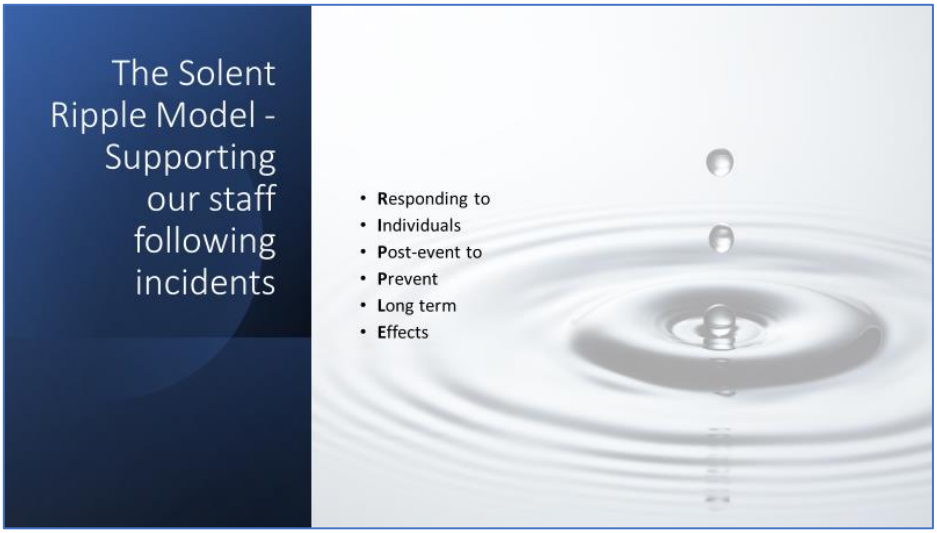

***Figure 1.9***

We were unable to identify a cause for this trend in Primary Care and Adult Services Southampton, or the peak in the Vaccination Centres, but acknowledge how the impact of the current national pandemic has influenced patient behaviour. As a result, all staff received debrief sessions from the Security Lead in the Trust and decisions were made based on what actions individual staff members would like the Trust to take. With regards to security, we increased support on individual sites as identified. The Security Lead continued to audit on a regular basis with the information being presented at the Trust Health and Safety Committee.

A review of the incidents of assaults to staff in Adult Mental Health services identified that environmental issues were a key factor. The refurbishment of Maple Ward (psychiatric intensive care unit) resulted in the ward being located in a less suitable environment with no dedicated seclusion room. A particularly challenging patient had caused damage to the unit and several assaults on staff. The Head of Quality and Safety, the Security Management Specialist and the Health and Safety Manager have undertaken a joint site visit to the Acute AMH wards to provide a supportive and collaborative approach, combining clinical, security and environmental expertise, to understand safety and security on the unit. A tour of the newly refurbished Maple Ward was also carried out.

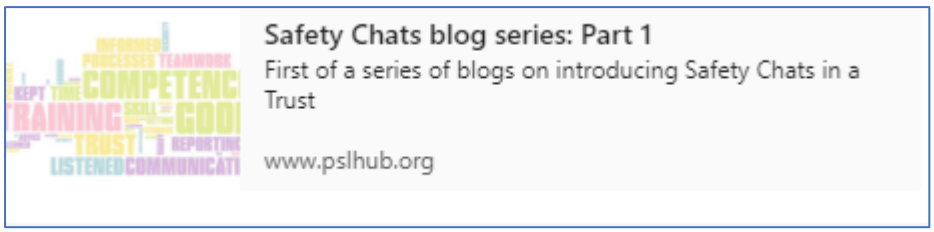
## Caring for and valuing our Staff

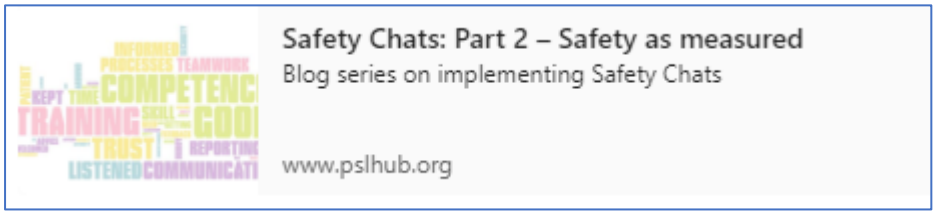
Working collaboratively with colleagues across the Chief Nurse Directorate, we recognise the challenge for services when managing hugely complex complaints and/or overseeing complicated incidents with multiple threads. In response to this, and to further reinforce our offer of support to Services and their staff, the Head of Quality & Safety has developed a model of support for services to access when needed – pulling together a broad range of specialist advice and experience from across the trust to offer targeted and tailored support, advice, and expertise. The framework, the RIPPLE Model, will be launched to staff on 11th April 2022 and will provide an opportunity for all staff to indicate that further support is required at the point of incident reporting on Ulysses.



The Associate Nurse Director for Quality and Safety has developed a model of 'Safety Chats' which provide an opportunity for frontline staff to discuss aspects of staff and patient safety in a safe, confidential environment. These have been undertaken in several areas and have been successful in identifying some key areas for improvement.

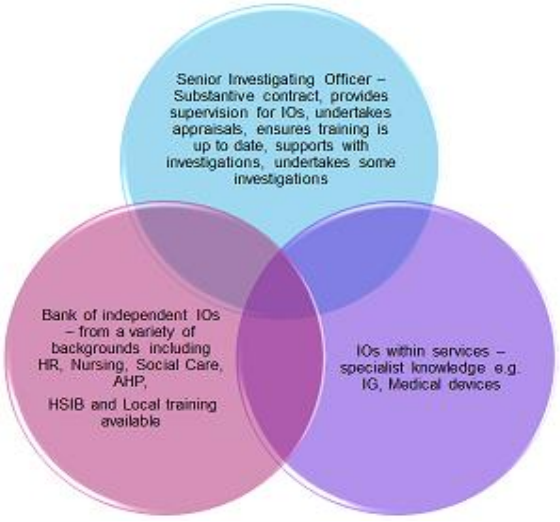
The Safety Chat initiative has been shared externally to Solent via a series of blogs. If you would like to view these please follow the links below.




## INVESTIGATION TEAM

Our investigation team comprises of a Senior Investigating Officer and a bank of independent investigators from a variety of backgrounds. The Senior Investigating Officer has provided the investigating officers with regular supervision and annual appraisals over 2021/22 and ensures that case supervision is available for individual investigations.




We have been successful in recruiting new investigators in 2021/22 and those who are new to our service have been supported to access the new national training from the Healthcare Safety Investigation Branch (HSIB). Existing investigators have received local training but will go on to undertake the HSIB training over the coming year.

In addition to the bank of independent investigating officers there are occasions when the use of an internal specialist investigator is appropriate e.g., for Information Governance, Medical devices etc. The Quality & Safety Team provides support and expertise for all patient safety focused reviews and investigations carried out by Solent.

## Safety, Excellence, and Improvement Forum

During 2021/22 three virtual Safety, Excellence and Improvement Forums took place. They are a collaboration between the Solent NHS Trust Quality and Safety Team and the Academy of Research and Improvement, to share learning through stories, presentations, and Q&As on safety, excellence, and improvement.


Held quarterly, the forum invites patients, members of the public and staff to learn from others, ask questions and reflect on safety events, excellent care, and Quality Improvement activity. The aim is to spread learning, best practice and most importantly, consider "what difference" these events and activity would make to other patients, people, staff, and services.

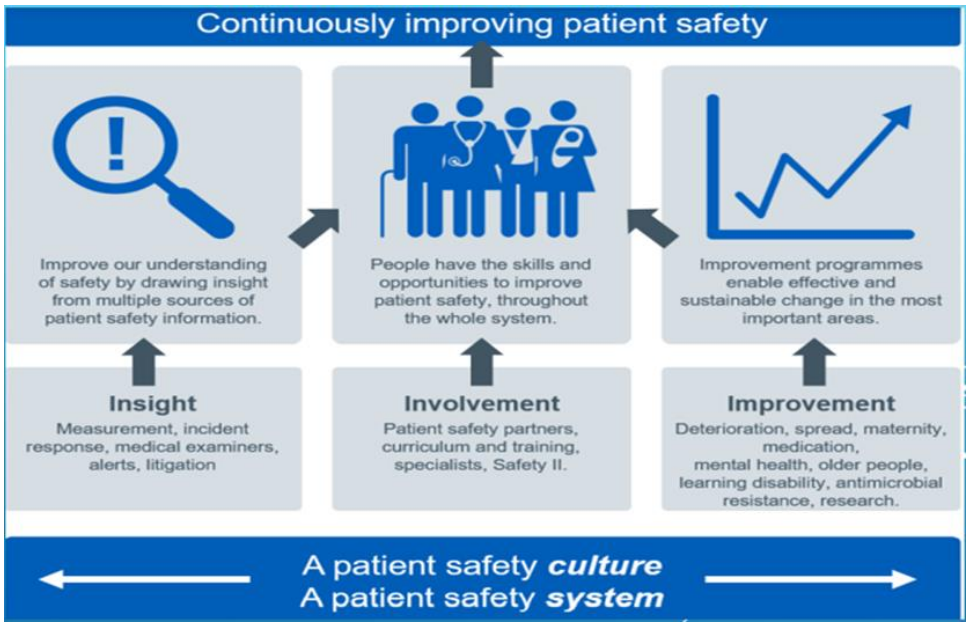
## Leading our staff

A number of the policies Solent has to guide staff on the correct way to care for our patients, were developed and updated during 2021/22. A new Incident Reporting, Investigation and Learning Policy was written. This aims to outline the process of incident reporting through to the outcomes from reviews.

We also took the opportunity to update our Being Open and Duty of Candour Policy to align it more with a 'doing the right thing' approach rather than a duty or legal obligation on us.

## PATIENT SAFETY STRATEGY

*Published in 2019, the Patient Safety Strategy outlines the plans for improving* Safety Cultures *and creating* Safer Systems *to provide* Safer Care.




The implementation of the Patient Safety Strategy continues to be managed by the Patient Safety Specialist – Operational Lead, with the support of the Patient Safety Specialist – Strategic Lead. Updates are provided at the Quality, Improvement and Risk Group, Board and the Quality Assurance Committee.

There are many achievements to celebrate during the year.

## Learning from Patient Safety Events (LFPSE)

Learning from Patient Safety Events is replacing the current National Reporting & Learning System (NRLS) and Strategic Executive Information System (StEIS). It will create a central service for the recording of events and will provide Solent and NHS England/Improvement (NHSEI) with greater analysis of patient safety events. There is a new section on psychological harm and includes questions on how human factors may be contributed to the event.

Solent have added the event form to the Ulysses test system and have invited staff to provide feedback. The feedback will be used to develop training and supporting documentation for staff. The national deadline for the implementation is April 2023.

## National Patient Safety Alerts

The Strategy requires Organisations to review their current processes for the distribution of the alerts. There is a requirement to ensure there is a process for documenting actions, gathering evidence and executive sign off. Solent are exploring the use of Ulysses to capture actions and evidence for greater assurance.

## Patient Safety Partners

In March 2022 Solent appointed their first Patient Safety Partner with further recruitment planned throughout 2022.

Patient Safety Partners are members of the public who have an interest in patient safety. They will support organisations by working with them to improve patient safety, help co – design services, and participate in improvement projects. There is a requirement they sit on Safety Committees.

Solent were invited by NHSEI (NHS England/Improvement) to be an early adopter of Patient Safety Partners. This enabled us to work with several organisations from across the country to shape not only the role, but the processes required to implement. The strategy requires two patient safety partners to be in post by September 2022. However, Solent recognise the opportunity and importance of recruiting one in each service line.

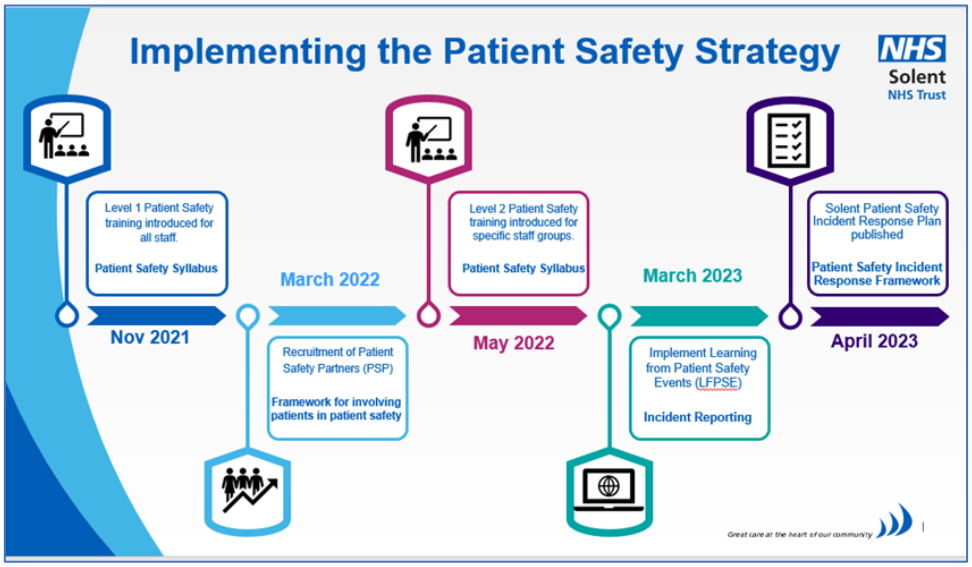
Solent have presented their Patient Safety Partner model nationally and regionally, which has generated lots of requests to share directly with other Organisations.

## Patient Safety Syllabus – Level 1 'Essentials for Patient Safety' training

The Essentials for Patient Safety training was released as part of the five levels of patient safety training syllabus. Solent followed NHSEIs recommendation and made it mandatory for all staff in November 2021. Trust compliance on the 31st March 2022 was 74%. Level 1 training for Boards and Senior Leadership teams was released at the same time, with Solent making this mandatory in December for 'Board' members. Trust Compliance on the 31st March 2022 was 64%.

The Patient Safety Specialist – Operational Lead presented the Solent model of implementation at the National Patient Safety Specialists meeting.

## Patient Safety Strategy Plans for 2022/23




## Patient Safety Incident Response Framework (PSIRF)

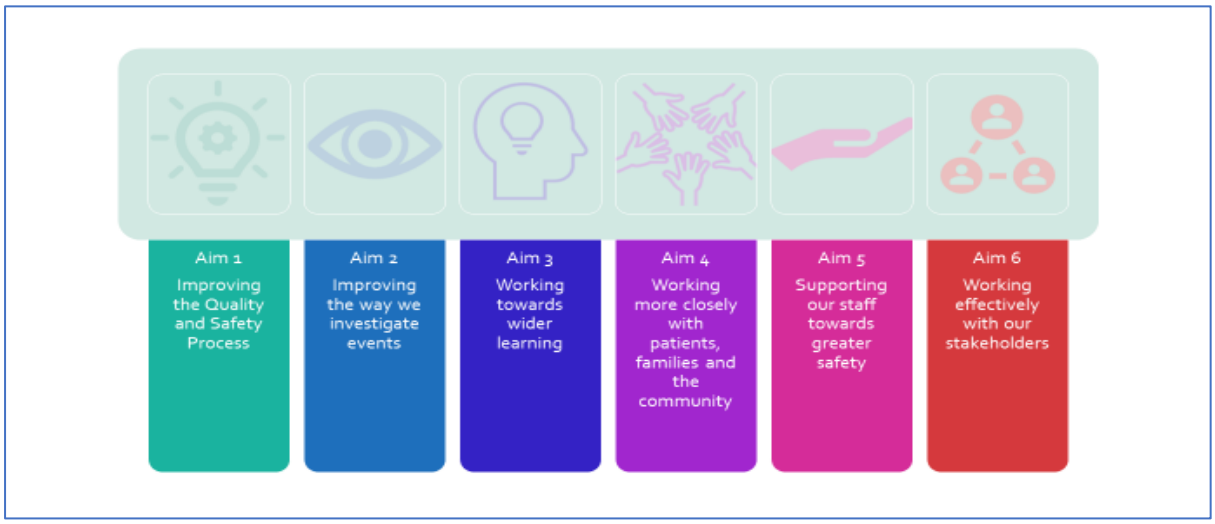
The implementation of Solent's Patient Safety Response Plan, due for board sign off and publication by April 2023, will be a large focus of 2022/23. This plan will not only replace the Serious Incident Framework it will also require Solent to work closely with the Integrated Care System to develop a plan for how we will learn from our patient safety events, what we will investigate, what tools we will use and what alternative ways we can implement to prevent further incidents. For example, the use of Audit and Quality Improvement Programmes. Further information will follow in the Patient Safety Q1 2022/23 report.

## Patient Safety Syllabus

Following the release of Level 2 'Access to Practice' training, a recommendation paper will be prepared outlining which staff groups will be required to undertake the training. Levels 3-5 are due for release in 2022. These will also be reviewed, and recommendations will be shared through the Quality Improvement and Risk Group.

## *Next steps*

The Quality and Safety Team has drafted a 3-year strategic safety plan which pulls together the Patient Safety Strategy implementation and other key safety workstreams and aligns with the Quality Account and Clinical Framework. This is being reviewed prior to ratification and launch and will shape our key aims and objectives for the 3 years ahead.




Some key objectives which will flow from the plan are:

Further Patient Safety Partners will be appointed along with Patient Safety Champions in each service line.

Working with patients and families who have been involved in events, the Team will seek feedback on how to involve them in the incident review process and the actions required to make improvements to the

Results from the implementation of the RIPPLE model will be reviewed and published nationally.

Key staff from the Quality & Safety Team will participate in the Pressure Ulcer Panel to help direct the Trusts response to pressure ulcers.

To support the updated policy, our Being Open and Duty of Candour training will be refreshed to give staff more confidence when dealing with patients.

Access to Practice – Level 2 training will be launched shortly, to build on the knowledge gained from completing Level 1.

## APPENDICES

### APPENDIX 1

| Service | Description |
|---|---|
| Adult Mental Health | Emergency escalation of a patient starting Clozapine with suspected myocarditis. |
| | Death of a patient who contracted COVID-19 whilst an in-patient. |
| | After a short in-patient admission, a patient is suspected to have taken their own life. |
| | A patient took their own life before a referral to secondary mental health services could be completed. This incident was escalated from a HRI to an SI following discussions with Portsmouth CCG. |
| Adult Services Portsmouth | Troponin levels were not included in the blood test of a patient experiencing epigastric pain, which meant a cardiac incident was not immediately diagnosed. |
| Adult Services Southampton | Emergency escalation of a patient following a fall on an in-patient ward. |
| | The correct reporting processes were not followed in relation to a pressure ulcer. |
| | Pressure Ulcer |
| | Emergency escalation of a patient suffering a hypoglycaemic event |
| Child & Family Services | A case notes review has identified instances of missing notes or referrals, incomplete equipment orders or missed appointments for 51 patients. |
| | Delayed referral for a patient with an eating disorder. |
| Primary Care | A patient developed a wound on top of their left foot which deteriorated resulting in an admission to University Hospitals NHS Foundation Trust. |
| Special Care Dental Service | Signs of abnormality evident on a radiograph were not immediately recognised in a patient who was subsequently diagnosed as having an oral squamous cell carcinoma. |

## APPENDIX 2

| Service | Summary of Identified Learning | Actions/Improvements Made |
|---|---|---|
| Adult Mental Health | Serious Incident investigations were completed into the death from COVID-19 of 4 in-patients. The learning was presented as a thematic review and shared with the wider system via the Portsmouth Clinical Commissioning Group. | Potential infection with COVID-19 is identified as a risk for all patients on our wards but risk assessments now include consideration of how individual characteristics can increase those risks. |
| | | The level/frequency of observations has been increased to better manage social distancing requirements in patients with a propensity to wander. |
| | | There must be greater access to COVID-19 vaccinations on in-patient settings. |
| | | Staff are supported to challenge colleagues if they identify any lapses in compliance with COVID-19 guidance e.g., use of Personal Protective Equipment. |
| | The death of a patient investigated as a High-Risk Incident identified that risks were clearly articulated throughout the patients notes but their risk assessment wasn't updated according to our NERD process (New Assessment, Escalation of Risk, Review at CPA or Discharge). | A clinical documentation sub-group has been established to audit and govern standards of documentation within the service. |
| | A Serious Incident Investigation highlighted the importance of thorough discharge planning for patients.<br><br>The case also raised the complexity of navigating a patient's wishes regarding consent to share which extends beyond death. | Solent NHS Trust policies will be updated to include the significance of considering poorly controlled symptoms in treatment decisions, risk management and discharge planning. |
| | | The Service have developed a process for recording and sharing information related to history and complexity of chronic illness, in line with the principles of AMH006 Care Programme Approach (CPA) policy. |
| | | A PowerBI dashboard is being created to allow Lead Nurses to monitor daily whether admission and discharge processes are being followed. |
| | | Challenging internal discussions have been held to ensure the patient's wishes regarding consent to share medical records are honoured whilst also providing support to grieving families. |

| | | |
|---|---|---|
| **Child and Family Services** | Therapies Teams and palliative care patients. | Multiple mortality reports have identified excellent practice by the Therapy Teams as they continue to be involved with patients who are placed on a palliative care pathway, organising equipment and providing support.<br><br>Although there is no requirement for them to remain involved, they do so because it is the right thing to do for patients and their families. |
| | External providers and agencies must fulfil their statutory responsibilities for child death reporting and notify Solent NHS Trust promptly of a death. | The service is working with partners to improve links so that Solent NHS Trust are notified earlier, enabling us to:<br><br>1) Determine the Cause of Death<br>2) Rapidly identify any actions that needs to be undertaken to potentially safeguard other children.<br><br>3) Provide support to the family and friends of the patient. |
| **Adult Services Southampton** | A Structured Judgement Tool review into a patient's care outlined exceptional practice by the Community Nursing Team. | A notable positive factor in this case was the willingness of staff to challenge other Healthcare professionals. The case has been shared as an example of the benefits for a patient's care when this is done effectively. |
| | | The team were also able to facilitate a truly multi-disciplinary approach for this patient which ensured the patient, and their family, received holistic care from several providers. |
| | A Serious Incident Investigation was completed into the death of an in-patient following a fall.<br><br>The investigation utilised a Case Review Methodology which allowed staff to reflect on the incident as a group, agree improvements together and provide each other with valuable peer support. | In conjunction with the Solent NHS Trust Resuscitation Lead, a significant event free scribe document has been. |
| | | Scenario based training is adapted to practice emergency responses within clinical areas. |
| | | Oxygen cylinders have been relocated onto wall mounts next to the emergency trolley with documented daily checks. |
| **Trust wide** | A theme concerning End of Life Care has been seen in mortality reviews across several service lines.<br><br>The focus is on the importance of Anticipatory | Adult Services Southampton have recorded a short video and distributed a poster to inform staff about the importance of determining the location of DNACPR documentation when kept in a patient's home. |
| | | Bitesize training sessions have been developed to provide staff with guidance on providing excellent End of Life Care. |

| | | |
|---|---|---|
| | Care Plans and awareness of DNACPR documentation. | Solent NHS Trust's End of Life Steering Group have commenced work with the wider system on Anticipatory Care Plans. |
| | | Adult Services Portsmouth is providing staff with additional education and support in managing terminal agitation. |
| | | As it forms an extension to the care they provide, staff in Child & Family Services CCN Team are reviewing training on the certification of child deaths. |

Item 8

# CEO Report – In Public Board

Date: 18 July 2022

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.

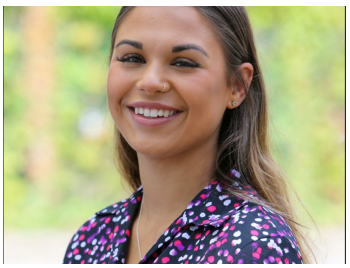
****In light of the Level 3 National Incident, contemporary updates will be provided where appropriate in relation to our continued response****

## Section 1 – Things to celebrate

### NHS heroes recognised at Solent Awards

I was delighted to host our awards ceremony in July, recognising our dedicated Solent heroes for their hard work and. We celebrated the incredible achievements of our colleagues working across Southampton, Portsmouth, wider Hampshire and the Isle of Wight at the event held at the Hilton Ageas Bowl in Southampton.
The ceremony saw a total of 14 awards presented following nominations from patients and colleagues. Winners were then selected by an independent panel.
Paralympic champion Aaron Phipps, who won gold at Tokyo 2020 in wheelchair rugby, was a guest speaker at the event and spoke about his admiration for the NHS.

