Agenda

Solent NHS Trust In Public Board Meeting

Date: Monday 6 February 2023
Timings: 09:30 – 12:40
Meeting details: Kestrel, 2nd Floor- Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Board Requirement
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive**	Chair	To receive
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
			Register of Interests & Declaration of Interests	Chair	To receive
2	09:35	30mins	**Patient Story** *Lorna Thomas - Community Partner*	Deputy CEO & Chief of Nursing and AHPs	To receive
3	10:05	30mins	**Staff Story** *Our Apprenticeship Programme – Growing and Retaining our own Talent*	Chief People Officer	
4	10:35	5mins	***Previous minutes, matters arising and action tracker**	Chair	To approve
Quality and safety first					
5	10:40	10mins	**Safety and Quality – contemporary matters including:** • **Board to Floor feedback** • **Freedom to Speak Up update**	Deputy CEO & Chief of Nursing and AHPs Chief of Staff	Verbal update
6	10:50	10mins	**Quarter 2 Safe Staffing Report**	Deputy CEO & Chief of Nursing and AHPs	To receive
			10-minute break		

Items to receive					
7	11:10	20mins	**Chief Executive's Report**	CEO	To receive
8	11:30	5mins	**Recent National Publications and Solent's Response**	CEO	To receive
9	11:35	35mins	**Integrated Performance Report** *Including:* • *Safe* • *Caring* • *Effective* • *Responsive* • *People* • *Finance* • *Research and Improvement* • *System Oversight Framework* • *Self-Declaration NHS Provider Licence*	Executive Leads	To receive
10	12:10	10mins	**Information Governance Update**	Chief of Staff	To receive
Reporting Committees and Governance matters					
11	12:20	15mins	**People Committee -** *Exception report from meeting held 26 January 2023*	Committee chair	To receive
12			**Mental Health Act Scrutiny Committee-** *No meeting held to report – next meeting 16 February 2023*	Committee chair	To receive
13			**Audit & Risk Committee –** *No meeting held to report – next meeting 9 February 2023*	Committee chair	To receive
14			**Quality Assurance Committee-** *Exception report from meeting held 26 January 2023* • *Patient Safety Quarterly Report including Learning from Deaths, Serious Incidents and Complaint*	Committee chair	To receive
15			**Non-Confidential update from Finance & Infrastructure Committee–** *non confidential escalation report from meeting held 30 January 2023*	Committee chair	Verbal update

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16			**Charitable Funds Committee –** *no meeting held to report. Next meeting 9 February 2023*	Committee chair	To receive
17			**Remuneration and Nominations Committee –** *Non-confidential update from meeting held 20 January 2023*	Committee chair	To receive
Any other business					
18	12:35	5mins	**Any other business and reflections including:**	Chair	-
19			• ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***	Chair	
20	---	---	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Chair	-

Date of next meeting:

- ***3 April 2023***

Minutes

Solent NHS Trust In Public Board Meeting

Date: Monday 5 December 2022
Timings: 09:30
Meeting details: Kestrel, 2nd Floor- Highpoint Venue, Burseldon Rd, Southampton, SO19 8BR

<table>
<tr><td colspan="2"><u>Chair</u>:
Catherine Mason, Trust Chair (CMa)</td></tr>
<tr><td><u>Members:</u>
Andrew Strevens, CEO (AS)
Jackie Munro, Deputy CEO & Chief of Nursing and Allied Health Professionals (JM)
Dan Baylis, Chief Medical Officer (DB)
Suzannah Rosenberg, Chief Operating Officer (SR)
Shahana Ramsden, Chief People Officer (SRa)
Rachel Cheal, Chief of Staff, Governance & Corporate Affairs (RC)
Nikki Burnett, Chief Finance Officer (NB)
Debbie James, Director of Strategic Transformation (DJ)
Mike Watts, Non-Executive Director (MW)
Gaurav Kumar, Non-Executive Director (GK)
Stephanie Elsy, Non-Executive Director (SE)
Calum Mercer, Non-Executive Director (CMe)
Vanessa Avlonitis, Non-Executive Director (VA)</td><td><u>Apologies:</u>
No apologies to note.</td></tr>
<tr><td><u>Patient Story (item 2)</u> - Virtual
Alice Willis-Ushamba, Patient (AWU)
Ophelia Watson, Experience of Care Lead (OW)
Elaine Peachey, Emergency Planning Lead (EP)</td><td><u>Staff Story (item 3</u><u>) - Virtual</u>
Pat Orosco, Staff Member- Crisis Team</td></tr>
</table>

1	**Chair's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests**
1.1	CMa welcomed Board members and attendees to the meeting. There were no apologies to note.
1.2	The meeting was confirmed as quorate. The declarations of interest form was circulated and there were no updates to note.
2	**Patient Story**
2.1	AWU briefed the Board on experience of receiving the Covid-19 vaccination at Oakley Road. Issues were shared, including being singled out on request for ID leading to uncomfortable and demeaning altercation. AWU shared effect of the experience, particularly differentiation of treatment due to race. AWU informed of support received via initial meeting held with OW and EP to listen to concerns and share experience in order to consider collaborative improvements and learning, including alignment to Diversity and Inclusion. Implemented improvements were shared, including posters and reminder of language/tone of communication.