### Young receptionist praised for helping heart patient



I was immensely proud to learn that one of our receptionists was praised for her calmness as she helped a patient suffering a suspected heart attack at Bitterne Health Centre. Quick-thinking Darcy, 19, an apprentice in our estates team, sat the woman down on a chair in the waiting room and dashed to get medical help. Unable to find anyone free downstairs, she raced upstairs and found the ideal candidate – a cardiac nurse. The patient was taken to Southampton General Hospital for further tests.

### Southampton Guides add colour to employee wellbeing gardens

I hosted a group of Southampton Guides when they returned to add some colourful finishing touches to our charity funded employee wellbeing gardens at the Western Community Hospital in Millbrook, Southampton. The 3rd Test Guide group came up with their own Jubilee focused designs for the garden area situated near to the entrance of the Adelaide Health Centre on the Western Community Hospital site. The group also spent time preparing and planting a border of colourful bedding plants, including flowers arranged in the shape of a crown, and sunflowers and sweet peas to attract bees.

### Estates and Facilities teams celebrated as part of national day

Cooks, cleaners and other unsung heroes who work behind the scenes to keep our hospitals and health buildings running smoothly were celebrated as part of the first national Healthcare Estates and Facilities Day in June.
The day raised the profile of the important work which goes on in the background by the teams, largely out of sight.

### Solent celebrates Platinum Jubilee

As part of the Queen's Platinum Jubilee celebrations we distributed cookies to staff across the Trust to celebrate the event created by our amazing catering team. The catering team went one step further, creating a special menu for inpatients on Solent's Southampton and Portsmouth hospital wards. There was a lunch menu centred around items popular over the last 70 years, including roast beef with Yorkshire Pudding, and Coronation chicken.
An afternoon tea was then served, with Victoria sandwich cake, fresh fruit and strawberry trifle on offer.

### Solent Charity receives donation following end of life care of patient


Friends and colleagues of a much-loved Nuffield Health Portsmouth employee who sadly died from cancer raised £750 for our Charity (Solent NHS Trust Charity) in her memory.
Kim Harris, 60 and from Southsea, sadly passed away in April 2021 after fighting a dignified battle with the disease for almost two years. She was supported at home by the Portsmouth Community Nursing Support Service and Specialist Palliative Care Team at Solent NHS Trust. Kim's family and friends wanted to donate the money as a thank you to all the care Kim had received.

### Family Assist Solent promoted for Maternal Mental Health Awareness Week and Mental Health Awareness Week

We supported Maternal Mental Health Awareness Week (2-8 May) and Mental Health Awareness Week (9-15 May) by promoting our new online portal, Family Assist Solent.
The portal offers a wealth of information, including mental health guidance to expectant and new mothers, parents, and families when needed most.

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

### Appointments

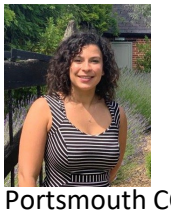
I outline news of our recent appointments.

### Director of Strategic Transformation

Debbie James, who is currently on secondment to the Hampshire and Isle of Wight Integrated Care System (ICS), will be returning to Solent to take up the role of Director of Strategic Transformation. Debbie will form part of the Executive team and will work as an advisor to the Board. She will have exec responsibility for commercial and planning, and will also play a key leadership role in the next steps of the community and mental health review.

### Deputy Chief Operating Officer

Alasdair Snell has been successfully appointed to the role of Deputy Chief Operating Officer, supporting Suzannah in the delivery of services across Solent. In his new leadership role, Alasdair will also be supporting our services as we go through the transformational change journey. We are grateful to Alasdair for stepping into the interim role of Operations Director (OD) for Child and Family Services through exceptionally challenging times.



### Chief Finance Officer

As I previously shared, Gordon Fowler will be leaving Solent in the Autumn for a new role in the Hampshire and Isle of Wight ICS. We are delighted to have appointed Nikki Burnett as the new Chief Finance Officer. Nikki will lead our finance and estates and facilities teams. Nikki joins us from NHS Portsmouth Clinical Commissioning Group (CCG) where she Deputy Chief Finance Officer at Portsmouth CCG. Starting her NHS career with Hull Primary Care Trust back in 2008, Nikki has worked across provider, commissioning and regulatory organisations.

In addition the appointments above, we have also made some changes to the Board. Effective immediately, Rachel Cheal, Chief of Staff will move from an advisor to the Board to a non-voting Board member.

These appointments, joining Shahana Ramsden as our new Chief People Officer, create an exciting refreshed team with the capacity and skills to lead us through the next stage of our journey.

## COVID-19

### Vaccination programme

We have continued our involvement as part of the HIOW COVID-19 vaccination programme which has delivered 4,188,550 vaccinations; of which we have delivered 822,000 vaccinations as part of this blended delivery model. HIOW are the highest performing ICS for spring booster vaccinations, 3rd in country for 5–11-year-olds and were the highest performing system for the 12–15-year-old delivery through the blended approach of in school delivery and mass vaccination centres/outreach.

During June/July the team have hosted visits from the national vaccination team and the HIOW Senior Responsible Officer; have presented to national forums on community outreach, 5–11-year-old service and the pilots of our health & wellbeing hubs and have been commended for the novel delivery approaches taken, particularly in engaging with our underrepresented communities. Recent innovations for targeting our most vulnerable communities have been a partnership approach adopted with Her Majesties Prison Winchester, Albany and Parkhurst (Isle of Wight) where we have a vaccination programme offering educational conversations as well as on site vaccinations.

The Spring booster phase completed at the end of June 2022. Over the summer period we are continuing to offer a vaccination service for anyone aged 5 and above as part of the evergreen offer whilst we plan for delivery of the Autumn boosters which will commence in September 2022. We are also supporting a number of place-based localities with care homes, housebound and outreach vaccinations where the Primary Care Networks have paused for the summer period.

There is a change in funding mechanism for the next phase which moves from a cost reimbursement model to a fixed item of service fee from 1 September - further information is shared within the Confidential CEO Board Report.

## Workforce matters

### Infection, Prevention and Control - further easing of restrictions.

The infection prevention team have been closely monitoring the rapidly changing situation with the ongoing SARS-CoV-2 pandemic. As we have continued to see an increase in case rates, both nationally and regionally, a risk-based decision was made to reintroduce some restrictions.

From Tuesday 5 July the use of facemasks by all staff, clinical and non-clinical, in all areas, clinical and non-clinical, was reintroduced to reduce the level of risk from exposure to those who may be asymptomatic. Some caveats, with mitigations, and alongside clinical based decisions, are supported for instances were staff or patients may need to remove masks for treatment or communication purposes.

Staff are still requested to do twice weekly lateral flow tests and outbreaks and clusters are responded to accordingly. Visitors to inpatient wards need to wear masks to protect or most vulnerable. All other patients or visitors are encouraged to wear a mask but this is not being enforced so that patients are not deterred from obtaining treatment. All staff have been reminded of other mitigations such as hands, face, space and air whilst we work through this current wave.

### Staff Vaccinations

We have seen significant progress in staff vaccinations with 95% of staff taking up a flu vaccination and 95% take up of Covid Vaccines and 86% have accessed boosters. We have continued to support staff who have requested COVID vaccinations, people who have recently been recruited through our international recruitment have accessed vaccines and we are signposting staff to the Vaccination Hubs and arranging appointments where needed. We have commenced planning the Flu programme for this year and we are working with Service Lines to deliver targeted clinics where needed as well, as well as offering specific appointments for anyone who is needle phobic.

### Cost of Living

The rise in the cost of living crisis is impacting everyone across the NHS. At Solent we are doing all we can to offer practical support to help ease this strain. We asked staff to tell us about how the cost of living is impacting them and had over 200 responses to our questionnaire in just a matter of days. Many staff shared their personal experiences which were undeniably sobering.

In response to staff feedback, we were able to put some immediate actions in place from July 2022

- We have organised a 30% discount on meals at restaurants managed by Solent at the Western Community Hospital and St Mary's Community Health Campus. All staff, including those from other NHS organisations, providers, partners, and volunteers who work at our sites, will be able to access this discount, as will their families. (All people need to do is to show their ID badge).

- We wanted staff to be the first to know about discounts and offers already available so are using our Solnet website and regular email updates to let people know about existing offers they can access.

- There is a range of signposting and support available through the HIOW People Portal, such as a cost of living toolkit for staff. This signposts to resources on money, mental health, foodbanks and financial advice and can be found here.

- The People Portal also provides access to the Health and Wellbeing Support Service to support staff to manage stress or discuss general health and well-being needs. Solent will be trailing an expansion of this service so that staff can also access financial advice.

We acknowledge that there is still more to do and have set up a Rapid Cost of Living Response group to work through over 33 ideas and suggestions generated by staff. Ideas we are exploring include an internal Food and Health Products bank, Helping Hands via Citizens Advice Bureau, travel discounts for public transport, pension advice and also a car sharing initiative.

## Demand and Capacity

### Contemporary update urgent care pressures

There is little change across the PSEH and SSWH urgent care systems with the pressure on NHS services continuing and summer feeling more like winter in terms of demand. Both SCAS and PHU called internal critical incident for a few days during July. Our Adults Southampton and Portsmouth teams continue to work hard to ensure discharges from the acute happen in a timely way and that our community beds are fully utilised.

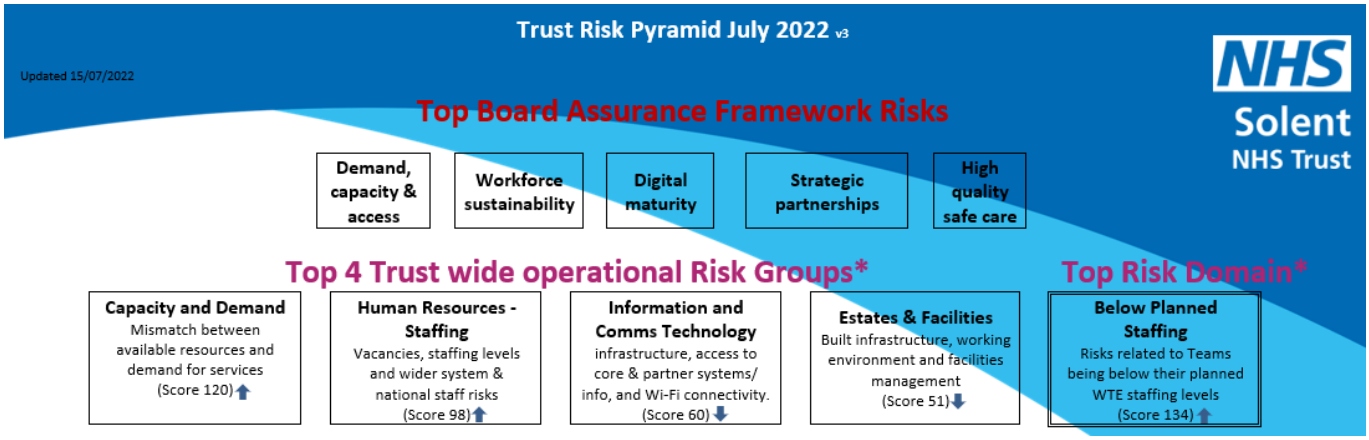
## Our key risks

### Operational Risk Register

The risk pyramid summarises our key strategic and trust wide operational risks. Our top risks are:

- Capacity & Demand
- Human Resources – Staffing
- Information and Comms Technology (ICT)
- Estates and Facilities
- Below Planned staffing - the most prevalent risk

All operational risks are being actively managed through our care groups and assurance is sought at the relevant Board Committees.




### Board Assurance Framework (BAF)

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 | S4 x L4 = 16 – by End March 2023<br>S4 x L3 = 12 – by end July 23 |
| Workforce sustainability | S5 X L4 = 20 | S4 x L4 = 16 | S4 x L3 = 12 by summer 2024/25 |
| Digital Maturity | S5 X L4 = 20 | S5 x L3 = 15 | S4 x L3 = 12 – by March 2023 |
| High quality safe care | S5 XL5 = 25 | S5 x L3 = 15 | S5 x L2 = 10- by end Q3 202/23 |
| Financial sustainability | S4XL5 = 20↑ | S4 x L4= 16↑ | S3 x L3 = 9↑ - by end 2023/24 |
| Strategic provision of services | S5 X L5 = 25 | S5 X L4 = 20 | S3 x L2 = 6 -timescale tbc |
| Risks removed from active BAF monitoring | | | |
| Strategic Partnerships | S5 x L4 = 20 | S4 x L4 = 16 | S4 x L3 = 12 **Risk suspended – new risk added #8 Strategic Provision of services** |
| 3rd party contractor assurance | S4 x L4 = 16 | S3 x L2 = 6 | S3 x L2 = 6 – by end June 22<br>**Target score achieved** |

## Section 3 –System and partnership working

### Isle of Wight (IOW) Partnership Update

Our partnership work with The IOW Trust is focussed on peer learning and support across the following service areas and has been extended to Southern colleagues.

- Community Nursing Services
- IAPT/iTALK Services
- Hospital Discharge into the Community Services

In the coming months this will extend further to include:

- Dementia Memory Services
- Virtual Ward Development
- In Patient Units (community)

## Update on HIOW Mental Health and Learning Disability Provider Collaborative (MHLDPC)

Following approval by sovereign Boards during June, kick off meetings for both MHLD and a Community equivalent group, are being held before the end of July. At these meetings it is anticipated that priority clinical workstreams and the process of identifying Senior Responsible Officers (who will lead the workstreams) supported by Executive Sponsors, will be agreed.

| | | | | | | |
|---|---|---|---|---|---|---|
| Item No. | **9** | | Presentation to | Trust Board – In Public | | |
| Date of paper | 22 July 2022 | | Author | Zoe Pink, Interim Head of Performance | | |
| Title of paper | Trust Board Performance Report | | | | | |
| Purpose of the paper | The report describes the key operational issues facing the organisation, including the services connected with Urgent and Emergency Care and the increasing demand on our services. It triangulates workforce and other issues and describes the actions that the organisation is taking to mitigate the issues. | | | | | |
| 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 Trust Board is asked to:<br><br>• 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, Chief Executive Officer. | | | Exec Sponsor signature: | | | |

# Integrated Performance Report (IPR) for May and June 2022

Solent NHS Trust is in the process of transforming our Trust Reports. In line with the Well-Led recommendations Solent is utilising the Making Data Count Methodology (where relevant and applicable) to streamline reporting. This change will offer a clear picture of how well we are performing and shine a spotlight on exactly where we can make changes for improvement.

To interpret the performance summaries please find a key below, or alternatively please find a more detailed crib sheet in annex A.

**Key**

**In-month Performance Indicator**

- Metric is achieving the target
- Metric is failing the target

**Trending Performance Indicator**

Target has been consistently achieved, for more than 6 months

There is a variable and inconsistent performance against the target

Target has been consistently failed, for more than 6 months

**Variance Indicator**

Special Cause Variation, for improved performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit

Special Cause Variation, for improved performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit


Common Cause Variation, the information is fluctuating with no special cause variation.

Special Cause Variation, for poor performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit

Special Cause Variation, for poor performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit

# 1. Safe

## a. Performance summary

| | Indicator Description | Internal /External Target | Target | Jun-22 Current Performance | | Jun-22 Trending Performance | Jun-22 Variance | May-22 Current Performance | | May-22 Trending Performance | May-22 Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Safe | Occurrence of any Never Event | E | 0 | 0 | | | | 0 | | | |
| | NHS England/ NHS Improvement Patient Safety Alerts outstanding | E | 0 | 0 | | | | 0 | | | |
| | VTE Risk Assessment | E | 95.0% | 93.0% | | | | 100.0% | | | |
| | Clostridium Difficile - variance from plan | E | 0 | 0 | | | | 0 | | | |
| | Clostridium Difficile - infection rate | E | 0 | 0 | | | | 0 | | | |
| | Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias | E | 0 | 0 | | | | 0 | | | |
| | Escherichia coli (E.coli) bacteraemia bloodstream infection | E | 0 | 0 | | | | 0 | | | |
| | MRSA bacteraemias | E | 0 | 0 | | | | 0 | | | |
| | Admissions to adult facilities of patients who are under 16 yrs old | E | 0 | 0 | | | | 0 | | | |

**Incident Reporting**

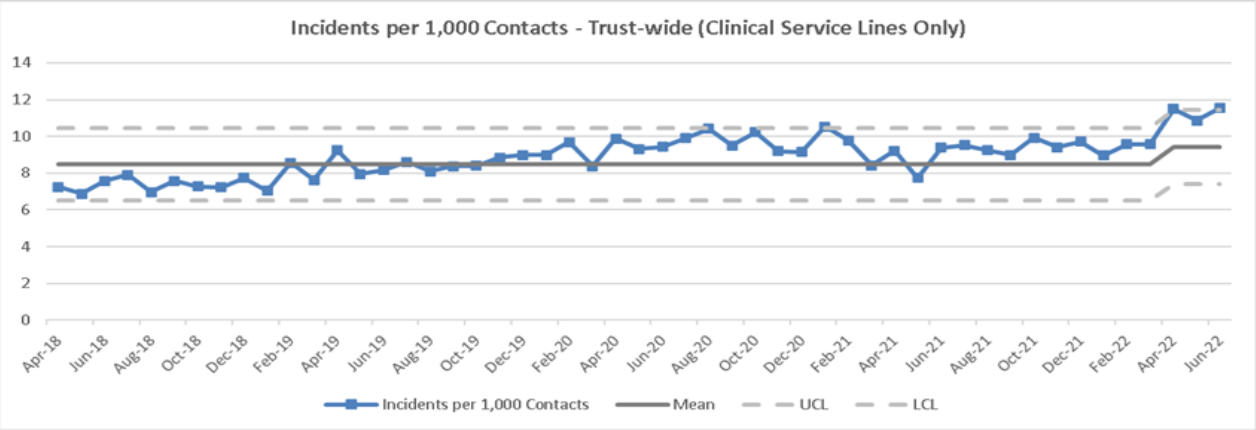



Figure 1 – Incidents per 1000 contacts

Incident reporting trends continue to increase (as shown in the graph above), additional analysis has established this increase is associated with Adults Services Portsmouth in particular. The increase in incidents is for those reported as "no harm identified" (previously under reported in the service line) and reflects an improving reporting culture in Adults Portsmouth. The top incident cause groups remain unchanged from previous reporting period.

## b. Actual Impact – Learning and action from Incidents

**Spotlight on Staffing**

Staffing levels has been identified as a very high-risk area for Adults Southampton and Adults Portsmouth.

Adults Portsmouth is seeing an increase in incidents with staffing levels identified as a contributory factor and a Serious Incident has been raised regarding a pressure ulcer with staffing levels identified as a factor. The team currently have a 25% vacancy rate. This has been discussed at Performance Review Meeting (PRM) and a further mitigating factors and actions required are under review.

Adults Southampton is not seeing an increase in incidents with staffing levels identified as a contributory factor at present. Discussion at PRM highlighted that this could be because staff aren't identifying staffing as a factor when reporting incidents or because staff are mitigating any risk by working additional hours/with additional pressure. Staff are being reminded to identify staffing as a contributory factor when reporting incidents if appropriate in order for accurate data analysis and triangulation. Further discussion will take place at the Quality Review Meetings with the service lines.

The Trust's People Operations resourcing and attraction teams are working very hard in mitigating and reducing the vacancy gap to help improve staffing levels, through targeted interventions such as: increased advance bank and agency planning (bank fill rate consistently hitting 90%) plus focused innovative Recruitment activity with service lines targeted role recruitment campaigns, such as CAHMS, Nursing apprentices, T-level apprentices (grow our own), Associate practitioners, AHPs, HCAs/HCSW, Physio's, Podiatrists, and the international recruitment of Community Mental Health Nurses (pilot project with NHSE/I) are all underway.

### c. Insights – Service concerns

**Service Concerns**
During May and June 2022 service concerns have decreased from 131 in March/April 2022 to 114.

**Service Concerns - Insights**
Communication and appointments were identified as the main reasons for contact, mirroring the data from the previous period and themes of complaints received. Communication around information being provided to patients was sighted as the main theme.

- Appointment Booking System and Appointment availability were the main cause of concern.
- Communication with patient, communication with GP and Communication with Relatives/Carers were the main cause of concern.

## 2. Caring

### a. Performance Summary

| | | | | Jun-22 | | | | May-22 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Indicator Description | Internal /External Target | Target | Current Performance | | Trending Performance | Variance | Current Performance | | Trending Performance | Variance |
| Caring | Community FFT % positive* | E | 95.0% | 98.2% | | P | | 97.4% | | P | |
| | Mental Health FFT % positive* | E | 95.0% | 93.6% | | ? | | 98.5% | | P | H |
| | People Pulse Survey - Advocacy Theme (Recommended for Care & Employment) | E | 6.7 | 7.4 | | | | - | | | |
| | Mixed Sex breaches* (Submission recommenced October 20221) | E | 0 | 0 | | P | | 0 | | P | |
| | Plaudits | - | - | 98 | | | | 95 | | | |

### b. Key Performance Challenges

The Mental Health FFT % Positive KPI is listed as having dropped in performance in the most recent month to below target, however the trend analysis shows that this is common cause variation, with variable achievement of the target and therefore is not of significant concern at this point.

## c. Spotlight On: Friends and Family

▲ A further increase in number of responses from 3661 for March/April to 3755 May/June

| | May 2021 | June 2021 | July 2021 | August 2021 | Sept 2021 | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 | April 2022 | May 2022 | June 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Number of responses | 1352 | 923 | 916 | 1566 | 1136 | 1662 | 2410 | 1759 | 1950 | 1445 | 1922 | 1739 | 2034 | 1721 |
| Very good/Good | 94% (1267) | 93% (860) | 93% (852) | 92% (1442) | 92% (1048) | 92.1% (1530) | 93.3% (2246) | 93.9% (1651) | 95.3% (1859) | 95.2% (1375) | 94.10% (1809) | 93.8% (1630) | 93.9% (1909) | 94.9% (1634) |
| Very Poor/Poor | 3% (41) | 3% (32) | 3% (28) | 3% (52) | 4% (43) | 3.4% (56) | 3.6% (86) | 2.7% (47) | 2.4% (46) | 2.2% (32) | 2.7% (51) | 2.5% (43) | 2.9% (60) | 2.8% (48) |

Figure 3 - Friends and Family Test Data – Dataset includes Mental Health Services (May 2021 – June 2022)

May/Junes figures in 2022 (3755) compared to May/June the previous (2275) and you will there has been a large increase in FFT, with 95% of people saying they would recommend and only 3% saying the service was poor.

# 3. Effective

## a. Performance Summary

| | Indicator Description | Internal /External Target | Target | Jun-22 Current Performance | Jun-22 Trending Performance | Jun-22 Variance | May-22 Current Performance | May-22 Trending Performance | May-22 Variance |
|---|---|---|---|---|---|---|---|---|---|
| Effective | Bed occupancy by ward | - | - | Metric under review by the BI and Performance Teams. | | | | | |
| | Length of stay | - | - | 24.95 | | | 20.6 | | |
| | Delayed Transfers of Care [patient count] | - | - | 20 | | | 15 | | |
| | Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS | E | 95.0% | 66.7% | | | 100.0% | | |
| | % clients in settled accommodation | E | 59.0% | 69.6% | | | 69.3% | | |

**Metric: Bed Occupancy**

Further to concerns raised, the BI and Performance Team are undertaking a project to review the bed occupancy metric and the information flows from wards to Trust Board. This project is being prioritised with an update regarding implemented changes expected by July-August Board Report.

**Metric: Length of stay**

The average Length of stay on Solent wards overall is in a state of common cause varition, there are no significant trends. However, when broken down by bed type there are slight varatiaions in the analysis.

**Community Wards**

Community Wards such as Spinnaker, Fanshawe, Brambles and Jubilee have been averaging below 20 days LOS since March 2021, however this is beginning to see an increasing trend. This is not concerning at this point as is is still well below the 2019 national benchmark of 24 days, though requires monitoring.

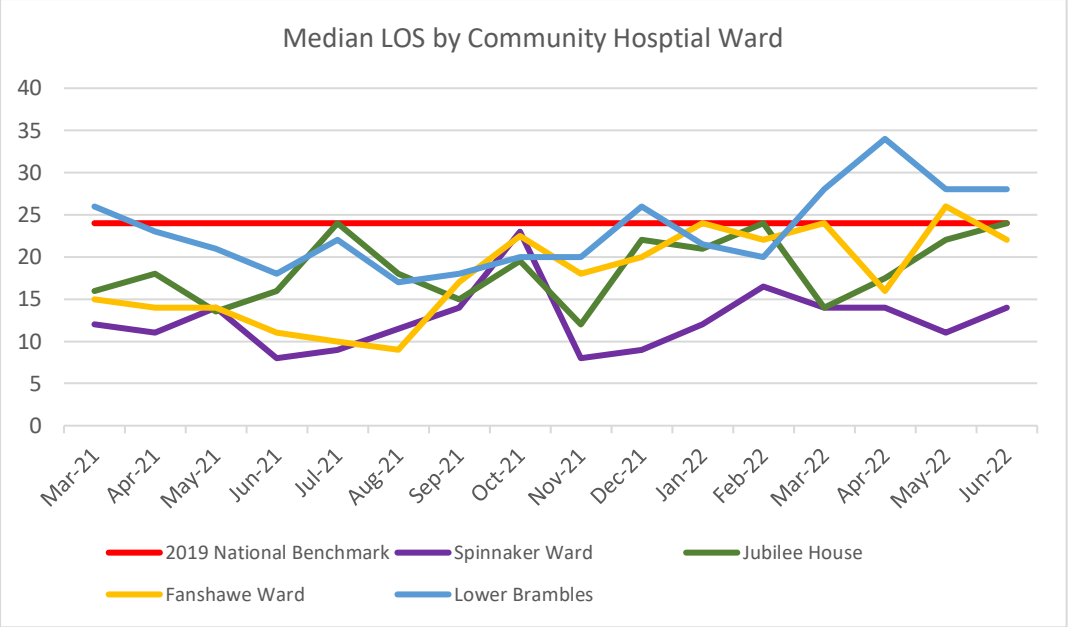



Figure 4 Average Length of Stay for Community Wards from Jan '21-June '22

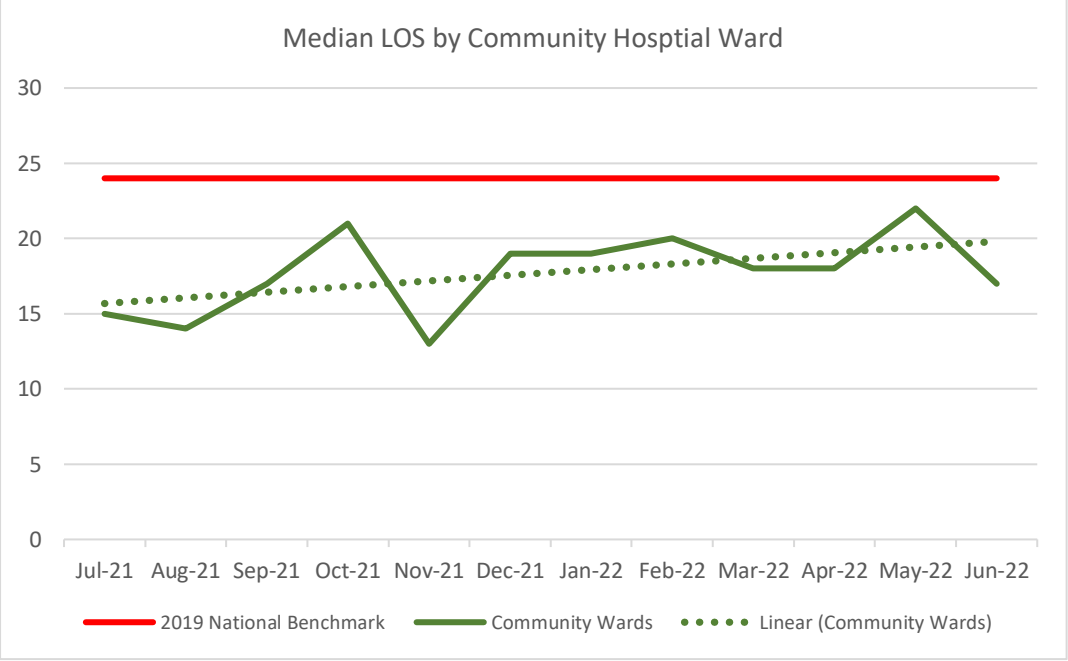



Figure 5 Total Average Length of Stay for Community Wards from Jul '21-June '22

**Rehabilitation Wards**

Neuro Rehabilitation wards Snowdon and Kite have a significantly variable length of stays due to the specialist nature of the wards. There are no national benchmarks for length of stay which can be included in this analysis.

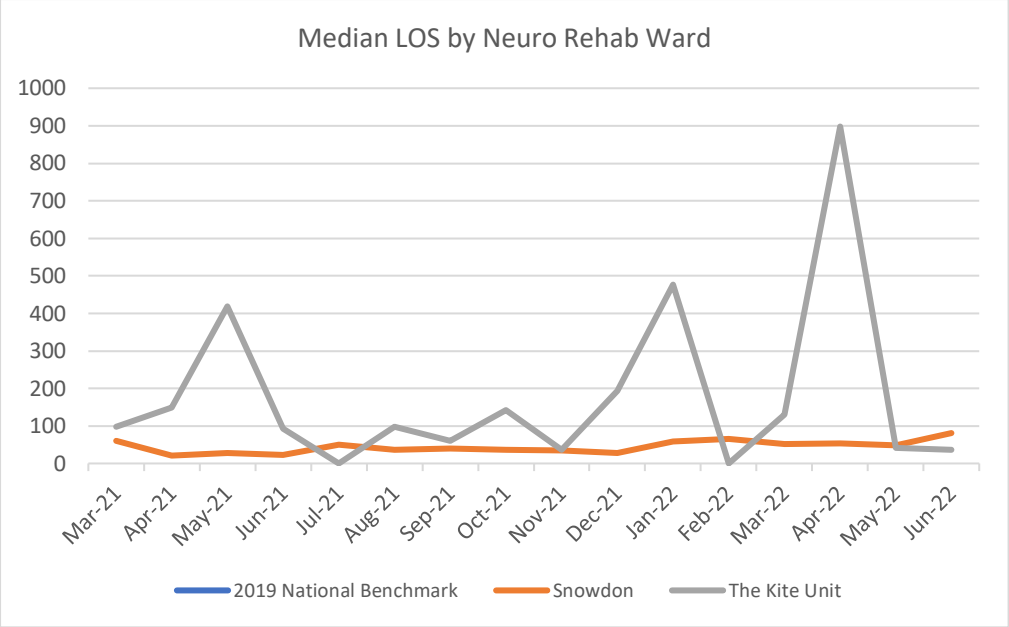



Figure 6 Average Length of Stay for Neuro Rehabilitation Wards from Mar '21-June '22

**Mental Health Wards**

Solent's Mental Health (MH) Wards are mostly showing a reduced length of stay (from Dec-21).

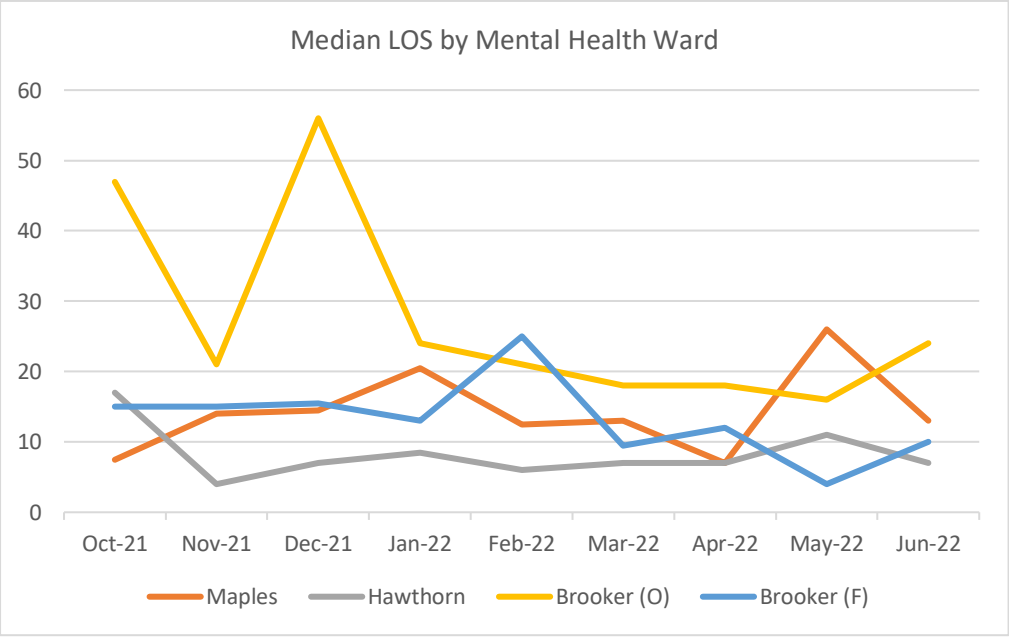



Figure 7 Average Length of Stay for Mental Health Wards from Oct '21-June '22

*National benchmark for MH wards is for acute only (Maples) at 32 bed days

*Ave. LOS (Length of stay) is based on Patient's discharge date

*Solent wards have differing acuity, cohort & variability in discharges

## b. Key Performance challenges

**Urgent Care reporting (UCR)**

The focus to improve our 2-hour response processes for both Portsmouth and Southampton Urgent Responses (URS) continues to the end of a July, after which the workstream moves into business as usual.

Process continues to be hindered by resource challenges within services (of which admin roles have now been recruited to support) alongside the human factors of embracing change. Patient System's have provided Standard Operating Procedures (SOPs) alongside on site and virtual training sessions. Support will continue over the following Months.

**2- hour wait figures via Community Services Dataset (CSDS)**

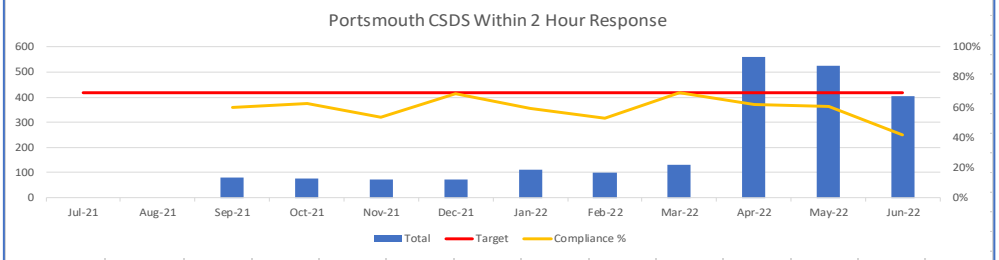
Southampton & Portsmouth Urgent Response Services (URS) now receive their figures as reported via the CSDS. Rules around validation of patients mean after a primary submission services have time to 'adjust' the previous month's figures prior to the final submission date. Please note reported figures for June (figure 8) for both UCS are only partially complete due to the primary and final submission.

Portsmouth continues to find completion of validations within the national timetable challenging. Performance & BI are supporting validation of activity until the end of July, after which the task reverts to the service. It is acknowledged due to continued data capturing issues, Portsmouth URS fail to reach the 70% target. However future plans included a push for teams to review and implement agreed processes to quality assure their data submission.

Southampton URS showing a more favourable position, achieving target from December 2022 to date.

**Portsmouth**

| | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 0 | 0 | 80 | 77 | 73 | 74 | 110 | 101 | 131 | 559 | 525 | 406 | 2255 |
| Compliant | 0 | 0 | 48 | 48 | 39 | 51 | 65 | 53 | 91 | 347 | 318 | 170 | 1250 |
| Compliance % | | | 60% | 62% | 53% | 69% | 59% | 52% | 69% | 62% | 61% | 42% | 55% |




**Southampton**

| | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 0 | 0 | 288 | 251 | 240 | 232 | 242 | 254 | 213 | 212 | 248 | 222 | 2786 |
| Compliant | 0 | 0 | 194 | 166 | 150 | 189 | 203 | 186 | 187 | 192 | 233 | 159 | 1888 |
| Compliance % | | | 67% | 66% | 63% | 81% | 84% | 73% | 88% | 91% | 94% | 72% | 68% |

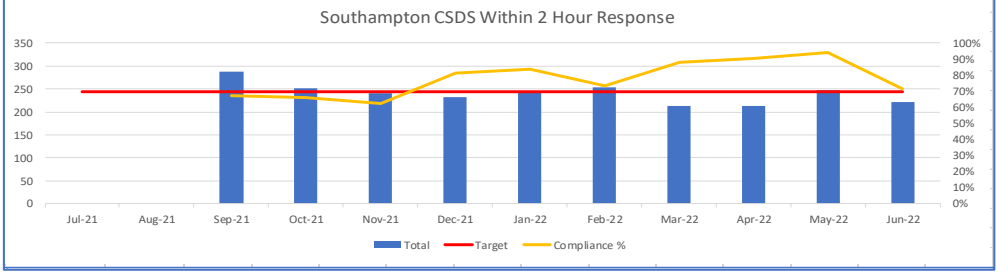



Figure 8 2-hour wait figures for Portsmouth and Southampton (CSDS) from Sept* '21-June '22

*Project start date

**Community Services Dataset (CSDS) discovery**

It was initially expected a discovery phase would last a maximum of 8 weeks, this however has been impacted severely due to the complexing of understanding the detail of SystmOne table structures, meaning additional resource time has been assigned. Workshops planning with clinicians of pilot services [Portsmouth & Southampton Urgent Response Services] is underway, with a date set for the first workshop to address functional and non-functional requirements on 20 July. It is proposed that several dates will be

offered to ensure all those stakeholders on the project have an opportunity to share their thoughts and feedback prior to any options being socialised.

**Platform as Service (Paas)**[1]

The project is now moving into the penultimate phase for technical delivery. Due to various unforeseen out of scope activities, the project has seen a deviation from the original agreement. However, the Solent team is working with the supplier to limit the impact on delivery.

Post Paas Implementation is in early initiation phase; funding has not been secured and will be dependent on a full business case. Engagement workshops are planned at the end of the month with multiple stakeholders to co-develop the plans and functional roadmap to deliver new capabilities, for example predictive analytics, capacity planning.

**Corporate Business Review meetings – Key areas**

**SPA Telephony**

The contract was signed 8 July, with a project meeting with stakeholders (SPA, MSK, GP Surgery) to agree next steps.

Solent is fully engaged with the supplier and stakeholders to set out the implementation plan, agree training and ensure have CGI complete limited technical tasks. GP Surgery and Sexual Health service are the agreed priority areas. Expected completion and handover is towards the end of September 2022.

**Capacity versus resource and capacity**

A common theme across all corporate functions is capacity & resource. Workload has increased significantly without the same additions to headcount, alongside several high profile workstreams which have been resource intensive.

Increasing compliance for mandatory training across clinical services is slow, which is down to increasing pressures of front line, and staff being stretched.

**Workforce**

It is recognised that there is a gap across the NHS in workforce, with significant challenges recruiting to a community provider (see People section for detail on our current recruitment & retention plans).

## d. Spotlight On: Urgent Community Response

**What is a virtual ward?**

Virtual Wards offer wrap around support to people in their own homes (including nursing homes), often including the use of remote monitoring utilising technology and a multi-disciplinary team approach. During the COVID pandemic COVID virtual wards were established to support the safe and early discharge of coronavirus pateints from hospital with a pulse oximeter to monitor oxygen levels at home.

[1] Paas will enable BI to 'future proof' compatibility & tools, offer the Trust cost saving of current versus new environment (circa 10k) per month, alongside a freeing of skilled resource within BI to exploit the provision of data to our services.

**The national ask**

NHS England are looking to build on this model of 'hospital at home' to include broader acute respiratory infection (including COVID-19) and also virutal wards for patients expereincing an acute exacerbation of a frailty-related condition. They have set a significant target; by December 2023 to have completed the comprehensive development of virtual wards towards a national ambition of 40-50 virtual ward beds per 100,000 population.

**Key Principles of virtual wards**

- Acute clinical care to be delivered in the community by an MDT, led by a named consultant practitioner alongside a suitably trained GP, with clear lines of clinical governance
- Clearly defined criteria to admit and reside, supported by daily review
- Ensure patients are given clear information on who to contact if their symptoms worsen with clear pathways to support early recognition of deterioration and escalation processes
- Provide patients with adequate information to allow informed consent including understanding of their care and to support the use of equipment or digital technology e.g. wearables, apps etc
- Have access to speciality advice and guidance and diagnostics equivalent to acute hospital care
- Deliver time-limited interventions (approx. 14 days) and monitoring based on clinical need for a secondary care bed
- Be fully aligned or integrated with other programmes e.g. Urgent Community Response (UCR) & same day emergency care (SDEC)
- Be designed for a range of conditions/symptoms/settings and track specific metrics measuring outcomes and patient safety

**Local implementation**

***Current trajectory (subject to in year revisions)***

| | March 2022 | June 2022 | September 2022 | March 2023 |
|---|---|---|---|---|
| Portsmouth Frailty | 0 | 10 | 25 | 25 |
| Portsmouth Palliative Care | 0 | 0 | 2 | 5 |
| Southampton Frailty | 30 | 36 | 42 | 48 |
| **TOTAL** | **30** | **46** | **69** | **78** |

*Numbers relate to actual beds

**Implementation plan**

Teams across Adults Portsmouth and Adults Southampton have been working to implement Virtual Wards in line with the national principles within each of the local delivery systems (PSEH & SSWH).

**Competed Milestones**

| Milestone | Start Date | Due Date |
|---|---|---|
| Scoping and mapping of existing virtual ward beds/services across Solent | 01-Mar-22 | 01-Apr-22 |
| Agree operational leadership and local governance | 01-Mar-22 | 01-Apr-22 |
| Define criteria to admit (including identification method) and admission processes (including screening and triage tools) | 01-Apr-22 | 31-May-22 |

**Work in progress**

| Milestone | Start Date | Due Date |
|---|---|---|
| Explore and pilot technology/digital solutions to deliver 'technology enabled care' to the Frailty patient cohort | 01-May-22 | 01-Sep-22 |
| Recruit additional staff for UCR and Virtual Wards | 01-Jun-22 | 01-Sep-22 |
| Complete TNA and identify and implement training requirements | 01-May-22 | 01-Dec-22 |
| Define escalation, diagnostic, and discharge processes/routes - including development of an aligned SOP | 01-Jun-22 | 01-Aug-22 |
| Monitor and evaluate impact of Virtual Wards | 01-May-22 | 01-Mar-23 |

# 4. Responsive

## a. Performance Summary

| | Indicator Description | Internal /External Target | Target | Jun-22 Current Performance | | Jun-22 Trending Performance | Jun-22 Variance | May-22 Current Performance | | May-22 Trending Performance | May-22 Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Responsive | Patients waiting > 18 weeks | - | - | 3558 | | | | 3304 | | | |
| | Accepted Referrals | - | - | 27062 | | | | 30553 | | | |
| | Formal complaints per 1000 WTE [TBC] | - | - | - | | | | - | | | |
| | Number of complaints | I | 15 | 13 | ● | P | | 7 | ● | ? | |
| | Number of breaches or re-opened complaints | - | - | 1 | | | L | 1 | | | |
| | RTT incomplete pathways* | E | 92.0% | 94.2% | ● | P | L | 95.6% | ● | ? | |
| | Maximum 6-week wait for diagnostic procedures | E | 99.0% | 99.0% | ● | ? | H | 98.0% | ● | ? | |
| | Inappropriate out-of-area placements for adult mental health services - Number of Bed Days | E | 0 | 8 | ● | ? | | 0 | ● | ? | |
| | People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral | E | 50.0% | 75.0% | ● | ? | | 66.7% | ● | ? | |
| | IAPT - Proportion of people completing treatment moving to recovery | E | 50.0% | 50.2% | ● | P | | 57.6% | ● | ? | |
| | IAPT - Waiting time to begin treatment - within 6 weeks | E | 75.0% | 99.0% | ● | P | H | 98.6% | ● | ? | |
| | IAPT - Waiting time to begin treatment - within 18 weeks | E | 95.0% | 100.0% | ● | P | | 99.8% | ● | ? | |
| | Data Quality Maturity Index (DQMI) - MHSDS dataset score* | E | 95.0% | 87.2% | ● | F | | 90.4% | ● | ? | |

*DQMI Measured 3 months in arrears in line with national reporting

## b. Key Performance areas

**Complaints**

The data remains within the upper control limits (Fig 2 below) The data breached the mean in November 2021, overall, it shows a period of volatility since Feb 2021 but we can see a decreasing trend, more stable from December 2021 with a slight increase in complaints received in June 2022.

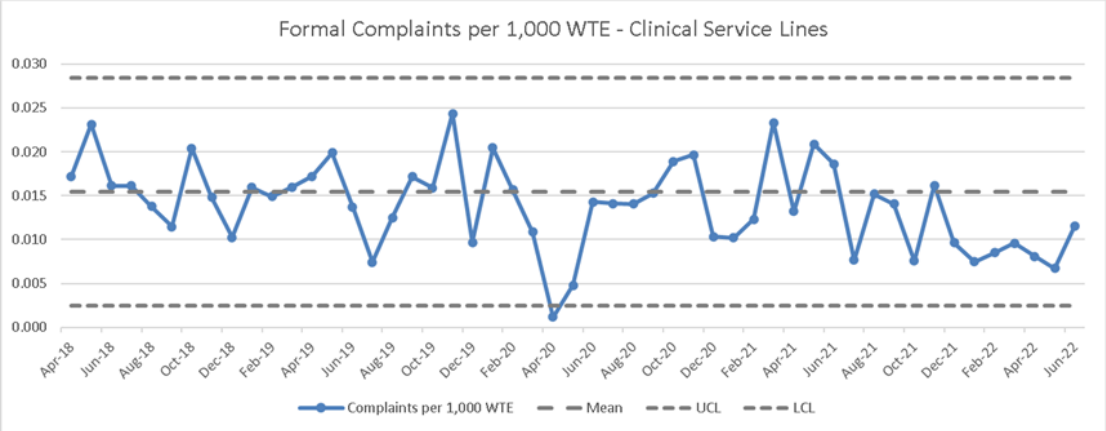



Figure 2 – Formal complaints per 1000 WTE

**Percentage of complaints acknowledged within 72-hour timeframe (April 21 – June 22)**

| April 21 | May 21 | June 21 | Jul 21 | Aug 21 | Sept 21 | Oct 21 | Nov 21 | Dec 21 | Jan 22 | Feb 22 | March 22 | April 22 | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 100% | 100% | 100% | 100% | 93% | 92% | 100% | 100% | 86% | 83% | 100% | 75% | 100% | 100% | 92% |

1 complaint was not formally acknowledged by the PALS and Complaint Team within 3 working day, it was a verbal complaint received by the Service, the Complaint's Team were unable to contact the enquirer to acknowledge the complaint.

The complaints team have worked alongside Service Lines to ensure response times are agreed with enquirers, therefore response times can vary depending on the needs of the enquirer and the complexity of the case concerned – ultimately to ensure enquirers remain informed and cases are investigated appropriately. Where a response date has not been received, we set a 40-day response date (based on the NHS England Complaints Procedure). We have been working with Services to improve response times 92% of complaints have been responded to within the agreed response time during May – June 2022.

**Complaints - Insights**

During May– June 2022, complaints received related to the following areas of concern:

- Appointments
- Communication
- Values and Behaviours of staff

This was also reported in the previous period (Jan – February 2022) complaints data.

To combat these findings, we will embark on a deep dive into attitudes of staff in Q2 which should also help unpick some of the issues encompassed in communication and values and behaviours of staff. In addition, our external training supporting staff on how to respond to negative feedback and teaches them how to 'listen to learn' has equipped a group of staff with some vital insights. The hope is that the information and tools that they have learnt regarding how to respond to adversity, whilst maintaining a good attitude, will be shared amongst their peers and eventually throughout the Trust.