2.2	CM formally apologised for the experience on behalf of the Board and asked about experience of how the Trust handled the issue. AWU commented on positive discussions held, with experience actively listened to and not dismissed by the Trust. The importance of being able to ensure improvement outcomes and work collaboratively to improve patient experience was emphasised.
2.3	JM commented on communication as a consistent complaint theme and reflected on further work required across the organisation in terms of tone. AS agreed importance of applicability across all services and OW informed of deep dive completed to review across services. SRa commented on potential consideration required in relation to unconscious bias. OW confirmed alignment to Diversity and Inclusion work.
2.4	SE emphasised the importance of acting on issues of racism to ensure clear action and learning, with bias being called out. OW commented on complexities and the need to continue with training and learning collaboratively. The Board agreed importance of learning and ensuring wider improvements across the organisation. **The Board noted the Patient Story.** *AWU & EP left the meeting.*
3	**Staff Story**
3.1	SRa welcomed SO to the Board meeting and introductions were made. SO shared personal background with the Mental Health Crisis Team and high standard of care received as a patient. SO explained her journey of recovery with the support of mental health services, including Solent MIND. The Board were briefed on exemplary support from a care coordinator to challenge and empower SO to re-enter employment. SO shared initial appointment as a peer support worker which encouraged her to re-enter nursing. Training/placements were confirmed and SO commented on experience of constant support and value. High level of learning and support was highlighted which led to progression to a developmental Band 6 role within the Crisis Team.
3.2	SRa reflected on journey from patient to staff member and the hope provided to others that experience mental health issues. CM thanked SO for sharing her story and emphasised the usefulness of lived experience from staff in services. JM agreed and thanked SO for her continued enthusiasm for delivering great care. **The Staff Story was noted.** *PO & OW left the meeting.*
4	**Previous minutes, matters arising and action tracker**
4.1	The minutes of the last meeting held on Monday 3 October were agreed as an accurate record, subject to minor amendment.
4.2	The following actions were confirmed as complete: AC004846, AC004848, AC004849, AC004850 • AC004847 (remote working for community services)- It was agreed to provide a further update at the January Quality Assurance Committee, with update provided to Board via exception. **Action- JM.**
4.3	Matters arising There were no matters to raise.

5	**Safety and Quality – contemporary matters including:** • **Board to Floor feedback** • **Freedom to Speak Up update**
5.1	JM provided a contemporary update in relation to CQC restructure. There were no further escalations to raise.
5.2	There were no Freedom to Speak Up matters to escalate to the Board.
6	**People Strategy**
6.1	Following previous review at Confidential Board, SRa presented the Strategy for In Public approval. SRa explained development, together with services, of 6 people centred priorities combined with the 4 pillars of the NHS People Plan deliverables. Ambitious KPI success measures were shared and ongoing work to refine method for collecting feedback highlighted. Work to launch and embed across the organisation was noted, including People Services Away Day scheduled to comprehensively consider.
6.2	GK queried links to previous ambitions and SRa explained the need to balance ambitions to ensure realistic measures. It was confirmed that the strategy was a 'point in time' document as opposed to a roadmap and usefulness of reviewing 2024 targets at a later stage was acknowledged.
6.3	DB emphasised the importance of the strategy and commented on the need to articulate the value, whether qualitative or quantitative and including in terms of financial benefit, in respect of implementation and positive outcomes. **The Board approved the People Strategy.**
7	**Chief Executive's Report**
7.1	<u>Industrial Action</u> AS provided a verbal update following call for strikes by the Royal College of Nursing (RCN). It was confirmed that 45 providers had been targeted, which excluded Solent. Planning for potential future action was shared and ongoing monitoring of developments assured, despite no national approach in place. The importance of clear and compassionate engagement was emphasised.
7.2	AS presented the CEO report. • Items to celebrate were shared, including Sky Dive charity fund raising activity completed by RC and Jas Sohal (previous Chief People Officer). • AS informed of service closure for the Covid-19 vaccination programme and commented on positive work achieved. It was confirmed that further details in relation to learning would be shared at the Confidential Board. • Significant demand and capacity pressures, particularly within the emergency response area, were explained. Ongoing discussions across the system were reported and links to winter planning noted. • The Board were informed that the Staff Survey had closed, with initial data highlighting high level of responses at 64.5%. Expected 2% increase was explained. • Commencement of building work for development of the Western Community Hospital was shared and it was confirmed that completion was expected by June 2024.