## c. Key Performance challenges

**Maximum 6 Week Wait for Diagnostics Procedures**

Current interventions have shown to be effective, with special cause variation demonstrating an improvement trend, and more consistent achievement of the 99% target:

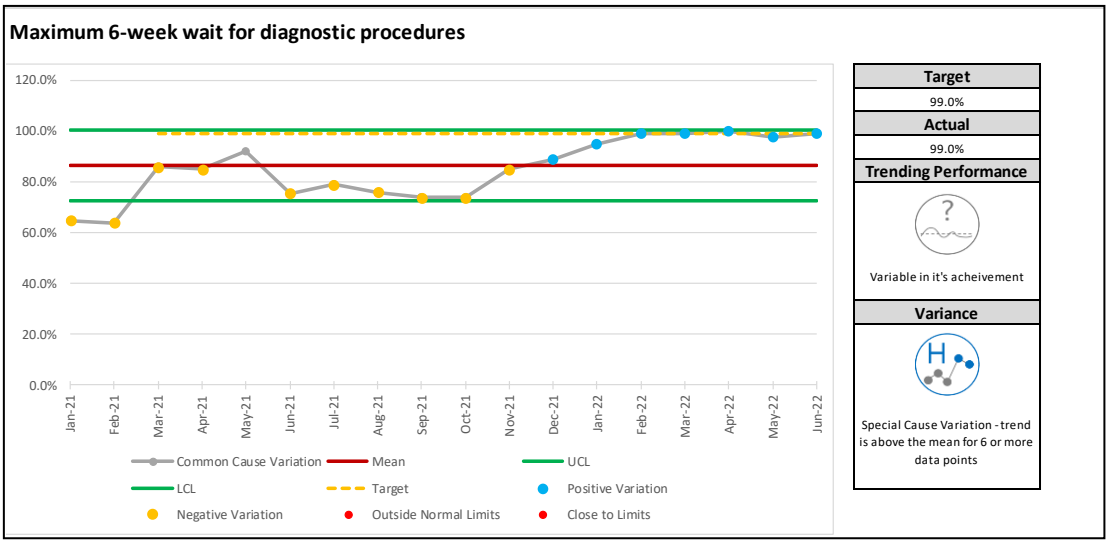



Figure 10 Percentage of Diagnostic Waits within 6 weeks from Jan '21-June '22

**System Oversight Framework**

A 2022/23 update to the System Oversight Framework (SOF) Metrics has been released by NHS Improvement & England on 29 June 2022. The performance team are currently reviewing the impact of this, and the dashboard will be updated for any changes by the July-August reporting period. The current dashboard (Appendix B) reflects the 2021/22 SOF Metrics.

**Out of Area Placements (Mental Health)**

An inappropriate out of area placement (OAP) for acute mental health in-patient care is defined as when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of their usual local network of services.

A project to review the information submitted for Solent's out of area placements was undertaken as the nationally reported figures did not reflect our local understanding. This has now completed, and the information currently reported is correct. Additional processes including service manager sign off have been put in place to ensure that these remain reflective.

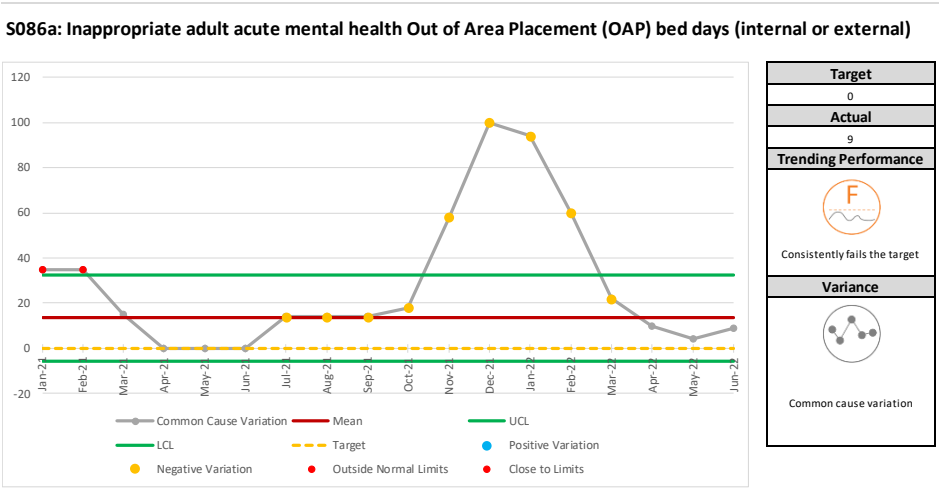



Figure 11 Total Inappropriate OAP bed days for adult acute mental health (3 months rolling period) from Jan '21-June '22

Whilst performance remains above target, it has significantly reduced from the negative trend seen in Jul-Mar 2022, where patients were being placed in alternate locations due to a lack of capacity.

Currently there is a singular patient placed out of area from our Mental Health wards, this is for patient confidentiality and privacy reasons.

**Waiting Lists**

Waiting lists continue to have special cause variation showing an increasing trend. This demonstrates the increasing pressure of referrals on our services, which is also highlighted within the Service Line Performance Review Meeting (PRM) escalations below.

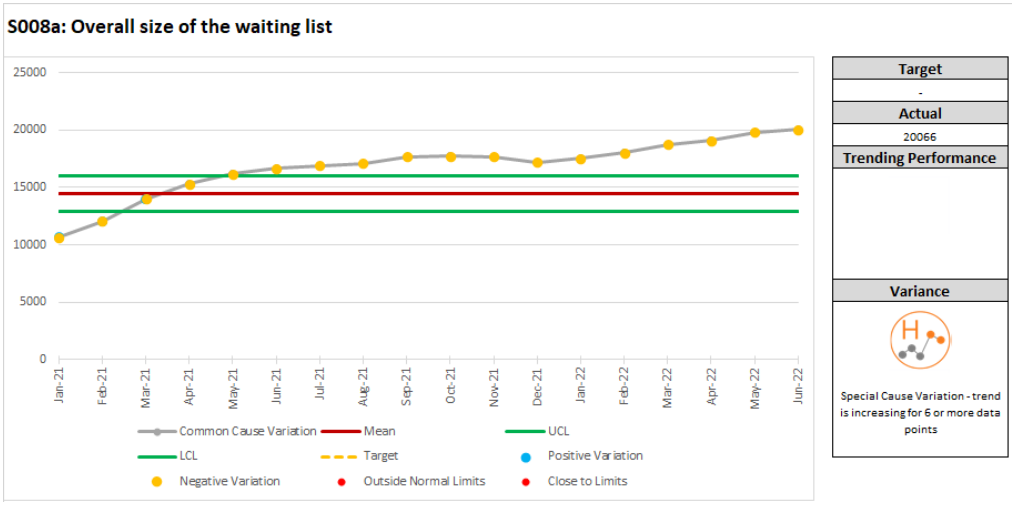



Figure 12 Figure 6 Overall size of waiting list from Jan '21-June '22

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

This is showing as a declining performance against the MHSDS dataset completeness score. The Trust has recently fully recruited to the Data Assurance Team, including the mental health position, and will be fully staffed from August. This will enable better focus to develop root cause analysis and corrective action to the causes of this dip in performance.

Reviewing the DQMI dataset one of the primary issues for this declining performance is with the Trust's recording of ethnicity. This is not a new problem, and stems from the sharing of records. On the front end of the clinical system SystmOne TPP clinicians and administrators can view a patient's details (if sharing is enabled) – even if this information has not been input on the Solent version of SystmOne TPP.

This shared data however, is not present in the reporting information passed to the data warehouse from SystmOne TPP. Therefore, patients are showing as a breach of the ethnicity recording standard, when on the clinical system ethnicity has been recorded.

The previously used solution required staff to re-enter this information for all current patients into the clinical system. This is not however the preferred method of resolution given the capacity challenges faced within services.

The preferred resolution to problem is to download additional files from SystmOne TPP which would include this shared data, however, this is recommended to be completed after paas has been implemented (quarter 4 2022/23) to ensure that server space is optimised.

### c) Service Line Performance review meetings (PRMs) – Key areas

| Service | Outline of topic | Actions or mitigation agreed |
|---|---|---|
| Adults Southampton - Neuro Psychiatry | Single handed practitioner. | Review of waiting list. Chief Medical Officer (CMO) and CD discussion regarding patients on the list Review other organisation's approach within system regarding services with a similar configuration, to inform future approach. Discussion with commissioners. |
| Adults Portsmouth - Speech and Language Therapy | Increase in total numbers waiting. | Action plan is in train (anticipated waiting list growth due to vacancies was not as high as forecast, offset by action plan improvements). |
| Community Nursing | Reducing workforce profile combined with an increase in demand. | Improvements in the management of the caseload (use of autoplanner) has seen a balancing of referrals and discharges, supporting proactive management of capacity, alongside wider Trust initiatives for recruitment and retention. |
| Community paediatric Medical Services (CPMS) | Growth in referrals is not significant, however patients waiting alongside an increase in LAC (looked after Children) is creating a pressure within the service. | Neurodiversity' is responsible for 80% of waits, with a pilot in train in SE Hants on a new pathway. Opportunity to source assessments from a third party subject to confirmation of funding. |

| | | |
|---|---|---|
| Special Care Dental, GA Waits | Request for additional theatre capacity. | Additional capacity has been requested with our system partners, with HHFT (Hampshire Hospitals Foundation Trust), and UHS (University Hospitals Southampton Trust) and PHU (Portsmouth Hospital University) responding positively. |
| Mental Health - Secondary Care Psychology | Patient waiting times. | The service is actively working through a contract with a private provider of secondary care level psychology, to support the management of the waiting list for Trauma and CBT. All patients continue to be supported by the wider Mental Health service. |
| Sexual Health Services (SHS) | Licensing restrictions when administering Monkeypox vaccine is creating extra demand, seeing a reduction in general SHS appointments. | As Monkeypox is not a sexually transmitted infection, SHS is recruiting bank registered nurses to help deliver this element of care. |

# 5. People

## a. Performance summary

| | | | | Jun-22 | | | | May-22 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Indicator Description | Internal /External Target | Target | Current Performance | | Trending Performance | Variance | Current Performance | | Trending Performance | Variance |
| People | Sickness (annual)* | I | 4.5% | 5.4% | | | | 5.2% | | | |
| | Sickness (in month) | I | 4.5% | 6.6% | | | | 5.7% | | | |
| | Turnover (annual)* | I | 14.0% | 13.2% | | | | 12.7% | | | |
| | Turnover (in month) | I | 1.2% | 1.5% | | | | 1.0% | | | |
| | New starters (FTE) | - | - | 38.4 | | | | 52.8 | | | |
| | Proportion of Temporary Staff (in month) | E | 6.0% | 5.6% | | | | 5.6% | | | |

## b. Key Performance challenges

**Sickness**

Sickness absence is increasing following the Omicron new emergent sub variants Ba4 and Ba5. The top 2 sickness absence reasons remain the same, 1. Infectious Diseases, 2. SAD – stress, anxiety, depression, and the third reason has changed to 3. Gastrointestinal (GI) problems, however GI problems can also present as a symptom for Covid, but people may not make this link until they have a positive LFT. Regarding Covid daily

rates, we typically see a 7 -14 day lag in results being reported to us, so expect the numbers from previous weeks to keep rising for a while longer, with anticipated sickness absence related reasons to this to correlate. Data analytics show us that since May 2nd, Covid related sickness absence has been seeing a steady increase from figures rising from early 40's to 100's.

As targeted interventions, we are proactively reviewing our sickness absence policy, data reporting and codes for sickness absence, and we also have a health and wellbeing plan that will be published in September 2022. We are constantly reviewing the absence rates, including sickness, and factor this in to our weekly safer staffing meetings and escalate any areas of concern, where we have utilised increased Bank and Agency staff usage, to ensure safer staffing levels are maintained. Furthermore, Solent has reintroduced face masks as part of our continuous IPC guidance review, and we are planning to send further communications out to staff regarding awareness of the diarrhoea and vomiting (GI) symptom related to Covid.

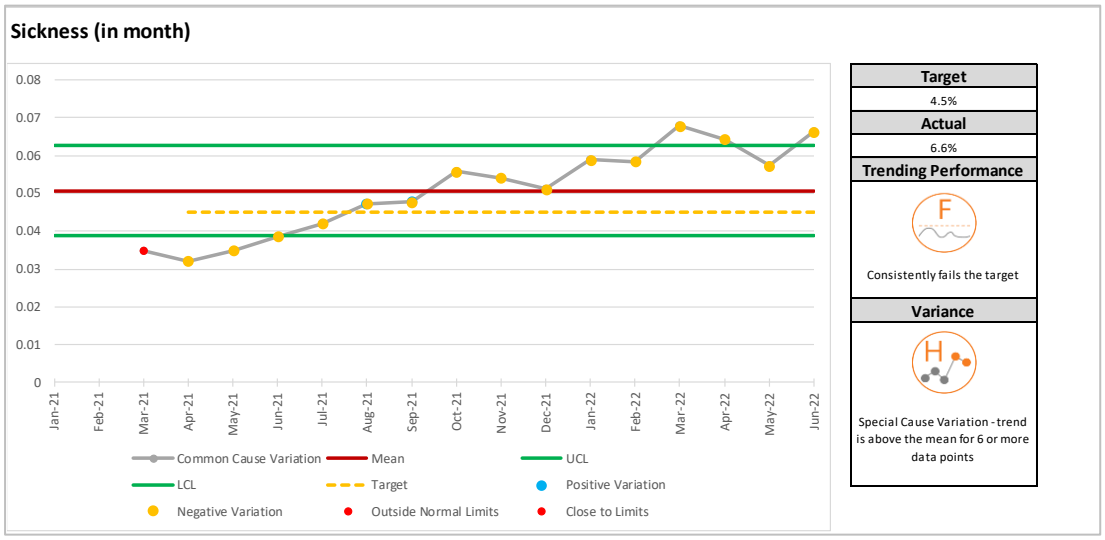



Figure 20 Sickness in month performance Jan '21 - Jun '22

## Turnover

Turnover is increasing, and the reasons identified in our latest Exit Interview Report for June 2022 highlights the top ranked primary reasons for leaving are, Work/Life Balance (26%), Personal Development (26%) and Working environment (26%). The most cited detailed reasons given for leaving are 'Stress of the job' and 'Poor working environment.' 'Excessive workload/pressure' and 'For promotion/career advancement' are the next most cited reasons. Mitigations and prevention measures are all captured in our Solent People Strategy, with active or in the pipeline objectives and projects of work to target these areas of concern. However, it is positive to see that the top ranked destinations on leaving the Trust shows, of the 46 Leavers, 41% are leaving for another NHS organisation, 15% are leaving to work in the private sector non-healthcare, 11% are leaving for a career break/not working and, 11% are leaving to retire. Also 37 of 46 Leavers would positively recommend the Trust as an employer.

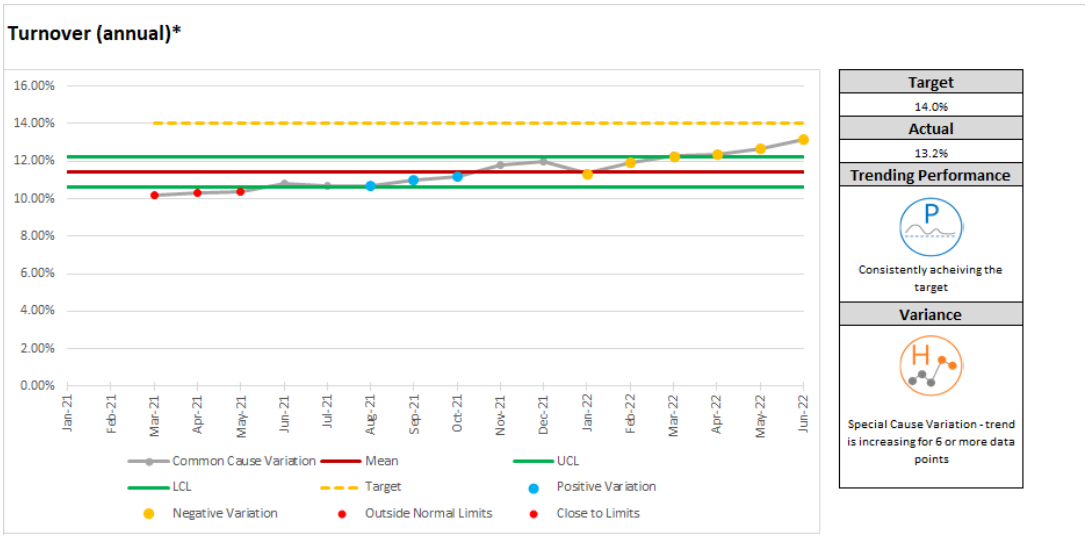



Figure 21 Turnover (12 months rolling) performance Jan '21 - Jun '22

## b. Spotlight On: Targeted interventions

**Flexible working**

Solent has targeted interventions such as our Agile Working Programme and are supporting staff with to help with work/life balance. This offer is in collaboration with Trade Unions, supporting flexible working for our staff; new and existing.

**Sustainable working environment**

Solent's Estates team have an Estates Strategy they're working towards collaboratively in the HIOW ICS to find innovative and tailored solutions for a sustainable working environment, along with partnering the Solent people team with the agile working programme, as this is interlinked.

**Retention programme**

Solent have a retention programme that incorporates driving innovative approaches to personal development and career pathways. Our resourcing and attraction team have a dedicated international recruitment team as Solent was appointed as the HIOW ICS lead recruiter for International Nurses, to support our ambitions for a sustainable workforce. The hope is this in turn should support the gaps in vacancies/sickness, which adds to the stress of the job. To further strengthen reducing the stress of the job, we also have a Solent health and wellbeing plan that will be published in September 2022.

# 6. Finance

## a. Performance summary

| | Indicator Description | Internal /External Target | Target | Jun-22 Current Performance | Jun-22 Trending Performance | Jun-22 Variance | May-22 Current Performance | May-22 Trending Performance | May-22 Variance |
|---|---|---|---|---|---|---|---|---|---|
| Finance | Year to date surplus/(deficit) Actual v budget | - | - | 0.14 % | | | 0.09 % | | |
| | Agency spend % pay | I | 3.5% | 4.5% | | | 5.0% | | |
| | Cash balance | - | - | £27.3 | | | £31.0 | | |
| | Aged debt (over 90 days) | - | - | 186 | | | 174 | | |
| | Use of Resources Score | - | - | 3 | | | 2 | | |

## b. Spotlight On: Month 3 Results

The Trust is reporting an in month adjusted surplus of £126k, £124k adverse to plan, with a year to date adjusted deficit of £1.2m, £94k adverse to plan. The move from reporting a deficit in months 1 and 2, to a surplus in month 3 is driven by recognition of 3 months income for additional inflation funding, additional discretionary funding and GP funding.

**22-23 Plan**

In quarter 1 we were informed that the ICS, and provider organisations within the ICS, would need to submit a breakeven plan in the June submission. The Trust has done this, moving from an original plan of a £9.3m deficit, to a breakeven position. This was mainly achieved with considerable non-recurrent items and assuming our vacancy rate is maintained.

**Covid-19 Expenditure**

The Trust continues to incur additional expenditure because of Covid-19, however this expenditure has dropped significantly in the first Quarter of 22-23, mainly due to incentive payments ending. The reported in-month costs were £132k compared to a plan of £242k.

**Capital**

The Trust's CDEL for 2022-23 of £15.1m consists of £5.5m of internally generated funding and £9.6m PDC funding.

The PDC funding consists of two projects, WCH bed optimisation and Highclere, neither of which can be spent until approval is finalised and funding released.

In month expenditure was £180k, £34k lower than forecast. Year to date expenditure is £403k, £51k lower than plan.

Approved projects forecast spend is £3.4m, £72k less than approved spend. The main underspend is forecast within the pharmacy EPMA project, driven by pay costs being lower than expected.

**Cash**

The cash balance was £27.3m as at 30 June 2022, £3.7m lower than May. The reduction in cash was primarily due to HSIOW CCG aligning payments for Q1 to plan.

**Aged Debt**

The Trust's total debt was £3.5m at the end of June, £0.2m debt 91+ days overdue, with no material movement from May.

# 7. Research and Improvement

## a. Performance summary

**Research Performance**

Since April 2022, we have recruited 185 participants into 18 studies. We have recruitment across all our service lines, with Paediatrics and Adult services being our most research active.

24 studies are currently open to recruitment, with a further 9 due to open in the next 2 months

Our Paediatric Research Team recruited the first UK participant in the PARROT trial.

## b. Spotlight On: Core areas of work

**Sexual Health**

**Positive Voices:** A national survey exploring the lives, experiences and healthcare need of people living with HIV in the United Kingdom. This study is currently running in Portsmouth, Southampton and the IOW.

**HIS-UK:** The study aims to promote the enjoyable condom use, decrease STI risks and costs to the NHS through education and training either face to face or on an interactive website.

In the pipeline:

**Patient Engagement Herpes Vaccine Trial:** Commercial research looking to understand the typical characteristics of a UK patients who suffer from recurrent genital herpes. It will also assess whether patients would find the procedures of a future clinical trial of an investigational herpes vaccine acceptable.

**Genital Herpes Vaccine trial:** Commercial trial looking at the safety and efficacy of a vaccine against HSV-2 in participants with recurrent HSV-2 genital herpes

**Mental Health Research**

**ARMS in IAPT:** The aim of this study is to investigate the feasibility of adapting primary care services to meet the needs of people with unusual experiences who have been referred to IAPT services.

In the pipeline:

**PIPA Trial:** Working in collaboration with local schools, this study is exploring the effectiveness of an online resource for parents/carers to help reduce depression and anxiety in young people

**Paediatric Studies**

**The PARROT Study:** Joint UK and Australia trial, comparing azithromycin to placebo in children with neurological impairment at risk of lower respiratory tract infection. Solent recruited the first participant in whole of the UK

**SIB Study:** This study is measuring behavior related to cognition, executive function and sleep in children with autism and intellectual disability.

**Recovery, Renewal and Reset of services to disabled children:** the study team wish to establish which reconfigurations of services, practices and strategies for disabled children arising from COVID-19 work well and should inform policy on system recovery and planning for future emergencies

**OSTRICH:** the aim of the study is to assess the clinical and cost – effectiveness of prefabricated orthoses in addition to exercises and advice compared with exercise and advice alone on the physical functioning of children aged 5-14 with flat feet.

**Glycopyrronium Bromide:** The aim of this study is to find out more information about how Glycopyrronium Bromide 1mg/5ml oral solution is being used in patients aged < 18 years with severe drooling.

**Parent's experiences of common baby symptom's:** Researchers what to a better understanding about parents' experiences about common baby symptoms such as crying and vomiting. Their views and experiences will help us understand how to better support parents with babies experiencing these symptoms.

**In the pipeline:**

**OPTIMA**: Researchers have developed an online parenting intervention called STEPS, which is looking to see if it helps parents find more effective ways to manage their children's behaviour in children with ADHD.

**ATTENS:** This research is testing a new non-drug treatment, called external Trigeminal Nerve Stimulation (eTNS) for children with ADHD. The study will establish whether eTNS is effective in reducing symptoms of ADHD and other symptoms such as mood and sleep.

**Care Home Research**

**Pnemo 65:** exploring the carriage of bacteria, vaccination efficacy and the diagnosis and treatment of pneumonia in people aged over 65 living in supported living, care or nursing home settings.

**HOPES 2**: Helping older people with mental health needs to engage with social care. Aimed at HCSW within community team. This is a pilot of the prototype to gain feedback to ensure that the intervention is deliverable

**The VENUS study**: Views of clinicians and care home staff on enhanced surveillance for possible UTI's.

**MSK, Pain & Podiatry**

**POISE:** to establish which patients most benefit from an epidural injection for sciatica
**In the pipeline:**

**GREAT**: investigating gait training and motivational interviewing techniques for newly diagnosed rheumatoid arthritis patients with foot pain. This will involve podiatry, physiotherapy and close working with PHUT.

**Fibromyalgia:** The new fibromyalgia service has opened in the west and is due to open in the east. We are sponsoring the research aspect of this which aims to evaluate the effectiveness of the self-management programme.