	• AS informed of opening of a staff memorial garden at The Limes in Portsmouth. • An update on Project Fusion was provided and it was confirmed that full discussions would be held in Confidential Board.
7.3	VA asked about potential impact of upcoming train strikes on staff, patients, and outpatients. SR assured that no issues had been highlighted.
7.4	MW queried selection of Trusts for RCN strikes and AS commented on potential reasoning. JM reflected on challenges, learning and ongoing discussions with regional leads. MW asked about support being provided to staff and SRa shared work via the People Team to ensure open and honest discussions. AS emphasised positive and proactive conversations with the RCN and the importance of clear and respectful engagements.
7.5	AS highlighted recent reference to cyber security within a HSJ article and assured of full oversight, with inclusion as the 3rd highest operational risk for the Trust. **The Board noted the CEO Report.**
8	**Integrated Performance Report**
8.1	Safe Regarding Insights- Deaths relating to suspected Suicide, CM queried reporting of cases. JM confirmed that reviews would be escalated through the Quality Assurance Committee governance route, with exceptions reported to Board. GK asked about reporting of 75 deaths in October 2022. It was confirmed that the increase was due to reclassification only.
8.2	Effective AS praised work of the transformation project to relocate Jubilee House to the Jubilee Unit at Harry Sotnick House and effectiveness demonstrated. It was confirmed that the model was being considered for Southampton going forward. CM queried status of cleanliness and hygiene standards and JM confirmed that Infection Prevention Control practices were in place.
8.3	Responsive CM commended improvements in relation to GA waiting times however queried actions being taken to increase activity, particularly in relation to UDAs. SR briefed the Board on current activity, including increased allocation of UDAs from 1 to 5. SR reflected on the impact of increased allocation, particularly in relation to delivery for complex patients. It was noted that the service was on a block contract and therefore had no financial impact. Ongoing work to continue improvements in consideration of Covid legacy was highlighted. It was confirmed that targets were being introduced and SR shared vacancy and performance issues being reviewed. MW asked about performance measures in terms of UDAs and ongoing work with the BI team was highlighted. CM agreed usefulness of inclusion of target trajectory.
8.4	Regarding Estates, the Board were informed of meeting with NHS Property Services in relation to challenges at the Royal South Hants Hospital site. Positive feedback was provided.
8.5	AS reported ICB confirmation that the Trust could take over the Oakley Road site, with strategic discussions in terms of the free hold expected.

8.6	CM asked about delivery of school age immunisations and vaccinations. JM commented on improvements made and continued monitoring.
8.7	People NB queried differing target levels detailed within the report and the People Strategy in relation to sickness/turnover. It was agreed to review as part of the Workforce Report at the People Committee. **Action- SRa.**
8.8	System Oversight Framework CM requested clarity on scoring and potential planning required. An overview of targets were provided and potential usefulness of benchmarking highlighted. The importance of follow up, particularly in relation to diagnostics was emphasised.
8.9	There were no specific escalations to highlight in relation to: • Caring • Finance • Research and Improvement • Self-Declaration NHS Provider Licence **The Board noted the Integrated Performance Report.**
9	**Health & Safety Annual Report and Statement of Intent**
9.1	NB presented the annual report and shared key highlights. • It was confirmed that there were no statutory failures in terms of adherence to policy. • A small increase in incidents was reported, however no underlying issues had been identified following review. • Regarding security, NB explained incidents reported and learning identified. • There were no issues to raise in terms of fire management. • Continued issues in terms of maintenance were highlighted, however positive investment was confirmed with risk-based prioritisation in place. • The Board were informed that the Statement of Intent had been signed.
9.2	AS assured the Board that the fire risk assessment detailed regarding Maples Ward had been completed and issues fully resolved.
9.3	CMe requested that colour ratings were also indicated in text for accessibility purposes.
9.4	CM queried statement of general compliance stating that no independent auditing had been completed. The Board were assured that PWC had completed an audit as part of their annual plan and a good rating was achieved. **The Health & Safety Annual Report was noted.**
10	**People Committee -** *Exception report from meeting held 17 November 2022*
10.1	MW presented the Committee Exception Report. • Extensive work in relation to Workforce Data Insights was shared. Consideration of methodology and resources were explained. • The Equality Delivery System Report was reviewed and importance of focus on impact and linking to QIR Group was noted. • Positive feedback from the Health and Wellbeing Plan was reported.

	• An update in relation to Workforce Sustainability was shared and the need to increase resourcing within the Bank Staffing Service was emphasised. NB queried correlation of enhancing resource to increase fill rates and potential further service review required. SRa briefed on direct engagement undertaken and review being held considering the correlation of data sets, with intention to identify reduction in agency/fill rates. **The Board noted the People Committee Exception Report.**
11	**Mental Health Act Scrutiny Committee-** *Exception report from meeting held 03 November 2022*
11.1	**The Board approved the Mental Health Act Scrutiny Committee Terms of Reference.**
11.2	VA provided an update on Committee activity. • A reduction in Deprivation of Liberty (DoLs) cases were reported. • National delays in relation to Mental Capacity Act amendments were confirmed. • Regular updates in terms of restraint and seclusion was provided, with particular focus on assurance following recent Panorama programme. • VA informed of attendance at Southern Health NHS Trusts upcoming equivalent Committee and noted feedback to follow. • It was confirmed that GK would be taking over membership at the Committee following CMs departure, with training to be provided. Further opportunity for full Board training was highlighted. **The Mental Health Act Scrutiny Committee Exception Report was noted.**
12	**Audit & Risk Committee – Exception report from meeting held 03 November 2022**
12.1	Key business was shared, including update provided on New Starter Internal Controls. Assurance of robust process and monitoring was emphasised. **The Board noted the Audit & Risk Committee Exception Report.**
13	**Quality Assurance Committee-** ***Exception report from meeting held 24 November 2022***
13.1	VA presented escalations from the Committee. • Assurance was provided via detailed Pressure Ulcer Briefing, including ongoing activity and monitoring. • Positive increase in Freedom to Speak Up concerns were confirmed and ongoing consideration of triangulation with incidents and complaints shared. • It was noted that full discussions in relation to inpatient concerns would be raised at Confidential Board. • Discussions regarding staff parking issues were highlighted and triangulation with the People Committee was confirmed. NB briefed on discussions held with the estates team/senior leaders and it was agreed to review further at execs, with an update in the next CEO Report to ensure issues addressed and assurance provided at Board level. **Action- AS.** **The Board noted the Quality Assurance Committee Exception Report.**
14	**Non-Confidential update from Finance & Infrastructure Committee–** ***non confidential escalation report from meeting held 28 November 2022***

14.1	There were no items to raise in public.
15	**Charitable Funds Committee – *Exception report from meeting held 09 November 2022***
15.1	GK briefed the Board on key activity from the Committee. • Formal thanks were given to RC and Jas Sohal for their Sky Dive fund raising activity, which raised circa £1921.00, and marked the re-launch of the charity's branding. • It was confirmed that DJ had joined as the new executive sponsor for the Committee. • Decision not to proceed with the NHS Charities Stage 3 application was highlighted. • Justification was given as to why the charity could not support the establishment of a staff hardship fund. SRa requested further consideration at exec level to fully explain benefits and revisit decision made. **The Charitable Funds Committee Exception Report was noted.**
16	**Non-Confidential Report from - Remuneration and Nominations Committee –** *Exception report from meeting held 11 November 2022*
16.1	**The updated Remuneration and Nominations Committee Terms of Reference were noted by the Board** *(previously approved by the Board).*
16.2	An update from the inaugural meeting was provided, including planning for Interim Chair, membership workarounds and succession planning.
16.3	**The Trust Standing Orders and Scheme of Reservation and Delegation were approved by the Board.**
17	**Any other business and reflections**
17.1	CM recorded formal appreciation for the opportunity to Chair Solent NHS Trust and thanked the Board for their support. It was confirmed that MW would be taking over as Interim Chair from January 2023. AS noted formal thanks to CM for all of her work as Chair and shared well wishes.
18	**Lessons learnt and living our values** **Matters for cascade and/or escalation to other board committees**
18.1	No other business was discussed and the meeting was closed.
19	**Close**

Action Tracker

Overall Status	Source Of Action	Date Action Generated	Minute Reference/ Additional URN	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
On Target	Board meeting - In Public	05/12/2022	4.2	AC004997	In Public Board- Action Tracker	Regarding action AC004847 - (*Effective (reduced capacity due to vacancies) - The need for co-ordination across the ICS was highlighted and JM commented on further work to consider innovative remote working for community services. It was agreed that JM review further with Clinical Directors and Heads of Quality & Professions to understand potential opportunities. Action- JM.)* - **It was agreed to provide a further update at the January Quality Assurance Committee, with update provided to Board via exception. Action- JM.**	Jackie Munro	
On Target	Board meeting - In Public	05/12/2022	8.7	AC004998	In Public Board- Integrated Performance Report	People- NB queried differing target levels detailed within the report and the People Strategy in relation to sickness/turnover. It was agreed to review as part of the Workforce Report at the People Committee. **Action- SRa.**	Shahana Ramsden	
On Target	Board meeting - In Public	05/12/2022	13.1	AC004999	In Public Board- Quality Assurance Committee Exception Report	Discussions regarding staff parking issues were highlighted and triangulation with the People Committee was confirmed. NB briefed on discussions held with the estates team/senior leaders and it was agreed to review further at execs, with an update in the next CEO Report to ensure issues addressed and assurance provided at Board level. **Action- AS.**	Andrew Strevens	

Item No.	6		Presentation to	In Public Board Meeting		
Title of paper	Quarterly Safe Staffing Report Quarter 2 July - September 2022					
Purpose of the paper	This report provides an overview of the Nursing & AHP safe staffing status for the period July - September 2022 and is set out in line with the National Quality Board (NQB) stand					
Committees /Groups previous presented and outputs	QIR Meeting and 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 Board is asked to: • Following review of workforce metrics, quality indicators and divisional commentaries the staffing levels across the nursing & AHP workforce in Solent NHS Trust were deemed as safe. • Note the continuing development of the safe staffing report and the ongoing work to improve the approach to safe staffing and improve reporting matrix. The Q2 report moves to a quarterly view as opposed to a monthly view. Therefore, future reports will provide quarterly comparison.					

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

Executive Summary

This report provides Trust Board with an overview of the Nursing & AHP safe staffing status for the quarter 2 period July – September 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/service 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 Committee is asked to note the current reported position and to endorse the action being taken to maintain and monitor safe staffing levels across the organisation.