**RADICA**L: NIHR funded clinical trial into radiofrequency lesioning of lumbar facets comparing the intervention with a sham procedure. There will be an opportunity for participants to go on to have the alternative treatment after three months, all but the person performing the intervention will be blinded.

**De-STRESS**: This is a crossover MSK/Primary care study exploring how peoples' experiences of pain relate to emotions and experiences of stress.

**Primary Care/ Adults Research**

**VenUS 6 Study:** This study is comparing different compression therapies to see if these make any difference to how quickly a venous leg ulcer heals, and whether the treatments reduce ulcer pain, increase the time before an ulcer returns and improve quality of life.

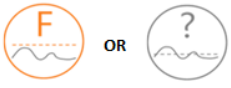
**Catheter 2**: Patients or carers with catheters will be taught how to use either a saline washout or a citric acid washout to see if this prevents UTIs/blockages.

**In the pipeline:**

**Treat to Target in gout (T2T):** This study will find out whether a gradual increase in the dose of urate-lowering medicines, guided by blood tests for urate levels, is better at preventing gout flares.

**BioResource**: involves a blood test for certain rheumatic conditions for a genetic data bank.

## Annex A: Making Data Count Icon Crib Sheet (what it all means)

| Process control | Variation Indicator | Trending Performance Indicator | Recommended action |
|---|---|---|---|
| In control |  |  | **Do nothing**<br>*your process is working perfectly!* |
| In control |  |  Capability within acceptable levels | **Do nothing**<br>*Your process is working well enough* |
| In control |  |  Capability outside of acceptable levels | **Consider process redesign**<br>*If no other areas to prioritise* |
| In control |  |  | **Process redesign**<br>*Your current process is designed to fail* |
| Out of control |  Cause unknown |  | **Investigate special cause origins BEFORE tackling process capability**<br>*Try to understand what is happening before responding*<br>*redesigning out of control processes is not advisable* |
| Out of control |  Cause known |  | **Root cause corrective action BEFORE tackling process capability**<br>*Seek to restore process control*<br>*redesigning out of control processes is not advisable* |
| Out of control |  Cause unknown |  | **Investigate special cause origins**<br>*Try to understand what is happening before responding* |
| Out of control |  Cause known |  | **Consider root cause corrective action**<br>*Seek to restore process control* |
| Out of control |  Cause unknown |  | **Investigate special cause origins**<br>*Try to understand what is happening before responding* |
| Out of control |  Cause known |  | **Celebrate achievement (if intentional) and share learning**<br>*Seek to restore process control* |
| Out of control |  Cause unknown |  | **Investigate special cause origins BEFORE tackling process capability**<br>*Try to understand what is happening before responding*<br>*redesigning out of control processes is not advisable* |
| Out of control |  Cause known |  | **Celebrate achievement in improvement (if intentional) and share learning**<br>*Seek to restore process control - redesigning out of control processes is not advisable* |

# Solent NHS Trust - System Oversight Framework

| | Indicator Description | Frequency | Internal /External Target | Target | Jun-22 Current Performance | | Jun-22 Trending Performance | Jun-22 Variance | May-22 Current Performance | | May-22 Trending Performance | May-22 Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality, Access & Outcomes | S038a: Potential under-reporting of patient safety incidents | Monthly | E | 100.0% | 100.0% | | ? | H | 100.0% | | ? | H |
| | S039a: National Patient Safety Alerts not completed by deadline | Monthly | E | 0 | 0 | | ? | | 0 | | ? | |
| | S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections | Monthly | E | 0 | 0 | | ? | | 0 | | ? | |
| | S041a: Clostridium difficile infections | Monthly | E | 0 | 0 | | ? | | 0 | | ? | |
| | S042a: E. coli blood stream infections | Monthly | E | 0 | 0 | | ? | | 0 | | ? | |
| | S043a: Venous thromboembolism (VTE) risk assessment | Monthly | E | 95.0% | - | | ? | | 100.0% | | ? | |
| | S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation | Monthly | - | - | 17.4% | | | | 17.0% | | | |
| | S081a: IAPT access (total numbers accessing services) | Monthly | E | 366 | 498 | | P | | 502 | | P | |
| | S082a: IAPT recovery rate (%) | Monthly | E | 50.0% | 50.2% | | P | | 57.6% | | P | |
| | S084a: Children and young people (ages 0-17) mental health services access (number with 1+ contact) | Monthly | - | - | 6422 | | | H | 6719 | | | H |
| | S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (3 months rolling) | Monthly | E | 0 | 9 | | F | | 4 | | F | |
| | S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only) | Monthly | - | - | 100.0% | | | | 100.0% | | | |
| | S087a: Number of people in adult acute mental health beds with a length of stay over 60 days | Monthly | - | - | 0 | | | | 2 | | | |
| | S087b: Number of people in older adult acute mental health care with a length of stay over 90 days | Monthly | - | - | 0 | | | L | 0 | | | L |
| | S089a: Waiting times for Urgent Referrals to Children and Young People's Eating Disorder services | Quarterly | E | 95.0% | Nationally Reported Figures are not yet available - Due Aug - 22 | | | | | | | |
| | S089b: Waiting times for Routine Referrals to Children and Young People Eating Disorder Services | Quarterly | E | 95.0% | Nationally Reported Figures are not yet available - Due Aug - 22 | | | | | | | |
| | S016a: Outpatient - Specialist Advice (including A&G) activity levels | Monthly | - | - | Metric Currently Under Development with support from South Central CSU | | | | | | | |
| | S016b: Outpatient - Patient Initiated Follow-Up activity levels | Monthly | - | - | Currently awaiting provision of community guidance for PIFU measurements from NHS I&E | | | | | | | |
| | S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital | Monthly | - | - | Metric Currently Under Development with support from South Central CSU | | | | | | | |
| | S008a: Overall size of the waiting list | Monthly | E | - | 20066 | | | H | 19793 | | | H |
| | S009a: Patients waiting more than 52 weeks to start consultant-led treatment | Monthly | E | 0 | 0 | | ? | | 0 | | ? | |
| | S013a: Diagnostic activity levels - Imaging | Monthly | I | 723 | 697 | | ? | | 803 | | ? | H |
| | S013b: Diagnostic activity levels - Physiological measurement | Monthly | I | 75 | 71 | | ? | | 70 | | ? | |
| Looking after our people | S067a: Leaver rate | Monthly | I | 14.0% | 13.2% | | P | H | 12.7% | | P | H |
| | S068a: Sickness absence (working days lost to sickness) | Monthly | I | 5.0% | 6.6% | | F | H | 5.7% | | F | H |

# Solent NHS Trust - System Oversight Framework

| Indicator Description | Frequency | Internal /External Target | Target | Jun-22 Current Performance | Jun-22 Trending Performance | Jun-22 Variance | May-22 Current Performance | May-22 Trending Performance | May-22 Variance |
|---|---|---|---|---|---|---|---|---|---|

**Key**

**In-month Performance Indicator**

Metric is achieving the target

Metric is failing the target

**Trending Performance Indicator**


Target has been consistently achieved, for more than 6 months


There is a variable and inconsistent performance against the target


Target has been consistently failed, for more than 6 months

**Variance Indicator**


Special Cause Variation, for improved performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit


Special Cause Variation, for improved performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit

Common Cause Variation, the information is fluctuating with no special cause variation.


Special Cause Variation, for poor performance. The trend is either:
- Above the mean for 6 or more data points
- An increasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the upper control limit


Special Cause Variation, for poor performance. The trend is either:
- Below the mean for 6 or more data points
- An decreasing trend for 6 or more data points
- Near the control limit for 2 out of 3 data points
- The value exceeds the lower control limit

# d6.1 NHS Provider Licence – Self Certification 2022/23 – June 2022

## 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 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 considers and adopts corporate governance standards, guidance and best practice as appropriate.

We regularly review our governance processes including our Board Code of Conduct and associated protocols.

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 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

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). The Executive Team Portfolios are continuously reviewed.

The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.

Solent NHS Trust

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

We regularly review our governance processes including our Board Code of Conduct and associated protocols. The Trust ended the financial year 2021/22 with a small surplus.

The Trust has submitted a break-even plan for 2022/23.

Internal control processes have been established and are embedded across the organisation as outlined within the Annual Governance Statement. In early 2022/23 the Board agreed actions to enhance the internal controls regarding pre-employment checks and recruitment processes. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls.

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 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).

The Executive Team Portfolios are continuously 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.

Solent NHS Trust

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

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. | **10** | | | Presentation to | Trust Board | | |
| Date of paper | 15/07/2022 | | | Author | Sadie Bell, Head of Information Governance & Security / Data Protection Officer | | |
| Title of paper | Information Governance Compliance Report April – June 2022 | | | | | | |
| Purpose of the paper | The aim of this paper is to update the Trust Board on the Trust's current compliance with Information Governance & Cyber Security Practices / Mandatory Requirements, to share the learning and areas for improvement including the priorities for the next quarter | | | | | | |
| 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 are asked to receive the report and in doing so:<br>- Note the risks identified and priority areas of focus for Q2, 2022/23 | | | | | | |
| To be completed by Exec Sponsor - Level of assurance this report provides : | | | | | | | |
| Significant | | Sufficient | x | Limited | | None | |
| Exec Sponsor name: | Rachel Cheal, Chief of Staff / Interim Deputy SIRO | | | Exec Sponsor signature: |  | | |

## 1. Purpose

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

1.2 Information Governance covers; Data Protection Legislation, Freedom of Information Act, Information Management, Information Security, and Cyber Security.

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

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

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

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

1.6 Key information to note, as of the 7th February 2022, the Trust appointed a new interim Deputy Senior Information Risk Owner (SIRO), Rachel Cheal, Chief of Staff, supporting Andrew Strevens, CEO and SIRO. The Trust's Data Protection Officer (DPO) meets with the SIRO monthly, to discuss the Trust's current Information Risk's and workstreams, current compliance, gaps, and risk assessments.

## 2. Data Protection and Security Toolkit

2.1 The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool, mandated by the Department of Health and provided by NHS Digital, which enables Health and Social Care organisations to measure their performance against Data Security and Information Governance standards and legislation.
The ten Data Security Standards were a result of the NDG review and therefore the focus of the new Toolkit, which is then split into three categories:

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

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

***The DSPT consists of 10 Assertions, with a total of 143 requirements; 110 of which are mandatory.***

2.2 **2021/22 Toolkit:** The Trust's 2021/22 submission was completed at the end of June 2022. The submission identified that the Trust had achieved a "Standards Met" compliance Level**.**

***Standard Status:***

- Standards Not Met – Mandatory (all) requirements have not been met
- Standards Not Met (with action plans) – Mandatory (all) requirements have not been met, but action plans have been submitted to NHS Digital
- Approaching standards – indicating that an organisation is making good progress but has not yet reached 'Standards Met'.
- Standards Met – All mandatory requirements have been achieved
- Standards Exceeded – If an organisation achieves 'Standards Met' and also has a current Cyber Essentials PLUS certification recorded in its Organisation Profile, then it's status will be displayed as 'Standards Exceeded'.

**Key points to note:**

- The Trust has met the minimum standards required for all 110 mandatory requirements
- The Trust has met the minimum standards required for 86% of all requirements (inclusive of non-mandatory)
- The Trust has met the minimum standards required for 13 out 33 non-mandatory requirements
- The Trust has actions plans in place to ensure compliance of mandatory requirements are maintained and all non-mandatory requirements achieve compliance in 2022/23. This will be a supporting factor in the Trust achieving "Standards Exceeded" status of the DSPT and Cyber Essentials Plus accreditation. This action plan has been shared and signed off by the SIRO.

*Further information relating to the Trust's DSPT submission can be found in Appendix A.*

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

3.1 ***2021/22 Annual Compliance:*** An overarching review of the Trust's Information Governance Legal Requirements (Freedom of Information Requests (FOI) and Subject Access Requests (SARS)) to date, shows that there continues to be a high number of requests being received by the Trust, compared to previous years. Compliance rates have however not been impacted by this;

- SARs have seen a 31.2% increase in the number of requests received 2021/22, when compared to 2020/21; despite this our compliance levels with the mandatory response time (within one calendar month) has risen from 95.6% to 97.3%, which is above the minimum requirement of 95% compliance.
- FOIs have seen a 24.9% increase in the number of requests received 2021/22, when compared to 2020/21; despite this our compliance levels with the mandatory response time (within 20 working days) has risen from 84.5% to 91.9%. Although, this is still below the mandated 95% compliance rate; it is important to note that the Trust's ability to respond to FOI's requests in 2021/22 has been impacted by its need to respond to the covid-19 pandemic e.g. staff

redeployment within services and the need to reprioritise covid response activity above some elements of business; however improvements have been made and continued to be made with regards to the Trust's response to such request, such as the improvements made to the Trust's Publication Scheme and the introduction of the FAQ page.

3.2 ***Q1, 2022/23 Compliance:*** An overarching review of the Trust's Information Governance Legal Requirements (Freedom of Information Requests (FOI) and Subject Access Requests (SARS)) to date, shows;

- SARs have seen an 8.9% decrease, in the average number of requests per quarter. Compliance rate for Q1, to date, stands at 97.5% compliance, which is above the mandated 95% mandatory compliance. Please note that there are currently 50 requests, currently not due to be released, and therefore figures are subject to change.
- FOIs have seen an 13.6% decrease, in the average number of requests per quarter. Compliance rate for Q1, to date, stands at 98.7% compliance, which is above the mandated 95% mandatory compliance. Please note that there are currently 4 requests, currently not due to be released, and therefore figures are subject to change.

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

## 4. Information Governance Incidents/Security

4.1 ***IG Incident Summary***

The Head of Information Governance & Security and Data Protection Officer, has undertaken a deep-dive review into the Trust's Information Governance (IG) Incidents, for Q1, 2022/23; this includes a review with regards to both how IG incidents are reported, recorded and validated within the Trust, as well as an assessment of the root causes of these incidents.

**Summary of findings:** In Q1, 2022/23, a total of 183 Information Governance Incidents were reported. However, out of them 86 were deemed to be either "Out of Our Control" e.g. breaches by third parties or "No IG Breach" e.g. near miss or the information was considered to not be identifiable and therefore no breach. This accounts for 47% of the reported incidents. Therefore 97 incidents, within Solent NHS Trust's control were reported within Q1, 2022/23; this is slightly below the quarterly average for 2021/22.

The most common type of reported incidents are;

- PID sent to wrong person / address
- PID in wrong record / record error

**Actions update from 2021/22 deep dive:**

***Completed Actions (completed April 2022)***

- Revision of IG Training (alongside bespoke IG Training), to include and address the most common types of reported IG incidents that impact Solent NHS Trust and the learning that has been identified as a result of these incidents.

***Actions outstanding, to be completed in Q2***

- IG Team to ensure that best practice / reminders of processes for all incidents reported with a Root Cause of Process (Failure to follow, Lack of and Unaware of) are cascaded to staff as "IG Learning"
- IG Team to reissue guidance on secure email systems, for the sharing of PID
- IG Team to undertake a communication campaign around "when is safe not safe", with regards to the storage of PID internally within the organisation
- Undertake key service engagement, aimed at assessing the human elements of incidents around "PID in wrong record / record error" and "PID sent to wrong person" and assess is new processes and practices can be proposed.

***Actions outstanding, to commence Q2***

- Undertake 3-month, 6 month and annual reviews of service engagement vs impact / change in practice (reduction in incidents)
- Implementation of the Trust's new Information Management & Cyber Security Strategy

***Ongoing actions, now part of BAU practice***

- Each IG incident will be continued to be look at in-depth, by the IG Officer(s), so that IG Learning can be identified and cascaded where applicable.
- Continue with IG Rapid Learning Communications

- Undertake a monthly assessment of reported IG incidents, undertaking service engagement on the most common themed incident, working with services to assess new practices

The above outstanding actions will aim to address the most common type of incidents reported in Q1, 2022/23 and therefore no further actions have been identified at present.

*A copy of the deep dive report can be found in Appendix C.*

## 5. Information Management, Information & Cyber Security Assurance

The Trust, like many other organisations across the world, has seen an increase threat of cyber security attacks and the need to protect itself against such attacks. This is something that the Trust takes very seriously and has implemented a number of actions to strengthen its protection against such attacks. The Trust has implemented a best practice model approach to cyber security, assessing this through a technical, governance and human factor lens.

***Technical:*** From a technical perspective the Trust continues to monitor cyber security preventative measures that have been put in place, as well as strengthening the current technical controls that will form part of the Trust's new ICT Outsource Contracts.

***Human:*** Following on from last years cyber training we have added a separate cyber security module to the current mandatory IG Training, which has already seen 74% of staff having completed this training, so far, this financial year. The IG Team are currently in the process of devising a cyber security education and communication plan which will work alongside the current training, bringing cyber security best practice to the forefront of staff's every day activity, as well as helping them remain secure in their personal life.

***Governance:*** The Trust's Information & Cyber Security Group has now been reconfigured to have oversight of an increased cyber security assessment, whilst looking to improve technical assurance and assess learning. The Head of IG & Security is currently in process of finalising a Cyber security Dashboard. Additionally, the following documents are now in place;

- Cyber Security Incident Response Plan
- ICT Infrastructure Business Continuity Plan

The above documents will be reviewed every three months, by the Information & Cyber Security Group, to ensure that they remain up-to-date and relevant.

The Trust's DSPT submission demonstrates the Trust's increase cyber security assurance, as well as the supporting action plan for 2022/23 (refer to the DSPT section of this report).

The Trust has commenced implementation of elements of the Information Management & Cyber Security Strategy[1] in April 2022; this is a three-year strategy that is aligned to and will supports the Trust's wider Digital Strategy. Some of the main aspects of this strategy that will be introduced over the next few years include, but are not limited to;

- Increased and continual Cyber Security Awareness (inclusive of annually refreshed Cyber Security Training – reflecting on the impact of social engineering)
- The Trust having an increased understanding of technology dependency and governance of technology risk
- The Head of Information Governance & Security providing the Board with an increase understanding of cyber security risks, providing regular reports, assessing the Trust's risk appetite and cyber resilience
- Ransomware-specific assessments
- Effective cyber security monitoring and response
- Testing of cyber security capability through simulated attacks
- Cyber security incident response and crisis management plans
- BCP and disaster recovery – planning for a ransomware scenario

Large parts of the above are focused around the key non-technical element of human factors, learning and education. They are built around providing our staff with the tools, processes and knowledge to detect, respond and prevent cyber-attacks;

[1] The Information Management & Cyber Security Strategy is a sub-strategy of the overarching Digital Strategy. The Digital Strategy is being presented to the Board in April 2022.

this is a fundamental foundation to build to support all the technical and business functions that are being put in place to prevent and if required respond to such a threat.

## 6. Information Governance Working with Services

The Information Governance Team continues to work with services and our working partners to streamline Information Governance Practices and ensure a greater level of compliance with Data Protection requirements. Since the last report an overarching Information Sharing Agreement has been implemented with Southampton NHS Foundation Trust's overarching agreements and are currently in the process of being signed – this signifies a significant step forward in ensuring the safe transfer of information between partners. The Trust is also looking at leading on implementing some additional Hampshire & Isle of Wight Information Sharing Agreements.

## 7. Top Three Security Risks (Taken from the last monthly SIRO Report: June 2022)

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

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

   This work has been incorporated into the Trust's Information & Security Strategy.

3. **Penetration Test Actions – ICT/CGI Requirement (assurance required):** This is currently being discussed with the SIRO and commercially with CGI, as well as being monitored through the Trust's Digital Information Group.

## 8. Summary

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

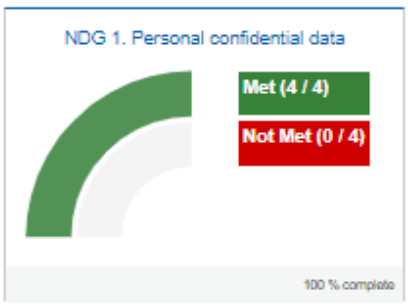
The Information Governance Team continue to focus on improving compliance, creating a learning culture and working collaboratively. The following are identified as priorities over the next financial year;

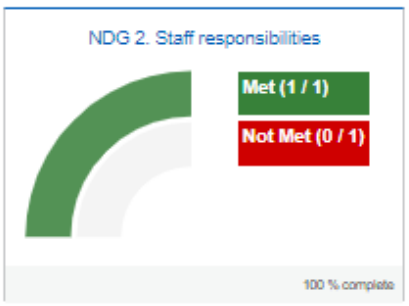
- Continual improvements in FOI & SAR Practices
- Incident Management Plan; service engagement focused on working with services in the revision of incident root causes, with the aim to identify improvements in working practice. This will also include embedding an IG culture from service level up.
- Information Sharing: continue to identify more efficient and service / patient beneficial information sharing arrangements, to make information sharing across organisation more efficient, whilst meeting our legal obligations. Working with Local Authority Practices to assess the possibility of overarching sharing agreements
- Implementation of an Information Management & Cyber Security Strategy

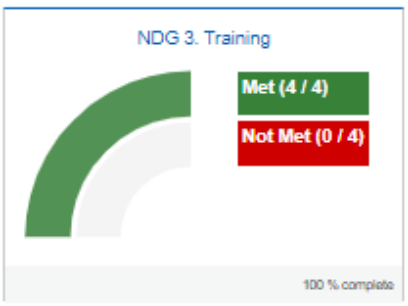
## Appendix A: DSPT 2021/22 Submission Compliance

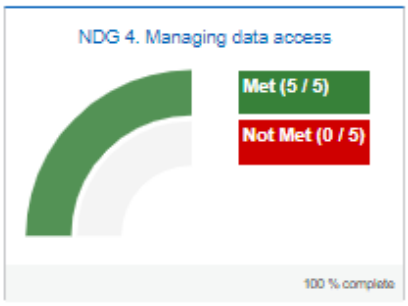
# National Data Guardian Standards

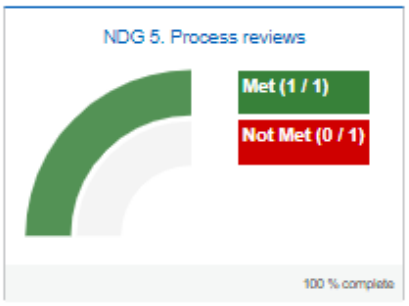
The National Data Guardian (NDG) standards have been calculated for your organisation based on the responses provided in your organisation profile.