Quarter 2 continued to be challenging for all services. Safe staffing and patient safety were managed effectively by reviewing caseload and flexible working. The impact of the outbreaks was managed effectively.

Within the inpatient areas, there has been a reduction in the numbers of registered nurses and a corresponding rise in vacancies. It is noted that we have seen an increase in our internationally educated nurses from adult inpatient areas moving to the acute sector.

Short notice absence is an area of concern within Jubilee and Kite and will continue to be monitored and managed by services within individual service line assurance frameworks.

Community Nursing across both cities remains a concern and service lines continue to explore how recruitment strategies can be employed to generate interest and career development pathways

Following review of workforce metrics, quality indicators and divisional commentaries the staffing levels across the nursing & AHP workforce in Solent NHS Trust were deemed as safe during this period and where there were concerns mitigations were put in place.

1. Background

1.1 Solent NHS Trust has a duty to ensure staffing levels are adequate so that 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).

1.2 This report provides inpatient data published and now includes Care Hours Per Patient Day (CHPPD) data. The significance of this data and its inclusion will be developed further in subsequent quarterly reports.

1.3 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. Overview of reporting period

Safe staffing meetings have continued during this reporting period, however due to the impact of annual leave there was no meeting held in August. Daily huddles within individual services were maintained and concerns escalated via the service line assurance framework as deemed necessary.

There were little to no national restrictions from an infection prevention perspective regarding Covid however, it is noted there were 4 outbreaks within the quarter relating to Brooker, Fanshawe, Lower Brambles and Spinnaker.

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.

In July, the Crisis Resolution Home Treatment (CRHT) team had stabilised following a series of interventions and actions from the team and Senior Leadership within MH and the weekly safe staffing meetings were discontinued with the cavate to be re-instated as required.

It is noted that concerns relating to patient and staff safety and wellbeing were raised throughout September within the MH Acute Admissions Ward. The concerns predominately related to skill mix and knowledge base, acknowledging there has been multiple new starters to the clinical areas across both the registered and unregistered workforce throughout 2021 / 22 and 2022 /23. An extensive review and rapid improvement programme have been introduced and will continue to be monitored within the assurance framework. Consequently, throughout Q3 MH inpatients and CRHT will move to a weekly safe staffing meeting schedule.

Also in July, Brooker moved to a period of focused safe staffing support for two weeks because of a higher than average percentage of annual leave being granted coinciding with a Covid outbreak. Whilst a challenging period, the ward leader took remedial action and was able to assure that staffing remained safe throughout.

HCSW retention and recruitment continues to fluctuate, with vacancies in inpatient wards within Southampton rising. A focused HSCW recruitment event has been scheduled for Q3 with planning underway in Q2, in addition to a wider recruitment event for all staff groups.

Mental Health and CAMHs services continue to report challenges with staffing and the increasing demand for services. Focused work has begun to develop a CAMHs Academy to attract and train nurses who wish to develop a career in CAMHs, this is predominately focused on the international cohort of nurses.

Community Nursing across both Southampton and Portsmouth continues to be challenged with vacancies across registered posts, impacting upon case load management. Tools to support the allocation of work have been introduced across both cities and the introduction of a community focused acuity and dependency tool will be implemented throughout Q3 and Q4.

3.0 Workforce

3.1 The following section of the report demonstrates the adult inpatient workforce skill mix and usage of temporary staffing at the end of Q2. This includes unavailability matrix and Care Hours Per Patient Day (CHPPD).

3.2 Table 1 below shows the skill mix and where temporary staffing has been utilised by ward %. It is acknowledged that during the reporting period, additional bed capacity had been utilised throughout the organisation predominately within the Portsmouth system in response to the Pandemic and system challenges. In addition, patient complexity would have impacted upon staffing in relation to increased observation requirements.

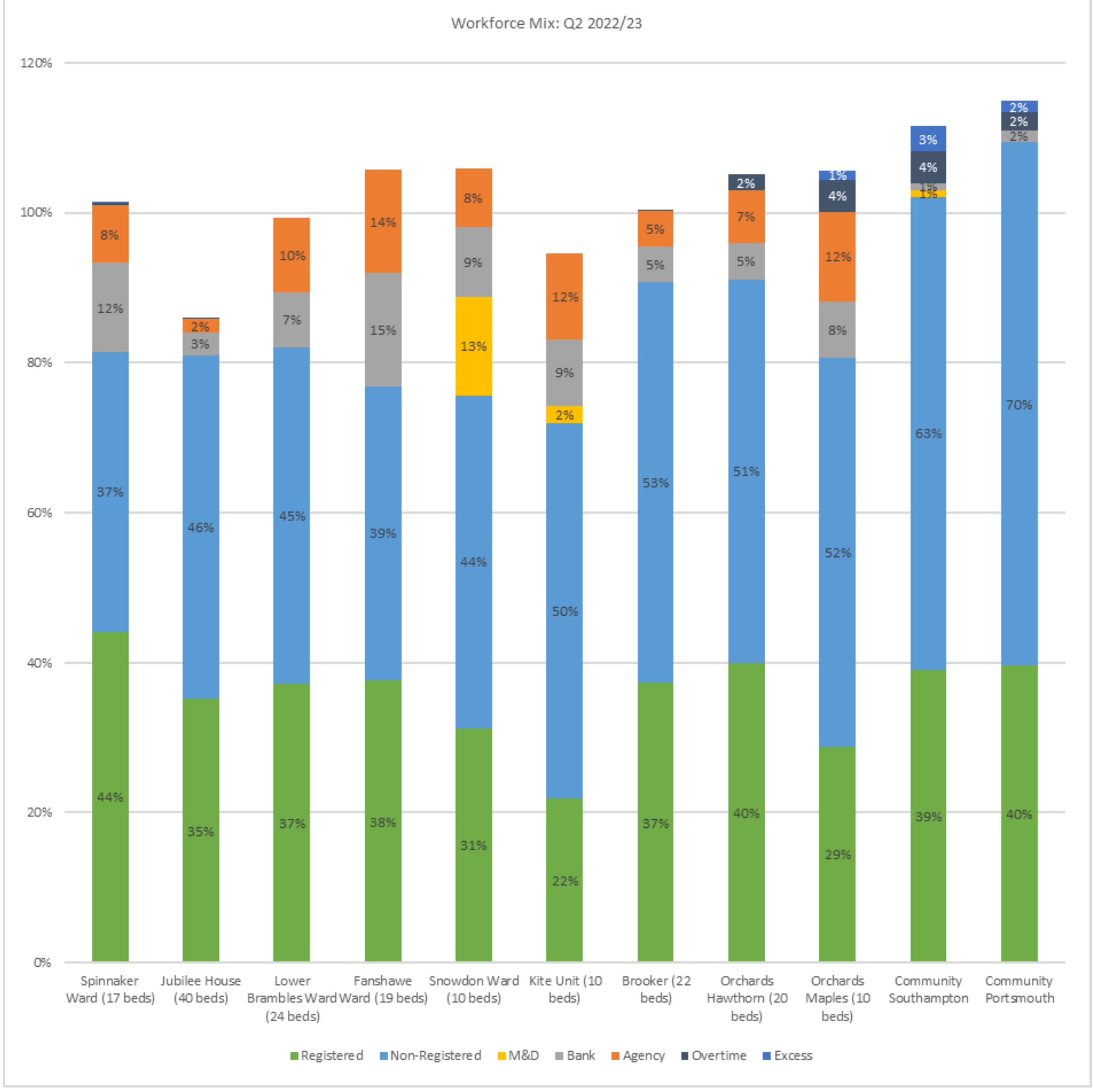


Table 1 Workforce by ward by % within the reporting September 2022

3.4 The data for Q2 in comparison from Q1 shows Jubilee has moved into under-staffed due to a reduction in bed capacity in preparation for moving to the new unit, whilst the Orchards now shows an over 100% staffing due to supernumerary staff.

Fanshawe has seen a reduction in the % of its workforce coming from registered nurses due to several resignations which are being reviewed. The ward remains safe through the use of additional hours and temporary staffing. With the exception of Fanshawe and Spinnaker, there has been a slight reduction in temporary staffing across the other inpatient areas.

4.0 Care Hours Per Patient Day (CHPPD)

4.1 CHPPD is calculated using the daily staffing numbers and the daily patient count at midnight and then 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. It is worthy to note that there is no option within CHPPD data

to benchmark nationally or a best practice %. The comparison, alongside professional judgement occurs locally and with reference to previous individual wards data.

4.2 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 and will form part of the Workforce Development Programme.

4.3 Table 2 below demonstrates the CHPPD by ward for the reporting period. There is little significant variance within the quarter, with a slight decrease within Maples and despite reduction in % staff from registered Nurses, Fanshawe shows no decline in its CHPPD metric. It is noted that the wards which have similar bed capacity and patient profiles have only slight variation in the registered and unregistered CHPPD which would suggest consistency across our similar wards. We would also expect our PICU, Maples, to have a higher percentage from other areas due to the nature of the care provided.