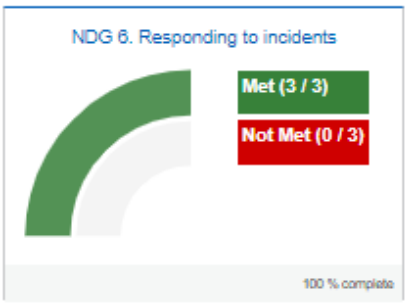


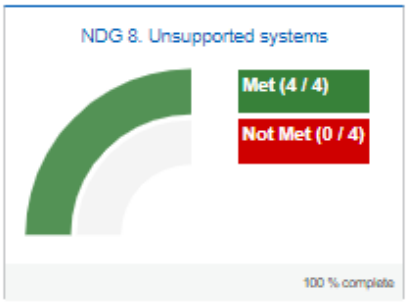



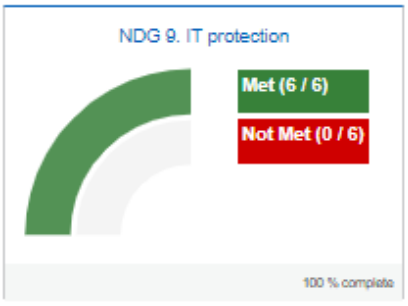








## Appendix B: Information Request Compliance Breakdown

***Subject Access Requests – Annual Breakdown***

| | 2020/21 | 2021/22 |
|---|---|---|
| No. requests received | 958 | 1257 |
| No. requests responded to within 21 days (best practice) | 807 | 1083 |
| No. requests responded to within mandated timescale (one calendar month) | 109 | 140 |
| No. breaches within (legal deadline) | 42* | 34 |
| % Compliance – Legal Requirement (approx. 30 days) | 95.6% | 97.3% |
| **Not Due** | - | - |

* Please note breaches in 2020/21 were a direct result of the Covid-19 pandemic

***Subject Access Requests – Quarterly Breakdown***

| | 2021/22 | | | | 2022/23 |
|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 |
| No. requests received | 312 | 291 | 321 | 333 | 286 |
| No. requests responded to within 21 days (best practice) | 282 | 270 | 286 | 245 | 182 |
| No. requests responded to within mandated timescale (one calendar month) | 29 | 20 | 27 | 64 | 48 |
| No. breaches within (legal deadline) | 1 | 1 | 8 | 24 | 6 |
| % Compliance – Legal Requirement (approx. 30 days) | 99.7% | 99.7% | 97.5% | 92.8% | 97.5% |
| **Not Due** | - | - | - | - | 50 |

***Freedom of Information Requests – Annual Breakdown***

| | 2020/21 | 2021/22 |
|---|---|---|
| No. Requests | 309 | 386 |
| No. Responded within 20 working days | 261 | 355 |
| No. Breaches | 48* | 31 |
| % Compliance – Legal Requirement (21 days) | 84.5% | 91.9% |
| No. Not Due | - | - |

* Please note breaches in 2020/21 were a direct result of the Covid-19 pandemic

***Freedom of Information Requests – Quarterly Breakdown***

| | 2021/22 | | | | 2022/23 |
|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 |
| No. Requests | 98 | 103 | 94 | 91 | 83 |
| No. Responded within 20 working days | 94 | 95 | 87 | 79 | 78 |
| No. Breaches | 4 | 8 | 7 | 12 | 1 |
| % Compliance – Legal Requirement (21 days) | 95.9% | 92.2% | 92.5% | 86.8% | 98.7% |
| No. Not Due | - | - | - | - | 4 |

## Appendix C: Deep Dive Information Governance Incident Report – Q1, 2022/23

**Summary of Initial Findings**

**Introduction / Purpose:**

The Head of Information Governance & Security / Data Protection Officer has undertaken a deep dive into the Information Governance (IG) Incidents reported within Q1, 2022/23, to date (April 2021 – February 2022). The purpose of this deep dive is to establish the following;

- Types of incidents reported
- Common root causes
- Analysis of best practice
- Assessment of the impact of Human Error on IG incidents
- Identify future learning and actions to reduce the number of reportable IG incidents

**Initial Findings**

In Q1, 2022/23, a total of 183 Information Governance Incidents were reported. However, out of them 86 were deemed to be either "Out of Our Control" e.g. breaches by third parties or "No IG Breach" e.g. near miss or the information was considered to not be identifiable and therefore no breach. This accounts for 47% of the reported incidents. Therefore 97 incidents, within Solent NHS Trust's control were reported within Q1, 2022/23; this is slightly below the quarterly average for 2021/22.

With regards to the remaining 97 incidents (53% of incidents), the types of incident reported are shown below, ranked highest reporting to lowest reporting.

| Type of Incident | No of Incidents Report April 22 – June 22 |
|---|---|
| PID Sent to Wrong Person / Address | 31 |
| PID in Wrong Record / Record Error | 27 |
| Inappropriate Access / Disclosure | 9 |
| PID Saved / Stored Insecurely | 8 |
| PID Found in Public Place | 8 |
| Other IG | 7 |
| Non-Encrypted Email Used for PID | 7 |
| Lost / Missing PID | 0 |
| Cyber Security | 0 *this type of incident is reported as "Out of Our Control" |
| Lost Smart Card / ID Badge | 0 *this type of incident is reported as "No IG Breach" |

**Important to Note:** The top two types of reported IG Breaches make up 59.8% of the reported IG incidents and should be the main focus of further investigation. Please refer to "next steps" within the report, for further actions.

***Human Error vs Process***

- 70.1% of the IG incidents reported were in connection with Human Error
- 26.8% of the IG incidents reported were in connection with Processes (Failure to follow, Lack of and Unaware of)
- 3.1% of the IG incidents reported were in connection with System Errors

These findings indicated that the root cause of incidents is not to do with the processes in place currently within the Trust, but the human elements of working practices. That being said, Human Error should not be dismissed as something we cannot reduce, but something we need to understand, assess, and ask the question "so what can we do". If we can get a better understand of these types of incidents and put mechanisms in place to reduce just half of the IG incidents, relating to Human Error, this will reduce IG incidents by 35%.

***IG Incidents vs No Breach / Out of Our Control***

An assessment of the number of IG incidents reported (183) vs the number of incidents reported that either resulted in No IG Breach or were Out of Our Control e.g. caused by a third party (86), show an approx. 50%/50% split. This demonstrates;

- A good reporting culture, as we are reporting just as many near misses / out of our control incidents as we are actual breaches. This allows for greater awareness and assessment of incidents, to prevent actual IG Breaches
- Is a testimony to changes in working practices to reduce the impact / IG breach and incident may have on data e.g. removing large amounts of PID from documents / communications, mean if an incident is to occur, it would not necessarily result in an IG Breach.
- Additionally, this data demonstrates a reduction in the number of IG incidents reported, that are classified as IG Breaches, when compared to 2021/22; whereby the split was 60%/40% split.

**Common Themes / Findings:**

1) **PID in Wrong Record / Record Error:** This type of incident is most commonly reported due to human error, specific service engagement is required to work with services and staff to assess the human elements of this type of incident and assess is new processes and practices can be proposed.

2) **PID Sent to Wrong Person / Address:** One of the most common themes / root causes associated with this type of incident in the past financial year has been bulking printing; the IG Team has recently undertaken service engagement and worked with services to implement new processes/practices. A review is scheduled for 3 months post service engagement to assess if the service engagement has made the desired impact.

**Actions update from 2021/22 deep dive:**

***Completed Actions***

- Revision of IG Training (alongside bespoke IG Training), to include and address the most common types of reported IG incidents that impact Solent NHS Trust and the learning that has been identified as a result of these incidents. **Completed April 2022**

***Actions outstanding, to be completed in Q2***

- IG Team to ensure that best practice / reminders of processes, for all incidents reported with a Root Cause of Process (Failure to follow, Lack of and Unaware of) are cascaded to staff as "IG Learning"
- IG Team to reissue guidance on secure email systems, for the sharing of PID
- IG Team to undertake a communication campaign around "when is safe not safe", with regards to the storage of PID internally within the organisation
- Undertake key service engagement, aimed at assessing the human elements of incidents around "PID in wrong record / record error" and "PID sent to wrong person" and assess is new processes and practices can be proposed.

***Actions outstanding, to commence Q2***

- Undertake 3-month, 6 month and annual reviews of service engagement vs impact / change in practice (reduction in incidents)
- Implementation of the Trust's new Information Management & Cyber Security Strategy

***Ongoing actions, now part of BAU practice***

- Each IG incident will be continued to be look at in-depth, by the IG Officer(s), so that IG Learning can be identified and cascaded where applicable.
- Continue with IG Rapid Learning Communications
- Undertake a monthly assessment of reported IG incidents, undertaking service engagement on the most common themed incident, working with services to assess new practices

The above outstanding actions will aim to address the most common type of incidents reported in Q1, 2022/23 and therefore no further actions have been identified at present.

| | | | | | | |
|---|---|---|---|---|---|---|
| Item No. | 11 | Presentation to | In-Public Board Meeting | | | |
| Title of paper | People Committee | | | | | |
| Purpose of the paper | To summarise the business transacted at the People Committee held on 14 July 2022. | | | | | |
| 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 following reports were noted by the Committee:<br>**Internal Audit & HR Self-Audit Update**:<br>• People Operations internal self-audit carried out; progress made on the NHS 6 standard checks. Report highlighted findings assuring the committee of reduced risk and appropriate mitigations.<br>• Committee approved suggested referencing approach; not appropiate to return to current employees to re-reference for 3 years (2 references obtained previously via QIA for efficiency; not always spanning 3 years). Agreement reached: any additional issues will be addressed via performance process.<br>• Internal audit has 2 open, on-track actions – 'Starters Control Design' and 'Shift Validation Operating Effectiveness'; aim to close both by next committee meeting in line with dates assigned.<br>**Workforce and Sustainability Report:**<br>• Report format discussed; improvement noted. Requirement to revisit data, connecting the BAF, Risk, and this report.<br>• Increased vacancy rate highlighted; connected with the budget establishment context change and aligned to increased turnover rate. Nursing vacancy rate also highlighted as an increase.<br>• Further detail requested on staffing, linking to performance reports in services.<br>• Interventions and remedial actions highlighted in risk report provided assurance to the committee that the staffing risks and vacancy rates were being appropriately managed.<br>• New Workforce Planning Programme will provide further detail on workforce plans across all service lines. 6 workstreams featured; 1 being safer staffing. Programme to be presented at September committee.<br>• Higher sickness levels noted, with higher levels of Covid rates likely to see further increases.<br>**Employee Relations Assurance Report:**<br>• New report and dashboard format to be presented in September; ensuring link featured to PMAF sub group for governance. | | | | | | |

- Committee assured that BAME % of cases in relation to the total number for formal cases was not a concern.
- Reduction in formal cases due to early intervention and informal resolution.
- Business case being finalised for online case management system to provide credible data and insights; exploring cost benefit and affordability.
- Long Covid policy changes; working group in place to consult with the 11 staff members concerned.

**Workforce Risk Appraisal:**

- A report overhaul planned for September providing greater narrative and determining trends. Committee requested to have greater focus on linked corporate risks.
- Committee assured that risks are being appropriately mitigated; requested greater insight into the relative risk to Services versus Trust wide – not currently clear in report structure.

**Board Assurance Framework:**

- Format reporting discussed; request to add narrative to summarise mitigations to the residual score.

**Sub-Committee Exception Reports:**

- Committee noted the received **People Forum Exception Report**. Committee discussion held regarding Cost of Living; updates provided on immediate and longer term actions being taken to help staff navigate through difficult times.
- No update from the **Joint Consultative Negotiating Committee** as no meeting had taken place.
- Committee noted the received **Wellbeing Oversight Meeting Exception Report**.
- Committee noted the received **Joint Local Negotiating Committee (formerly DDNC) Exception Report**.

**Diversity and Inclusion Action Plan:**

- Committee discussion held regarding top-focus areas/risks of the WRES/WDES diversity action plan. Agreement reached confirming the Board is not a top 3 risk for Solent (challenge based on BAME data).
- Annual WRES/WDES return due by 31 August 2022; will reflect committee discussion to include narrative focusing on BAME % trust-wide and at senior leadership team level.

**Annual Report & Effectiveness Review:**

- Committee member survey responses presented a positive review of the People Committee; low number of survey responses, however. Agreement made to re-survey in 6 months due to new committee members present.

**NHS Staff Survey Long-Term Action Plan:**

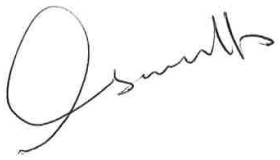
- Committee pleased with survey results, recognising hard work of Solent's managers in achieveing such scores. Also noting, 4 improvement themes have now increased to 5.
- Committee shared ambitions for Solent to remain in top 3 across staff survey main themes.

**Update on Development and Delivery of Health and Wellbeing Plan:**

Not covered; agenda item for next Committee.

**Escalations:**

Sickness and vacancy rate increases being presented to Confidential Board.

| To be completed by Exec Sponsor - Level of assurance this report provides: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Significant | | Sufficient | X | Limited | | None | |
| Exec Sponsor name: | Mike Watts, Non-Executive Director | | | Exec Sponsor signature: |  | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Item No. | **12** | | Presentation to | Trust In Public Board | | |
| Title of paper | Community Engagement and Inclusion Committee Exception Report- June 2022 | | | | | |
| Purpose of the paper | Information | | | | | |
| Committees /Groups previous presented and outputs | n/a | | | | | |
| Statement on impact on inequalities | Positive impact (inc. details below) | **Y** | Negative Impact (inc. details below) | | No impact (neutral) | X |
| Action required | For decision | **N** | For assurance | **Y** | | |

**Summary of Recommendations and actions required by the author**

**Engagement and Inclusion Committee**

Headlines from meeting held Tuesday 23rd June 2022:

1. *Presentation by Carraway Dementia Friends – Wellbeing Volunteers Scheme*

The Carraway Dementia friends were provided with some funding by the Community Engagement and Experience Team to carry out a wellbeing scheme working with volunteers to support people living with dementia.

The project begun in 2021 during the peak of the pandemic when many people were feeling isolated and lonely. People living with dementia were particularly impacted. The project set out to address this by recruiting volunteers to make wellbeing calls. Key elements of the project are:

- Project started by offering telephone support to people with dementia
- People were called every two weeks and sometimes they used the phone calls to signpost people to particular services or even to help escalate any problems that the caller was concerned about.
- 15 volunteers were recruited to make the wellbeing phone calls.

With Covid restrictions at an end the need for Dementia Friends has grown and now Carraway is not only doing wellbeing phone calls but has also opened up Memory Cafes that people can attend in person and connect with others.

Carraway was seeking additional funding to enable them to take forward their work.

2. *Alongside Communities – the Solent approach to engagement and inclusion – Year 2 delivery plan progress report.*

    a. Following the completion of our Year 1 delivery plan we have now started delivering our Year 2 delivery plan. All deliverables for Year 2 are currently on track with the exception of our deliverable around demographic data collection for which progress has been slow in some aspects of the work whilst we have made progress in the following areas:

        - CAMHS East and West are continuing to pilot demographic data collection.

- PALS and Complaints are continuing to refine the equality monitoring data set into our complaint and patient experience surveys.

The challenge for the next months will be to do more work with our services and staff to encourage more people to fill out their demographic data when providing us with feedback.

b. As part of our Year 2 programme we have delivered the following:

- Community partner programme continues to grow – with significant success in recruiting partners from minority ethnic communities and children and young people groups.
- Supporting family carers – discharge to assess project complete and reported to NHSE/I; staff support network established; system wide carers event held; project to develop culturally appropriate support for carers from minority ethnic groups started.
- Waiting well programme - volunteers have made well-being calls to people on the waiting lists in our MSK services to offer support and signposting.
- Mental health well-being amongst minority ethnic communities – initial event had 48 people from across HIOW, plans for quarterly sessions.
- Improving access to feedback opportunities – young people advised on preferred methods (online, group settings, educational settings) and work in progress to implement.

2. *Impact and Outcomes Report*

a. The first Community Engagement and Experience Impact report was published and sets out the Team's key deliverables and impact of the work that has been carried out over the past year. The impact report includes

i. highlights from projects that we have supported our Community Partners to deliver over the past year.

ii. The journey so far in developing our community partners' programme illustrating the depth in both numbers and diversity of our community partners.

iii. Illustrations of the impact we have been making working with our communities over the past year for example having had nearly 2000 conversations with members of our communities to help build covid vaccine confidence.

iv. Creation of a community hub in which we have set up working groups for our community partners to be part of thereby ensuring we are continuing to work with our communities in everything we do.

v. Embedding the Asset Based Community Development Approach in the projects being delivered with our services and community partners. Some examples are work being done with our Podiatry services, Primary Care and URS.

| | |
|---|---|
| | 3. *Quality Improvement Project*<br><br>Evaluation of community engagement events that we have hosted whether virtually or face to face have low presentation from men particularly men from minority ethnic communities. We have now embarked on a Quality Improvement project with a team composed of CEET staff and men from ethnic minority communities. We hope that the QI project will develop our understanding and equip us with better methods for engaging with men - particularly men from minority ethnic communities. |

| 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: |  | | |

# Report template- Board and Committees

| | | | | | |
|---|---|---|---|---|---|
| Item No. | **13** | Presentation to | In Public Board | | |
| Title of paper | Mental Health Act Scrutiny Committee Exception Report | | | | |
| Purpose of the paper | To summarise the business transacted at the Mental Health Act Scrutiny Committee held on 23 June 2022. | | | | |
| Committees/Groups previously presented | N/A | | | | |
| Statement on impact on inequalities | Positive impact (inc. details below) | | Negative Impact (inc. details below) | No impact (neutral) | X |
| Action required | For decision | | For assurance | X | |
| Summary of Recommendations and actions required by the author | The In Public Board is asked to:<br>• 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: | Dan Baylis, Chief Medical Officer (in the absence of Vanessa Avlonitis) | | Exec Sponsor signature: |  | | | |

## Summary of business transacted:

- **Terms of Reference Review & Outcomes**– The Committee were briefed on discussions held outside of the meeting. It was noted that a higher level of executive attendance was required and it was confirmed that a further Non-Executive had been added as an invitee going forward. The Committee emphasised consideration of future changes that may be required, following expected amendment to laws under the Mental Capacity Act.
- The **Mental Health Act Report** was noted and exceptions/comments shared.
    - Review of the presentation of data for SPC charts was shared.
    - Reduction in s2 and s53 were reported, with confirmation of work within community teams to ensure correct admission criteria and consideration of capacity requirements.
    - The Committee commended no use of s4 for this period.
    - Ongoing consideration of potential report benchmarking was discussed.
    - Further work with the Diversity and Inclusion team was agreed in order to review ethnicity data.
    - The Committee were informed of national updates to the Mental Capacity (Amendment) Act 2019, which will introduce the Liberty Protection Safeguards. It was confirmed that communications had been circulated to request feedback for the open consultation.
- Standard scrutiny of the **Restraint and Seclusion Assurance Report** took place, with assurance that episodes were appropriate and lawful. Impact on acuity due to larger PICU was shared and reduced restraints and seclusions noted. Improvements as a result of the Use of Force Act was highlighted and ongoing collaborative working explained.
- The Mental Health Act and Mental Capacity Act Lead provided an **Associate Hospital Managers (AHM) Update**.
- The Committee approved the **Committee Annual Report** and objectives for the year ahead.

- There were no open **Internal Audit Recommendations** relating to mental health. There were no risks to report in relation to the **Board Assurance Framework (BAF).**

## 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 template- Board and Committees

| | | | | | | |
|---|---|---|---|---|---|---|
| Item No. | 14.1 | | 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 & Risk Committee held on 13th June 2022. | | | | | |
| Committees/Groups previously presented | N/A | | | | | |
| Statement on impact on inequalities | Positive impact (inc. details below) | | Negative Impact (inc. details below) | | No impact (neutral) | X |
| Action required | For decision | | For assurance | X | | |
| Summary of Recommendations and actions required by the author | The In Public Board is asked to:<br>• 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 Chair | | Exec Sponsor signature: |  | | |

## Summary of business transacted:

The following **public disclosure documentation** was reviewed, ahead of final approval at the EO Board.

- **Draft Annual Accounts**- The Committee received the draft accounts for financial year 2021/22 as presented, and recommended these for onward approval, subject to confirmation from external auditors of finalisation of outstanding work on Goods Received Not Invoiced (which may impact on Income & Expenditure).
- **Going Concern**- No concerns noted.
- **Draft Annual Report & Annual Governance Statement**- The Committee agreed the statement and approved the Annual Report and Annual Governance Statement for recommendation to the EO Board, subject to final confirmation of accounts within the summary financial statement.
- **Draft Quality Account**- The Quality Account was approved, for onward submission to the EO Board.
- **Internal Audit Annual Report including Head of Internal Audit Opinion**- The Committee approved the Internal Audit Annual Report and Head of Internal Audit Opinion.
- **Draft Annual Results Report for the year ended March 2022**- The Committee received the report recommended for onward approval, subject to confirmation from external auditors of finalisation of outstanding work on Goods Received Not Invoiced (which may impact on Income & Expenditure).

The **standard Audit and Risk Committee** resumed:

- The Chief Finance Officer presented reports outlining the **Single Tender Waivers** and **Losses and Special Payments** processed since the last meeting. Rationales were provided for each report, which were **noted** by the Committee.
- The **External Audit Plan** was **noted**.
- The following **Counter Fraud, Bribery & Corruption updates** were provided and key highlights shared, including overview of proactive work and assurance regarding case matters:
    - Fraud, Bribery and Corruption Progress Report- **noted**
    - Fraud, Bribery, Corruption, Loss and Error Risk Assessment 2022–2023- **noted**
    - Fraud, Bribery and Corruption Work Plan 2022–2023- **approved**
    - Fraud, Bribery and Corruption Annual Report 2021–2022- **noted**
    - Fraud, Bribery and Corruption–Year One Strategy Review- **noted**
- An **update on external reviews / (un)announced visits** was presented. Update on continued CQC visits were highlighted and the Committee were informed of appointment of a new CQC Mental Health Act Lead.
- The Committee **noted** the **Clinical Audit Annual Plan – Year End Summary**. An overview of activity from the year was shared and the Committee were assured that all audits had followed/informed by NICE guidance as required.
- The **6 Monthly Litigation Report**, detailing the Trust litigation position, was **noted**.
- The Committee agreed assurance provided and **noted** the **IT Asset Management Update**.

## 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.

# Internal audit risk assessment and plan 2022/2023

Solent NHS Trust
DRAFT
July 2022

*This is a draft prepared for discussion purposes only and should not be relied upon; the contents are subject to amendment or withdrawal and our final conclusions and findings will be set out in our final deliverable*

pwc

# Contents



**Distribution list**

For action: Audit and Risk Committee

For information: Trust Executive Directors



# Introduction and approach (1 of 3)

## Introduction

This document sets out our risk assessment and our internal audit plan for Solent NHS Trust (the Trust) for 2022/23.

## Approach

The internal audit service will be delivered in accordance with the Internal Audit Charter included within Appendix D. A summary of our approach to undertaking the risk assessment and preparing the internal audit plan is set out on the right.

The internal audit plan is driven by the Trust's organisational objectives and priorities, and the risks that may prevent the Trust from meeting those objectives. A more detailed description of our approach can be found in Appendix A.

To help update our understanding of the risk profile of the Trust we have held meetings with a number of the Executive directors at the Trust over the course of the 2021/22 internal audit. In addition we attended an Executive Team meeting in March 2022 to discuss the contents of the internal audit plan and met with the Chief of Staff and Corporate Affairs, CFO and CEO in June to further refine the plan.

| | | |
|---|---|---|
| **Step 1** | Understand corporate objectives and risks | Obtain information from the Trust and utilise sector knowledge to identify corporate level objectives and risks. |
| **Step 2** | Define the audit universe | Identify all of the auditable units within the organisation. Auditable units can be functions, processes or locations. |
| **Step 3** | Assess the inherent risk | Assess the inherent risk of each auditable unit based on impact and likelihood criteria. |
| **Step 4** | Assess the strength of the control environment | Assess the strength of the control environment within each auditable unit to identify auditable units with a high reliance on controls. |
| **Step 5** | Calculate the audit requirement rating | Calculate the audit requirement rating taking into account the inherent risk assessment and the strength of the control environment for each auditable unit. |
| **Step 6** | Determine the audit plan | Determine the timing and scope of audit work based on the organisation's risk appetite. |
| **Step 7** | Other considerations | Consider additional audit requirements to those identified from the risk assessment process. |

# Introduction and approach (2 of 3)

## Key Contacts

Input from the Executive team was sought during the performance of the 2021/22 internal audit plan and during the planning for the 2022/23 internal audit plan. Alongside hot topics, key sector risks and themes, the discussions with Executive team helped us develop a long list of potential reviews to be considered for the internal audit plan for 2022/23.

With the Executive we prioritised the reviews to be included in the draft internal audit plan for 2022/23, which are presented within this document.

## Basis of our plan

The level of agreed resources for the internal audit service for 2022/23 is £74,000 inclusive of out of pocket expenses but exclusive of VAT. Therefore the plan does not purport to address all key risks identified across the audit universe as part of the risk assessment process. Accordingly, the level of internal audit activity represents a deployment of limited internal audit resources and in approving the risk assessment and internal audit plan, the Audit and Risk Committee recognises this limitation.

## Basis of our annual internal audit conclusion

Internal audit work will be performed in accordance with PwC's Internal Audit methodology which is aligned to Public Sector Internal Audit Standards (PSIAS). As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

Our annual internal audit opinion will be based on and limited to the internal audits we have completed over the year and the control objectives agreed for each individual internal audit. The agreed control objectives will be reported within our final individual internal audit reports.

In developing our internal audit risk assessment and plan we have taken into account the requirement to produce an annual internal audit opinion by determining the level of internal audit coverage over the audit universe and key risks. We **do not** believe that the level of agreed resources will impact adversely on the provision of the annual internal audit opinion.