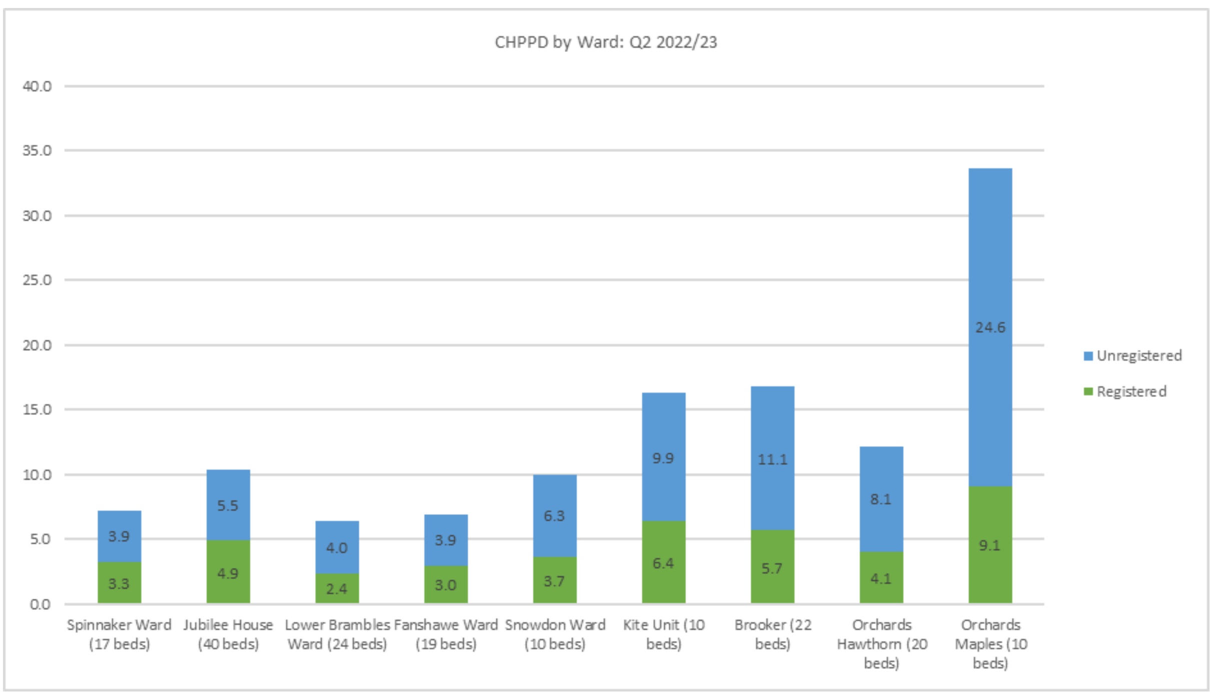


Table 2 CHPPD by ward for September 2022. Please note there is an error in the commissioned capacity for Jubilee within Q2. This should read 12.

5.0 Non-Productive / Unavailability

5.1 A key factor in managing safe staffing is the management of the unavailability of staff to support the roster period. Currently, the trust target for non-productive working is set at 22%, however within this 22% there are specific trust targets for annual leave, study leave and sickness.

A roster is a tool that is used to ensure that the right people with the right skills are in the right place at the right time, to meet the demands of the service whilst considering staff numbers, capacity, capability, adequate rest and headroom.

5.2 The data in table 3 below shows unavailability by theme and will support comparison against key performance indicators as listed within the eRoster Policy (2020) appendix A.

5.3 The Q2 data shows that short notice absence rates doubled from Q1 in both Jubilee and Kite, there was a notable surge in cases of Covid across our communities at this time which may account

for this rise. There is a significant increase in annual leave within Lower Brambles and there was a 50% reduction in study leave within Maples. It is acknowledged that the reporting period includes the summer school holiday period, which may account for higher than average leave. Within the monthly safe staffing meetings ward leaders have been reminded of the importance of annual leave management and to consider the impact of the additional leave / carry over accrued during the Pandemic.