# Introduction and approach (3 of 3)

## Other sources of assurance

In developing our internal audit risk assessment and plan we have taken into account other sources of assurance and have considered the extent to which reliance can be placed upon these other sources.

The other sources of assurance for the Trust include, but are not limited to, the following:

- External audit
- Local Counter Fraud Specialist (LCFS) work and investigations
- Care Quality Commission inspections
- Previous internal audit reports
- Internal contract monitoring
- Internal performance reporting

We do not intend to place reliance on these sources of assurance but will use the above for information purposes.

# Audit universe, corporate objectives and risks (1 of 5)

## Audit universe

The diagram below represents the high level auditable units within the audit universe of the Trust. These units form the basis of the internal audit plan.

**Solent NHS Trust**

### Clinical services

| Adults and Older Persons | Child and Adolescent Services | Mental Health and Speciality Services |
|---|---|---|
| Homeless Healthcare | Community Health | Rehabilitation Units |
| Community Beds and Rehabilitation | Children in Care | Commissioned Services |
| Specialist Palliative Care | Mental Health | Community Mental Health |
| Musculoskeletal | Health Visiting | Speciality Services |
| Community Nursing | Learning Disability | Older Persons Mental Health |
| Neuropsychology Services | School Nursing | Substance Misuse |
| General Practitioners | | |
| Pharmacy Services | | |
| Community Dentistry | | |
| Sexual Health | | |

### Cross cutting areas

- Business Continuity Planning
- Clinical Governance
- Corporate Planning and Performance
- Corporate Governance
- Communications
- Estates, Facilities and Transport
- Finance
- Cost Improvement Plans
- HR and Staff
- IT
- Legal and Legislation
- Procurement
- Risk Management
- Serious Incident Reporting
- Quality Governance
- Information governance
- Data quality

### Stakeholders

- Commissioning
- CQC
- NHS Improvement
- Partnership Working Organisations
- Patients
- Staff
- Members Council
- Education, Training & Research
- PALS
- Sustainability and Transformation Plan

# Audit universe, corporate objectives and risks (2 of 5)

## Corporate Objectives

Corporate level objectives have been determined by the Trust and recorded within their strategy document for 2021 - 2026; 'Our Vision and Strategy'. These are detailed below and have been considered when preparing the internal audit plan.

The Trust outlines its mission as being *"to provide great care, be a great place to work and to deliver great value for money. Our mission drives everything we do."* It has also outlined the following 15 strategic priorities, mapped against the three key pillars of this mission:

| | |
|---|---|
| **Deliver great care** | • 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.<br>• Our communities are at the heart of what we do and we will work alongside our communities to improve the way we deliver care.<br>• We will focus on outcomes that matter, co-created with the people who know our services best.<br>• We will adopt a life-course approach which removes barriers and personalises care.<br>• We will work collaboratively, at the appropriate scale, as one health and care team.<br>• We will drive and embrace research and innovation to deliver excellent, evidence-based care.<br>• We will ensure strong clinical and professional leadership is at the heart of delivery and decision making across our area. |
| **Make Solent a great place to work** | • Looking after our people – we will look after the health and wellbeing of our people and prioritise work-life balance.<br>• Belonging in the NHS – we will create an inclusive, compassionate culture which addresses inequalities.<br>• New ways of working – we are committed to embedding new ways of working and delivering care.<br>• Growing for the future – we will develop a workforce which is sustainable for the future. |
| **Deliver the best value for money** | • 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.<br>• 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.<br>• 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.<br>• Partnerships and added value – we will work effectively with partners to address unwarranted variation, deliver social value, improve NHS and community sustainability and ensure effective use of resources. |

# Audit universe, corporate objectives and risks (3 of 5)

## Board Assurance Framework (BAF)

The Trust has identified their key corporate risks, all of which are recorded and monitored through their BAF. We have reviewed the Trust BAF as at July 2022, and listed the risks therein below, all of which have been considered when preparing the internal audit plan.

| Risk ref | Key risk area | Description of risk | Residual risk score |
|---|---|---|---|
| **Risks currently being actively monitored through the BAF** | | | |
| **1** | **Provision of consistently high quality, safe care with clear person-centered outcomes, driven by strong clinical leadership and a prominent community voice.** | There is a risk that<br>● We are unable to effectively identify and meet the needs of our population (through community engagement and development of patient centred outcomes), and<br>● We are unable to deliver safe and effective care, particularly in light of holding higher acuity and greater complexity within our community services that would have traditionally been managed within acute hospitals, and<br>● We are unable to reference effectiveness through meaningful outcomes alongside strong and empowered clinical leadership with robust and effective quality and governance processes. | **15** |
| **4** | **Workforce sustainability** | There is a risk that:<br>● We are unable to recruit and / or retain sufficient numbers of staff with the qualifications, skills and experience required to safely meet rising demand, and new clinical models (including supporting digital models of care)<br>● With rising sickness levels there is a higher dependency on Bank and Agency<br>● Our workforce is not representative of the community we serve<br>● Due to high costs of living and associated workforce fatigue, that the NHS is not an attractive employer | **16** |
| **5** | **Financial sustainability** | The Trust has submitted a break-even plan to the ICB and NHSE for 2022/23 but recurrent financial sustainability is at risk due to:<br>● Reduced income being received in 2022/23 and ongoing (for core services, with Covid and HDP funding also reduced)<br>● Higher cost improvement expectations within our funding allocation<br>● Significant increases in inflation with little additional funding to cover it.<br>● Significant increases in demand for services and rising waiting lists.<br>● The System wide Control Total further restricts the Trust's ability to secure additional resources and additional national funding is limited. | **9** |

# Audit universe, corporate objectives and risks (4 of 5)

| Risk ref | Key risk area | Description of risk | Residual risk rating |
|---|---|---|---|
| **Risks currently being actively monitored through the BAF** | | | |
| **6** | **Digital Maturity** | In an increasingly digital world, there is a risk that our digital infrastructure, processes and workforce digital literacy are insufficient to:<br>● Provide efficient, patient focussed services<br>● Provide sufficient timely evidence for the organisation to make informed decisions<br>● Provide security against cyber attacks<br>● Enable innovation<br>There is also a risk that IT procurement, and the exit and transition phase, leads to significant service disruption. | **15** |
| **7** | **Demand, Capacity and Access** | As a result of the COVID pandemic, waiting lists have significantly increased and are continuing to increase. There is therefore a risk that demand for services may outstrip capacity for a number of reasons:<br>● Continued national recruitment challenges<br>● Recovery of services<br>● Lack of funding and efficiency requirements<br>● Unknown levels of referrals yet to be reviewed (where patients have elected to/not been able to access services)<br>● Increased acuity<br>● Extremely high levels of winter demand | **20** |
| **8** | **Strategic Provision of Services** | There is a risk that the outcome of the HIOW Strategic Review will:<br>● detract Solent's Senior Leadership from delivering our agreed strategy, priorities and 'business as usual'<br>● adversely affect staff engagement by staff becoming disenfranchised<br>● result in the loss of key personnel during the process as people look to secure their futures<br><br>Ultimately resulting in:<br>● detraction in patient care, quality, safety and outcomes, with the potential for levelling down rather than levelling up<br>● non-delivery of strategy and priorities<br>● over-stretched leadership team<br>● reduced staff engagement / staff survey results<br>● reputational damage – with our partners, community partners and internally<br>● weaker governance and confusion regarding accountability<br>● financial deficit if funding and resourcing is not confirmed, which will result in deterioration in front line patient care as funds are diverted<br>● dilution of our culture and values | **25** |

# Audit universe, corporate objectives and risks (5 of 5)

| Risk ref | Key risk area | Description of risk | Residual risk rating |
|---|---|---|---|
| **Risks not currently being actively monitored through the BAF** | | | |
| **2** | **Strategic Partnerships** | Due to the:<br>● target timeframe<br>● capacity and capability of organisations<br>● potential for competing political demands<br>Solent fails to undertake sufficiently robust due diligence and assurance activity, resulting in unmitigated and/or unknown risk impacts.There is also a risk that reputationally Solent is adversely affected, if, based on information provided, Solent decides not to proceed with the proposed transfer of services<br><br>**As per the BAF (June 2022), it was agreed by the Trust Executive that monitoring of this risk should be suspended due to consideration of the Isle Of Wight provision within the wider Hampshire & Isle Of Wight Strategic Review, and the new associated risk *'Strategic Provision of Services'.*** | **16** |
| **3** | **3rd Party Contractor Assurance** | There is a risk to patient safety, contractual performance and reputational damage in relation to partnership/third party supplier arrangements that are not under direct control of Solent ("Indirect commercial relationships"). This includes:<br>● where Solent subcontracts directly to another provider (lower risk, due to provider to provider contract)<br>● where the contract is managed by the CCG and we are in receipt of a service our patients need provided by a third party provider (higher risk, as we do not have direct control of contractual levers to manage supplier performance).<br><br>**This risk has met its target risk score, therefore monitoring no longer in place.** | **6** |

# Annual plan and internal audit performance (1 of 3)

## Annual plan and indicative timeline

The following table sets out the internal audit work planned for 2022/23, consisting of required reviews in order to support the Head of Internal Audit Opinion and a selection of recommended reviews based on our risk assessment (see Appendix B).

| Ref | Review | Indicative Cost | Audit Sponsor | Proposed Quarter | High-level description |
|---|---|---|---|---|---|
| **A1** | **Business Intelligence (BI) and data management** | £12,500 | Andrew Strevens, Chief Executive Officer, Stephen Docherty, Digital Consultant | Q3 | The Trust has a number of data sources across the organisation which are managed by different parts of the organisation and there is currently no overall data management strategy.<br>This review will look at the data that is held, and how data is used, shared and triangulated across the organisation to drive strategic decision making, in particular financial and workforce data. |
| **A2** | **Human Resources - Core Controls** | £11,000 | Shahana Ramsden, Chief People Officer | Q2 | We will undertake a review of your core HR controls relating to process-wide considerations, employee recruitment and onboarding, employee terminations and payroll. We will identify the relevant policies, procedures and processes over the recruitment and onboarding of new starters, admin of movers and leavers and segregation of duties and assess whether or not the various HR processes abide by these. |
| **A3** | **Financial sustainability** | £10,000 | Nikki Burnett, incoming Chief Finance Officer | Q2 | NHS England has highlighted the need for a renewed focus on financial sustainability across the sector. The objective of this audit is to perform a gap analysis between the self-assessment created by the Trust in response to the HFMA guidance and the evidence provided in support of the self assessment. We will look to provide challenge on the quality of the response and the strength of the evidence to support it. We will also look to provide potential follow-up questions in order to enable the Trust to ensure that their responses and associated action plans are robust, timely and relevant. |
| **A4** | **Data Security Protection Toolkit** | £5,000 | Andrew Strevens, Chief Executive Officer, Stephen Docherty, Digital Consultant | Q3 | The Data Security and Protection (DSP) Toolkit is a self-assessment and reporting tool that organisations must use to assess local performance in line with the requirements set out in the NHS Informatics Guidance and Operating Framework. We are required to review the process and controls in place for completing the toolkit and test compliance for a sample of the toolkit sections on an annual basis. |

# Annual plan and internal audit performance (2 of 3)

| Ref | Review | Indicative Cost | Audit Sponsor | Proposed Quarter | High-level description |
|---|---|---|---|---|---|
| **A5** | **Corporate Governance (Mental Health Service)** | £11,000 | Suzannah Rosenberg, Chief Operating Officer | Q2 | Due to the significant transformation and work currently happening within the Mental Health Service this review will focus governance and more specifically make sure that: appropriate and up to date policies, procedures are in place and available to relevant staff responsible for mental health services and staff comply with these, policies and procedures refer to applicable standards and legislative requirements and are updated on a regular basis should there be changes to legislation. |
| **A6** | **E-rostering** | £11,000 | Shahana Ramsden, Chief People Officer | Q3 | This review will look at the processes and controls and day to day practices around roster management (including use of clocking in and clocking out) and the flow of this data through to payroll (and ultimately, to individual's pay). |
| **A7** | **Follow Up** | £3,500 | Nikki Burnett, incoming Chief Finance Officer | Throughout the year | We will use this time to follow up the progress made by the Trust in relation to prior internal audit recommendations. |
| **A8** | **Audit Management and Planning** | £13,000 | | Throughout the year | **Audit needs assessment** - We will use this time to meet with key individuals and review documentation to produce our internal audit plan which will address a number of the Trust's key risks.<br>**Management, planning and liaison** - Ongoing communication with you is of paramount importance, and we will use this time to attend regular programme updates with you. We will also supplement this with informal communications on an ad-hoc basis as well as attend the key committees and meetings.<br>**Head of Internal Audit Opinion** – We will use this time to produce our annual Head of Internal Audit Opinion |
| | **Total indicative cost of reviews** | **£77,000*** | | | |

**As agreed with the Chief Finance Officer, £3,000 has been rolled forward from the 2021/22 budget for use on the 2022/23 plan. The baseline fee for 2022/23 is £74,000.*

# Annual plan and internal audit performance (3 of 3)

## Annual plan and indicative timeline (continued)

The risk assessment we have undertaken as part of our planning for the 2022/23 internal audit plan identified a number of areas within the audit universe which will not be audited within the 2022/23 year - these areas have been listed below. The Trust may want to consider whether they are comfortable with the current prioritisation of the internal audit plan, whether further reviews should be included to cover those risks and whether there is assurance being provided over these areas by another means

- Homeless Healthcare (due every 3 years)
- Specialist Palliative Care (due every 3 years)
- Pharmacy Services (due every 2 years)
- Children in Care (due every 2 years)
- Health Visiting (due every 3 years)
- Learning disability (due every 3 years)
- School nursing (due every 3 years)
- Commissioned services (due every 2 years)
- Speciality services (due every 3 years)
- Substance misuse (due every 3 years)
- Clinical governance (due every 2 years)
- Communications (due every 3 years)
- Cost improvement plans (due every 3 years)
- Quality governance (due every 2 years)
- Commissioners (due every 3 years)
- CQC (due every 3 years)
- NHS Improvement (due every 2 years)
- Partnership working organisations (due annually)
- Members council (due every 3 years)
- Education, training and research (due every 3 years)
- PALS (due every 3 years)

## Key performance indicators

Appendix E sets out the proposed Key Performance Indicators for internal audit. Performance against these indicators will be reported quarterly to the Audit and Risk Committee.

# Appendices

# Appendix A: Detailed methodology (1 of 2)

## Step 1 – Understand corporate objectives and risks

In developing our understanding of your corporate objectives and risks, we have drawn upon our knowledge of the following:

Requirements of the Public Sector Internal Audit Standards (effective 1 April 2013);

Reviewed strategy, organisational structure and corporate risk register

Drawn on our knowledge of the health sector

Met with the Trust Executive Officers.

## Step 2 – Define the Audit Universe

In order that the internal audit plan reflects your management and operating structure we have identified the audit universe for the Trust made up of a number of auditable units. Auditable units include functions, processes, systems, products or locations. Any processes or systems which cover multiple locations are separated into their own distinct cross cutting auditable unit.

## Step 3 – Assess the inherent risk

The internal audit plan should focus on the most risky areas of the business. As a result each auditable unit is allocated an inherent risk rating i.e. how risky the auditable unit is to the overall organisation and how likely the risks are to arise. The criteria used to rate impact and likelihood are recorded in Appendix 2.

The inherent risk assessment is determined by:

- Mapping the corporate risks to the auditable units
- Our knowledge of your business and the health sector
- Discussions with management.

| Impact Rating | Likelihood Rating | | | | | |
|---|---|---|---|---|---|---|
| | 6 | 5 | 4 | 3 | 2 | 1 |
| 6 | 6 | 6 | 5 | 5 | 4 | 4 |
| 5 | 6 | 5 | 5 | 4 | 4 | 3 |
| 4 | 5 | 5 | 4 | 4 | 3 | 3 |
| 3 | 5 | 4 | 4 | 3 | 3 | 2 |
| 2 | 4 | 4 | 3 | 3 | 2 | 2 |
| 1 | 4 | 3 | 3 | 2 | 2 | 1 |

## Step 4 – Assess the strength of the control environment

In order to effectively allocate internal audit resources we also need to understand the strength of the control environment within each auditable unit. This is assessed based on:

- Our knowledge of your internal control environment;
- Information obtained from other assurance providers; and
- The outcomes of previous internal audits.

# Appendix A: Detailed methodology (2 of 2)

## Step 5 – Calculate the audit requirement rating

The inherent risk and the control environment indicator are used to calculate the audit requirement rating. The formula ensures that our audit work is focused on areas with high reliance on controls or a high residual risk.

| Inherent Risk Rating | Control design indicator | | | | | |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 6 | 6 | 5 | 5 | 4 | 4 | 3 |
| 5 | 5 | 4 | 4 | 3 | 3 | N/A |
| 4 | 4 | 3 | 3 | 2 | N/A | N/A |
| 3 | 3 | 2 | 2 | N/A | N/A | N/A |
| 2 | 2 | 1 | N/A | N/A | N/A | N/A |
| 1 | 1 | N/A | N/A | N/A | N/A | N/A |

## Step 6 – Determine the audit plan

Your risk appetite determines the frequency of internal audit work at each level of audit requirement. Auditable units may be reviewed annually, every two years or every three years.

In some cases it may be possible to isolate the sub-process (es) within an auditable unit which are driving the audit requirement. For example, an auditable unit has been given an audit requirement rating of 5 because of inherent risks with one particular sub-process, but the rest of the sub-processes are lower risk. In these cases it may be appropriate for the less risky sub-processes to have a lower audit requirement rating be subject to reduced frequency of audit work. These sub-processes driving the audit requirement areas are highlighted in the plan as key sub-process audits.

## Step 7 – Other considerations

In addition to the audit work defined through the risk assessment process described above, we may be requested to undertake a number of other internal audit reviews such as regulatory driven audits, value enhancement or consulting reviews. These have been identified separately in the annual plan.

# Appendix B: Risk assessment (1 of 6)

## Risk assessment results

Each auditable unit has been assessed for inherent risk and the strength of the control environment, in accordance with the methodology set out in Appendix A. The results are summarised in the table below along with a reference to the work performed recently by internal audit.
The audit requirement rating drives the frequency of internal audit work for each auditable unit. Our recommended planning approach involves scheduling an audit annually for those rated 4-6, biannually for those rated 3 and every three years for those rated 2.

## Key to frequency of audit work

| Audit Requirement Rating | Frequency – PwC standard approach | Colour Code |
|---|---|---|
| **4-6** | Annual | ● |
| **3** | Every two years | ● |
| **2** | Every three years | ● |
| **1** | No further work | ● |

| Ref | Auditable unit | BAF | Inherent risk rating | Control environment indicator | Audit requirement rating | Colour code | Frequency | Last reviewed | 2022/23 Plan |
|---|---|---|---|---|---|---|---|---|---|
| **A - Clinical Services** | | | | | | | | | |
| **A1 - Adults and Older Persons** | | | | | | | | | |
| **A.1.1** | Homeless Healthcare | | 3 | 2 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **A.1.2** | Community beds and rehabilitation | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **A.1.3** | Specialist Palliative Care | | 3 | 2 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **A.1.4** | Musculoskeletal | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **A.1.5** | Community Nursing | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **A.1.6** | Neuropsychology services | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **A.1.7** | General Practitioners | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |

# Appendix B: Risk assessment (2 of 6)

| Ref | Auditable unit | BAF | Inherent risk rating | Control environment indicator | Audit requirement rating | Colour code | Frequency | Last reviewed | 2022/23 Plan |
|---|---|---|---|---|---|---|---|---|---|
| **A - Clinical Services (continued)** | | | | | | | | | |
| **A1 - Adults and Older Persons (continued)** | | | | | | | | | |
| **A.1.8** | Pharmacy Services | | 5 | 3 | 3 | ● | Every 2 years | 2019/20 Medicine and Pharmacy Management | No reviews planned |
| **A.1.9** | Community Dentistry | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **A.1.10** | Sexual Health | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **A2 - Child and Family Services** | | | | | | | | | |
| **A.2.1** | Community Health | | 2 | 2 | 1 | ● | No further work | 2018/19 Risk Management | No reviews planned |
| **A.2.2** | Children in Care | | 4 | 3 | 3 | ● | Every 2 years | 2018/19 Risk Management | No reviews planned |
| **A.2.3** | Mental Health | | 4 | 3 | 3 | ● | Every 2 years | 2018/19 Risk Management | Corporate Governance |
| **A.2.4** | Health Visiting | | 3 | 3 | 2 | ● | Every 3 years | 2018/19 Risk Management | No reviews planned |
| **A.2.5** | Learning Disability | | 3 | 3 | 2 | ● | Every 3 years | 2018/19 Risk Management | No reviews planned |
| **A.2.6** | School Nursing | | 3 | 3 | 2 | ● | Every 3 years | 2018/19 Risk Management | No reviews planned |

# Appendix B: Risk assessment (3 of 6)

| Ref | Auditable unit | BAF | Inherent risk rating | Control environment indicator | Audit requirement rating | Colour code | Frequency | Last reviewed | 2022/23 Plan |
|---|---|---|---|---|---|---|---|---|---|
| **A - Clinical Services (continued)** | | | | | | | | | |
| **A3 - Mental Health and Speciality Services** | | | | | | | | | |
| **A.3.1** | Rehabilitation Units | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **A.3.2** | Commissioned Services | | 4 | 3 | 3 | ● | Every 2 years | Not previously reviewed | No reviews planned |
| **A3.3** | Community Mental Health | | 4 | 3 | 3 | ● | Every 2 years | Not previously reviewed | Corporate Governance |
| **A.3.4** | Speciality Services | | 3 | 3 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **A.3.5** | Older Persons Mental Health | | 3 | 3 | 2 | ● | Every 3 years | Not previously reviewed | Corporate Governance |
| **A.3.6** | Substance Misuse | | 3 | 3 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **B - Cross cutting areas** | | | | | | | | | |
| **B.1** | Business continuity planning | 13 - Amber<br>59 - Red<br>65 - Red<br>61 - Red | 5 | 3 | 4 | ● | Annual | 2021/22 - Risk Identification, escalation and reporting | Financial Sustainability |
| **B.2** | Clinical governance | 64 - Amber<br>57 - Amber | 4 | 3 | 3 | ● | Every 2 years | 2019/20 Medicine and Pharmacy management | No reviews planned |

# Appendix B: Risk assessment (4 of 6)

| Ref | Auditable unit | BAF | Inherent risk rating | Control environment indicator | Audit requirement rating | Colour code | Frequency | Last reviewed | 2022/23 Plan |
|---|---|---|---|---|---|---|---|---|---|
| **B - Cross cutting areas (continued)** | | | | | | | | | |
| **B.3** | Corporate planning and performance | 64 - Amber<br>65 - Red<br>61 - Red<br>58 - Amber<br>59 - Red | 4 | 3 | 5 | ● | Annual | 2020/21 Financial data | Business Intelligence (BI) and Data Management<br>Financial Sustainability |
| **B.4** | Corporate governance | 64 - Amber<br>65 - Red<br>61 - Red | 4 | 3 | 3 | ● | Every 2 years | 2020/21 Risk Management: Restoration of services/ recovery from Covid-19 | Corporate Governance |
| **B.5** | Communications | | 3 | 3 | 2 | ● | Every 3 years | 2018/19 Learnings review | No reviews planned |
| **B.6** | Estates & Facilities | 27 - Amber | 4 | 3 | 3 | ● | Every 2 years | 2021/22 - Estates, Facilities and Transport | No reviews planned |
| **B.7** | Finance | 53 - Amber<br>58 - Amber | 5 | 3 | 4 | ● | Annual | 2021/22 - Key Financial Systems | Financial Sustainability |
| **B.8** | Cost improvement plans | 53 - Amber | 3 | 3 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **B.9** | HR and staff | 55 - Red | 5 | 3 | 4 | ● | Annual | 2021/22 - Key Financial Systems | Human Resources: Core Controls<br>E-Rostering |

# Appendix B: Risk assessment (5 of 6)

| Ref | Auditable unit | BAF | Inherent risk rating | Control environment indicator | Audit requirement rating | Colour code | Frequency | Last reviewed | 2022/23 Plan |
|---|---|---|---|---|---|---|---|---|---|
| **B - Cross cutting areas (continued)** | | | | | | | | | |
| **B.10** | IT | 13 - Amber | 5 | 3 | 4 | ● | Annual | 2021/22 - Cyber Security | Business Intelligence (BI) and Data Management Data Security and Protection Toolkit |
| **B.11** | Legal and legislation | | 2 | 2 | 1 | ● | No further work | Not previously reviewed | No reviews planned |
| **B.12** | Procurement | | 3 | 3 | 2 | ● | Every 3 years | 2020/21 - Outsourced IT services tender assurance | No reviews planned |
| **B.13** | Risk management | 58 - Amber | 5 | 3 | 4 | ● | Annual | 2021/22 - Risk Identification, escalation and reporting<br>2021/22 Fit and Proper Persons review | Corporate Governance |
| **B.14** | Serious incident reporting | 61 - Red<br>65 - Red | 4 | 3 | 2 | ● | Every 3 years | 2021/22 - Cyber Security<br>2021/22 - Risk Identification, escalation and reporting | No reviews planned |
| **B.15** | Quality governance | | 4 | 3 | 3 | ● | Every 2 years | 2018/19 - Learnings | No reviews planned |
| **B.16** | Information governance | 13 - Amber | 4 | 3 | 3 | ● | Every 2 years | 2021/22 - Data Security and Protection Toolkit | Data Security and Protection Toolkit |
| **B.17** | Data Quality | 59 - Red | 4 | 3 | 3 | ● | Every 2 years | 2017/18 Clinical Data Quality | Business Intelligence (BI) and Data Management |

# Appendix B: Risk assessment (6 of 6)

| Ref | Auditable unit | BAF | Inherent risk rating | Control environment indicator | Audit requirement rating | Colour code | Frequency | Last reviewed | 2022/23 Plan |
|---|---|---|---|---|---|---|---|---|---|
| **C - Stakeholders** | | | | | | | | | |
| **C.1** | Commissioning | 66 - Amber | 3 | 3 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **C.2** | CQC | 66 - Amber | 3 | 3 | 2 | ● | Every 3 years | 2018/19 Learnings review | No reviews planned |
| **C.3** | NHS Improvement | 66 - Amber | 4 | 3 | 3 | ● | Every 2 years | Not previously reviewed | No reviews planned |
| **C.4** | Partnership working organisations | 58 - Amber<br>61 - Red<br>63 - Red<br>66 - Amber | 5 | 2 | 4 | ● | Annual | Not previously reviewed | No reviews planned |
| **C.5** | Patients | 63 - Amber | 4 | 3 | 3 | ● | Every 2 years | 2018/19 Learnings review | Business Intelligence (BI) and Data Management<br>Corporate Governance |
| **C.6** | Staff | 55 - Red | 4 | 3 | 3 | ● | Every 2 years | 2020/21 Health and safety and occupational health<br>2020/21 E-rostering and payroll | Human Resources: Core Controls<br>E-Rostering |
| **C.7** | Members Council | | 2 | 1 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **C.8** | Education, training and research | | 3 | 3 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **C.9** | PALS | | 3 | 3 | 2 | ● | Every 3 years | Not previously reviewed | No reviews planned |
| **C.10** | Sustainability & Transformation Plan | 58 - Amber<br>61 - Red<br>63 - Red<br>66 - Amber | 5 | 2 | 4 | ● | Annual | Not previously reviewed | No reviews planned |

# Appendix C: Risk assessment criteria

## Determination of Inherent Risk

We determine inherent risk as a function of the estimated impact and likelihood for each auditable unit within the audit universe as set out in the tables below.

| Impact rating | Assessment rationale |
|---|---|
| 6 | Critical impact on operational performance resulting in inability to continue core activities for more than two days; or<br>Critical monetary or financial statement impact of £2m; or<br>Critical breach in laws and regulations that could result in material fines or consequences over £2m; or<br>Critical impact on the reputation or brand of the organisation which could threaten its future viability, e.g. high-profile political and media scrutiny i.e. front-page headlines in national press. |
| 5 | Significant impact on operational performance resulting in significant disruption to core activities; or<br>Significant monetary or financial statement impact of between £1m and £2m; or<br>Significant breach in laws and regulations resulting in significant fines and consequences over £1m and £2m; or<br>Significant impact on the reputation or brand of the organisation, resulting in unfavourable national media coverage. |
| 4 | Major impact on operational performance resulting in moderate disruption of core activities or significant disruption of discrete non-core activities greater than 1 week; or<br>Major monetary or financial statement impact of between £500k and £1m; or<br>Major breach in laws and regulations resulting in fines and consequences between £500k and £1m; or<br>Major impact on the reputation or brand of the organisation, resulting in limited unfavourable media coverage. |
| 3 | Moderate impact on operational performance resulting in moderate disruption of core activities or major disruption of discrete non-core activities for between 1 day and 1 week; or<br>Moderate monetary or financial statement impact of between £250k to £500k; or<br>Moderate breach in laws and regulations resulting in fines and consequences over £250k to £500k; or<br>Moderate impact on the reputation or brand of the organisation, resulting in limited unfavourable media coverage with a long-term reduction in public confidence.. |
| 2 | Minor impact on the organisation's operational performance resulting in moderate disruption of discrete non-core activities for greater than 8 hours but less than 1 day; or<br>Minor monetary or financial statement impact of less than £125k; or<br>Minor breach in laws and regulations with limited consequences less than £125k; or<br>Minor impact on the reputation of the organisation, resulting in limited unfavourable media coverage restricted to the local press with a short-term reduction in public confidence. |
| 1 | Insignificant impact on the organisation's operational performance resulting in minor disruption of discrete non-core activities for between 1 hour and 8 hours; or<br>Insignificant monetary or financial statement impact; or<br>Insignificant breach in laws and regulations with little consequence; or<br>Insignificant impact on the reputation of the organisation, resulting in minor unfavourable media coverage restricted to the local press. |

| Likelihood rating | Assessment rationale |
|---|---|
| **6** | Has occurred or probable in the near future |
| **5** | Possible in the next 12 months |
| **4** | Possible in the next 1-2 years |
| **3** | Possible in the medium term (2-5 years) |
| **2** | Possible in the long term (5-10 years) |
| **1** | Unlikely in the foreseeable future |

# Appendix D: Internal audit charter (1 of 3)

## About this charter

This Internal Audit Charter provides the framework for the conduct of the Internal Audit function in the Trust and has been approved by the Audit and Risk Committee. It has been created with the objective of formally establishing the purpose, authority and responsibilities of the Internal Audit function.

## Purpose

Internal Auditing is an independent, objective assurance and consulting activity designed to add value to and improve an organisation's operations It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluating and improving the effectiveness of risk management, control and governance processes.

## Scope

All of the Trust's activities (including outsourced activities) and legal entities are within the scope of Internal Audit. Internal Audit determines what areas within its scope should be included within the annual audit plan by adopting an independent risk based approach. Internal Audit does not necessarily cover all potential scope areas every year. The audit program includes obtaining an understanding of the processes and systems under audit, evaluating their adequacy, and testing the operating effectiveness of key controls.

Internal Audit can also, where appropriate, undertake special investigations and consulting engagements at the request of the Audit and Risk Committee or senior management.

Notwithstanding Internal Audit's responsibilities to be alert to indications of the existence of fraud and weaknesses in internal control which would permit fraud to occur, the Internal Audit activity will not undertake specific fraud-related work.

Internal Audit will coordinate activities with other internal and external providers of assurance and consulting services to ensure proper coverage and minimise duplication of efforts.

## Authority

The Internal Audit function of the Trust derives its authority from the Board through the Audit and Risk Committee. The Head of Internal Audit is authorised by the Audit and Risk Committee to have full and complete access to any of the organisation's records, properties and personnel. The Head of Internal Audit is also authorised to designate members of the audit staff to have such full and complete access in the discharging of their responsibilities, and may engage experts to perform certain engagements which will be communicated to management. Internal Audit will ensure confidentiality is maintained over all information and records obtained in the course of carrying out audit activities.

# Appendix D: Internal audit charter (2 of 3)

## Responsibility

The Head of Internal Audit is responsible for preparing the annual audit plan in consultation with the Audit and Risk Committee and senior management, submitting the audit plan, Internal Audit budget, and resource plan for review and approval by the Audit and Risk Committee, implementing the approved audit plan, and issuing periodic audit reports on a timely basis to the Audit and Risk Committee and senior management.

The Head of Internal Audit is responsible for ensuring that the Internal Audit function has the skills and experience commensurate with the risks of the organisation. The Audit and Risk Committee should make appropriate inquiries of management and the Head of Internal Audit to determine whether there are any inappropriate scope or resource limitations.

It is the responsibility of management to identify, understand and manage risks effectively, including taking appropriate and timely action in response to audit findings. It is also management's responsibility to maintain a sound system of internal control and improvement of the same. The existence of an Internal Audit function, therefore, does not in any way relieve them of this responsibility.

Management is responsible for fraud prevention and detection. As Internal Audit performs its work programs, it will be observant of manifestations of the existence of fraud and weaknesses in internal control which would permit fraud to occur or would impede its detection.

## Independence

Internal Audit staff will remain independent of the Trust and they shall report to the Head of Internal Audit who, in turn, shall report functionally to the Audit and Risk Committee and administratively to the Chief Financial Officer.

Internal Audit staff shall have no direct operational responsibility or authority over any of the activities they review. Therefore, they shall not develop nor install systems or procedures, prepare records or engage in any other activity which they would normally audit. Internal Audit staff with real or perceived conflicts of interest must inform the Head of Internal Audit, then the Audit and Risk Committee, as soon as these issues become apparent so that appropriate safeguards can be put in place.

## Professional competence and due care

The Internal Audit function will perform its duties with professional competence and due care. Internal Audit will adhere to the Definition of Internal Auditing, Code of Ethics and the Standards for the Professional Practice of Internal Auditing that are published by the Institute of Internal Auditors.

Internal Audit will also adhere to the requirements of the Public Sector Internal Audit Standards (PSIAS).

# Appendix D: Internal audit charter (3 of 3)

## Reporting and monitoring

At the end of each audit, the Head of Internal Audit or designee will prepare a written report and distribute it as appropriate. Internal Audit will be responsible for appropriate follow-up of audit findings and recommendations. All significant findings will remain in an open issues file until cleared by the Head of Internal Audit or the Audit and Risk Committee.

The Audit and Risk Committee will be updated regularly on the work of Internal Audit through periodic and annual reports. The Head of Internal Audit shall prepare reports of audit activities with significant findings along with any relevant recommendations and provide periodic information on the status of the annual audit plan.

Periodically, the Head of Internal Audit will meet with the Chair of the Audit and Risk Committee in private to discuss Internal Audit matters.

The performance of Internal Audit will be monitored through the implementation of a Quality Assurance and Improvement Programme, the results of which will be reported periodically to Senior Management and the Audit and Risk Committee.

# Appendix E: Key Performance Indicators

| KPI | Measurement |
|---|---|
| 100% of audits delivered against the annual internal audit plan each year | Progress against plan will be detailed in the regular Internal Audit update reports to the Audit and Risk Committee. Budgets in the plan will not be exceeded without prior consent. Any changes to the Internal Audit plan will be agreed with the client and Audit and Risk Committee prior to action. |
| Service delivery standards met | Internal audit will submit written reports quarterly for discussion with the Audit and Risk Committee describing the performance of internal audit against the service delivery specifications in the table above highlighting potential problems and suggesting improvements. |
| Staff mix | % of qualified staff used and number of staff representing continuity. Target minimum 50% of staff with direct client involvement to be qualified. |
| Reliance on work by external audit | The external auditors will make an annual assessment of the quality of the internal audit service and the degree of reliance that may be placed on their work. |
| Follow up of audit recommendations | Number of internal audit recommendations implemented determined via follow up audit review. 100% target implemented. |
| Terms of Reference agreed promptly | Scope agreed 2 weeks prior to fieldwork. |
| Closing meetings held | A closing meeting is held at the end of the fieldwork prior to the issue of the draft report. |
| Draft reports issues promptly | Draft report issued within 10 working days of completion of closing meeting. |
| Management response to draft report | Management response received within 10 working days of receipt of draft report. |
| Issuing of final report | Final report issued within five working days of agreement of management response. |

# Thank you

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# Board and Committees- In Public Board Exception Report

| | | | | | |
|---|---|---|---|---|---|
| Item No. | 15.1 | 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 Thursday 19th May 2022. | | | | |
| 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:<br>• To note the report from the Committee | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Significant | | Sufficient | X | Limited | | None | |
| Sponsor name: | Mike Watts, Non-executive Director | | Exec Sponsor signature: |  | | | |

## Summary of business transacted:

- There were no **Freedom to Speak Up Concerns or Partnership Governance Arrangements** to report.
- **Urgent Matters of Safety-** The Committee noted that throughout discussions at the Committee, safe staffing remained the theme across service lines.
- **Matters arising**- The Committee received an overview of the main tenets of the Ockenden and Government Safety Reports and updates on Trust actions were summarised.
- A **Child & Family Service Deep Dive** was presented, including a full overview of key work programmes and quality priorities. Impact of 'Badger Net' was reported and it was confirmed that the Integrated Care System (ICS) were now leading.
- The Committee **noted** the following standard reports presented:
    - **Patient Safety Annual Report & Patient Safety Strategy Update-** An update on activity from the year was provided and areas of focus/improvement highlighted. Discussions were held regarding incidents and implementation of learning. Increase in Tissue Viability cases were reported and it was agreed to provide a Deep Dive to the next Committee for full oversight.
    - **Safeguarding Q4 Report, Annual Report & Improvement Plan Feedback (L3 Training)**- Continued increase in safeguarding cases were highlighted and ongoing support noted. An update on training compliance was presented and system updates confirmed. It was agreed to consider potential safeguarding impacts aligned to the cost of living challenges. *(Annual Report provided to Board as supplementary paper- item 15.2)*
    - **Infection Prevention Control Q4 Report, Annual Report & IPC BAF**- Annual activity was shared and reduction in Covid-19 outbreaks reported. *(Annual Report provided to Board as supplementary paper- item 15.3)*
    - **Safe Staffing 6 Month Report-** The Committee were informed of challenges across NHS Trusts and regular ongoing review was emphasised. An overview of key mitigation work and support to staff was provided. Discussions were held in relation to ongoing workforce planning.

    - **Annual Quality Impact Assessment (QIA) Report 2021/22-** Annual activity and an overview/assurance of review processes shared.

- The **Performance & Quality Exception Report** *(formally Exception Report from the Quality Improvement and Risk (QIR) Group and Chief Operating Officer)* was **noted**. A contemporary update relating to GA Dentistry was provided- confirming support from 3 local acute hospital spaces, with waits now reducing. Continued challenges in relation to staffing were highlighted.
- The **Board Assurance Framework (BAF) consideration and oversight of risks Report** was presented and update provided. Recommendations were **noted** by the Committee.
- Key items arising from the **Mental Health Act Scrutiny Committee** held on 23rd June 2022 were provided.
- There were no **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)** to report. The Chief of Nursing & AHPs informed of ongoing communication with the CQC and briefed on expected changes to the regulatory model. It was agreed to provide a full update to the September 2022 meeting.
- **Ethics and Caldicott Panel Exception Report**- There was no panel held since the last meeting.
- The **Committee Annual Report** was approved.

## 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 template - Board and Committees

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Item No. | **16.1** | | | Presentation to | In-Public Board | | |
| Date of paper | 7 July 2022 | | | Author | Jayne Jenney, Corporate Services Manager and Assistant Company Secretary | | |
| Title of paper | Governance and Nominations Committee | | | | | | |
| Purpose of the paper | To summarise the business transacted at the Governance and Nominations Committee held on 7 July 2022 | | | | | | |
| 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 | Y | | | |
| Summary of Recommendations and actions required by the author | The In-Public Board is asked to:<br>• Approve the amalgamation of the Remuneration and Governance and Nominations Committees to form the Remuneration Nominations Committee.<br>• Approve the new Remuneration Nominations Committee Terms of Reference.<br>• Note the report from the Committee | | | | | | |
| To be completed by Exec Sponsor - Level of assurance this report provides: | | | | | | | |
| Significant | | Sufficient | X | Limited | | None | |
| Exec Sponsor name: | Catherine Mason – Trust Chair | | | Exec Sponsor signature: |  | | |

## Key messages /findings

- The Committee noted the Annual Assurance Report on AHM Appointment Process and were assured that all AHMs are suitably monitored and trained to carry out their role. It was suggested to approach Alongside Communities in addition to the Recovery College to source future AHMs.
- A governance overview was provided. The Committee approved the disbanding of the existing NED chaired Engagement and Inclusion Committee to an executive led group 'Community Engagement Group' that will report to the Quality and Assurance Committee now that the Alongside Communities Programme is complete.
- The Committee noted that Gaurav Kumar has become a temporary invitee of the MHASC which is to be reviewed after 6 months.
- There were no changes to NED lead roles, the Committee noted NED tenure extensions.
- The successful appointments of the Director of Strategic Transformation and Chief Finance Officer were noted.
- The Committee approved the amalgamation of the Remuneration and Governance and Nominations Committees to form the Remuneration Nominations Committee. The new Terms of Reference are also presented with this report for the Board's approval.
- The Committee Annual Report was approved subject to changes requested to the recorded attendance. It was agreed that proposed objectives would be agreed at the next meeting.
- The Committee Effectiveness Review was noted and outcomes discussed.

- The Committee agreed to receive a skills-gap analysis to identify areas of potential Board development support.

# Solent NHS Trust Remuneration & Nominations Committee
# Terms of Reference

The Solent NHS Trust Board hereby establishes a Committee of the Board to be known as the Remuneration & Nominations Committee ('the Committee') in accordance with its Standing Orders and Scheme of Delegation.

The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated by the Board in these Terms of Reference which are incorporated within the Trust's Standing Orders.

## 1 Principles

1.1 In line with the Department of Health Guidance and best practice the Remuneration & Nominations Committee will operate to the following principles at all times:

- bear in mind the necessity of keeping comprehensive written records of their dealings, in line with general good practice in corporate governance; and
- seek to ensure that all compensation decisions taken are fair and equality of opportunity, diversity and inclusion impacts are considered

## 2 Purpose

2.1 Remuneration

The Committee makes decisions on behalf of the Board regarding remuneration and terms of office relating to the Chief Executive and other Executive Directors. It oversees and approves:

- Employer Based Clinical Excellence Awards
- severance payments over £100k
- all non-contractual payments

2.2 Governance and nominations

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

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

## 3. Duties – The Committee will:

3.1 Remuneration

- Be responsible for aligning the Trust's Remuneration Policy for Directors with national Very Senior Management (VSM) terms
- Within the constraints of national frameworks, the Committee will agree the remuneration package, allowances and terms of service of the Trust's executive directors. No executive director shall be involved in any decisions as to their own remuneration.

- Make decisions on behalf of Solent NHS Trust Board and where necessary make recommendations to NHSI/E about appropriate remuneration, allowances and terms of service for the Chief Executive, and other Executive Directors, to include:
    - Salary - Consulting the Chair and/or the Chief Executive concerning proposals relating to the remuneration of other Executive Directors. Recommend and monitor the level and structure of remuneration for Senior Management (the definition of Senior Management to be determined by the Trust Board, but will normally include the first layer of management below Board level).
    - Pensions - Consider any pension consequences and associated costs to the Trust of basic salary increases and other changes in pensionable remuneration.
    - Performance related pay and Directors' eligibility and performance evaluation for annual bonuses
    - Provision of other contractual terms and benefits
    - Approval of settlement agreements/severance pay or other occasional payments to individuals and
    - out of court settlements, taking account of national guidance
    - Approval of other non-contractual payments
    - Receive and approve decisions of the Employer Based Clinical Excellence Awards (EBCEA) panel
    - be sighted on any substantial changes to nationally agreed terms and conditions.
    - Ensure that levels of remuneration for the Chair and other non-executive directors reflect the national terms.

3.2 Performance evaluation

- Monitor and oversee the evaluation of the performance of the Chief Executive.
- Approve participation in any performance related pay schemes, where operated by the Trust, and approve the total annual payments made under such schemes.
- The Committee will ensure that any:
    - pay-outs or grants under any incentive schemes are subject to challenging performance criteria reflecting the objectives of the Trust.
    - performance criteria and upper pay limits for annual bonuses and incentive schemes are disclosed

3.3 Termination matters

- Ensure that contractual terms on termination, and any payments made, are fair to the individual, and the NHS, aligned with the interests of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised, in line with national guidance where appropriate

3.4 Severance payments

- The Committee will refer the following matters to the NHS Improvement (NHSI) in accordance with the NHS TDA (now NHSI) Guidance for NHS Trusts on processes for making severance payments;
    - All severance payments (contractual or non-contractual) to Chief

Executives and Directors of NHS Trusts. For these purposes, "Director" means any Director reporting to the Chief Executive whether or not an executive member of the Board
    - Non-contractual severance payments to all staff (including to Chief Executives and Directors as defined in 3.1)
    - Contractual severance payments over £100,000 to all staff (including to Chief Executives and Directors as defined in 3.1)

3.5 Appointment of Remuneration Consultants

- To be responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any Remuneration Consultants who advise the committee, and to obtain reliable, up-to- date information about remuneration in other Trusts. Where Remuneration Consultants are appointed, a statement will be made available of whether they have any other connection with the Trust or conflicts of interest.

3.6 Mutually Agreed Resignation Schemes (MARs)

- To have oversight of Mutually Agreed Resignation Schemes (MARs) and to approve schemes as necessary.

3.7 Governance arrangements

- Consider and keep under review governance arrangements, making recommendations to the Board as appropriate, including:
    - committee structure
    - membership and composition – including nominations of NEDs and Executive members to Board Committees and in consideration of balance of skills/experience
    - Terms of Reference of the Board and its Committees
    - nominations of key roles
    - overseeing appraisals of the Board and its Committees
    - fit and proper person arrangements

3.8 Succession Planning and NED Tenure

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

*For NEDs:*

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

*For Executives:*

- ensuring the leadership of the organisation remains appropriate in consideration of the evolving system developments, collaborative working, talent pool and market forces – working with the Chief People Officer and

Workforce and OD Committee as appropriate
    - Provide support to the Chief People Officer in the appointment process of executive team members as required
    - Reviewing the annual executive succession plan
- Acknowledge that it is for the NEDs to appoint and remove the Acting Chief Executive, and that the appointment of the Chief Executive requires Board approval.
- Be informed of any matters of concern regarding the continuation in office of any Director including the suspension or termination of service of an Executive Director as an employee of the Trust subject to the provisions of the law and their service contract.

3.9 Associate Hospital Managers (AHM)

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

3.10 Board Development

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

## 4 Membership

4.1 Membership of the Remuneration & Nominations Committee will comprise:

- The Non-Executive members of Solent NHS Trust -one of whom will be appointed as the Committee Chair
- The Trust Chair

4.2 In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting. The Trust Chair shall not be the Chair of the Committee.

## 5 Attendance

5.1 The Chief Executive, Chief People Officer and Chief of Staff will be invited to attend the meeting as required to provide advice. No person will be present when the Committee is considering the remuneration, succession or appointment of their respective roles.

## 6 Quorum

6.1 The quorum necessary for the transaction of business shall be three members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

## 7 Frequency of meetings

7.1 The Committee will meet three times a year. Additional meetings can be called by the

Chair.

## 8 Meeting administration

8.1 The Secretary to the Committee will be coordinated by the Chief People Officer with the Committee Chair.

8.2 Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated promptly to all members. Minutes of Committee meetings shall be circulated promptly to all members of the committee.

8.3 The terms of reference will be reviewed annually and the Committee will conduct an annual effectiveness review.

## 9 Reporting responsibilities

9.1 AGM attendance

The Chair of the Committee, or nominated deputy, shall attend the Annual General Meeting prepared to respond to any stakeholder queries in relation to the committee activity.

9.2 Annual Report

Remuneration matters will be disclosed within the Annual Report as per the requirements of the Department of Health and Social Care, Group Accounting Manual.

9.3 Trust Board

The committee will report to the In Public Board on non-confidential matters (for example concerning governance and nominations) and the Confidential Board on all confidential matters.

| | |
|---|---|
| Version | 9 |
| Agreed at Rem Com | |
| Date of Next Review | |