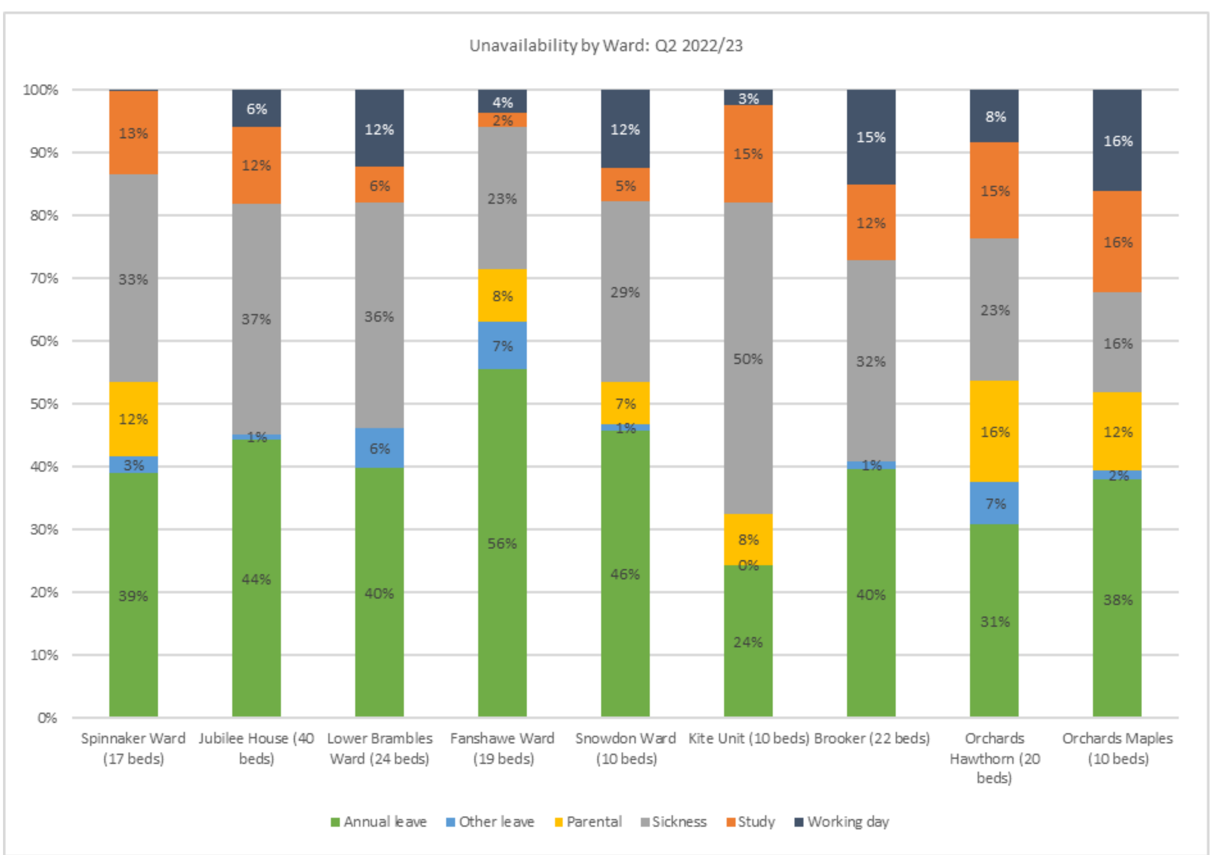


Table 3 Unavailability by ward for Q2 2022

6.0 Recruitment and Vacancies

6.1 International Recruitment (IR) continued throughout the reporting period and an additional 10 RMNs joined the Trust in Q2, with 3 RMNs due to arrive during Q3.

6.2 As a consequence of the challenges within the MH Inpatient wards, the difficult decision to pause international recruitment for a period to support the interventions and rapid improvement programme has been made. As part of the rapid improvement programme, an extended education programme has been developed with the aim to provide enhanced physical and mental health skills sessions in a concentrated programme. These elements would normally be delivered within the ward induction however, it was felt the enhanced programme delivered over an 8-week period would be beneficial and support the transition of international staff to working in the NHS. With agreement from NHS E and the service Senior Leadership the remaining 7 RMNs will arrive in late Q4 and once enhanced programme completed, will join their wards within Q1 2023 /24.

6.3 For 22/23, the international recruitment target for Community Nurses (both Adult Community and Inpatient areas) is 24. The Trust remains on target to achieve this by the 31st of December 2022. The team are working with Hampshire Hospitals Foundation Trust to provide the OSCE training and following completion the nurses will enter the Community Transition Programme. The 2nd cohort of Community Nurses will be arriving within Q3 as expected with 3rd cohort planned for December 2022.

There has been discussion with both Adults Portsmouth and Southampton Leadership Teams to see how the programme can be utilised for any nurse whether an international or UK based recruit who are new to community posts. This is seen as a positive step to encourage transfer of skills where there are concerns about the transition from acute to community and the need to work in a more autonomous model of care. The table below shows the number of expected international nurses by wte by quarter.

Wte	**Q1 target Apr-June**	**Q1 Arrivals**	**Q2 target Jul-Sept**	**Q2 arrivals**	**Q3 target Oct - Nov**	**Q4 Target**	**Total**
RMN	4	4 *(3 from 2021 bid)*	6	5	6	8	20
Community					24		24

Table 4 Achieved and projected IEN recruitment Q2 /Q3/Q4 by wte

6.4 Within the quarter, it is noted a further 5 of our 21/22 internationally recruited nurses are leaving and / or considering leaving the organisation, totalling 8 across Q1 and Q2 equating to 13% of our international arrivals (61). Initially our leavers were predominately from our Mental Health cohort however, we are aware our leavers are now focused within our adult inpatient wards. The overarching theme for leaving is cited as cost-of-living increases, to join family internationally and to move to work in the acute care settings. In collaboration with our ICS Lead for Workforce and the NHSE Team we are reviewing the trend across other organisations to identify if we are an outlier in this regard.

In order to support the challenges within housing, the HIOW Housing Hub are linking with our international staff to signpost and support. The International Recruitment team continue to work closely with all the nurses and signposting all staff to appropriate support.

Our first community nursing cohort completed their Community Transition Programme and are now settled within their teams. We continue to face challenges with access to timely driving test due to the backlog as a result of the pandemic. The international recruitment team continue to liaise with community colleagues to identify an interim solution to the issue.

6.5 It is acknowledged that the ability to recruit and retain community nurses across all bandings continues to be extremely challenging for services across both Southampton and Portsmouth and is in line with the national picture. This is monitored / reviewed within safe staffing meetings, with additional focus and support when required.

6.6 Table 6 below shows the vacancies as a percentage by registered and non-registered staff. Within the quarter there has been an increase in vacancies within both Fanshawe and Jubilee. Due to reliance on additional hours and temporary staffing this has been mitigated with no impact on patient care within Q2, however it is accepted in the long term this could have a potential impact on staff wellbeing.

Unfortunately, at the time of reporting it was not possible to record the vacancies within the community services however, this will be addressed in future reports as well as comparison between quarters.

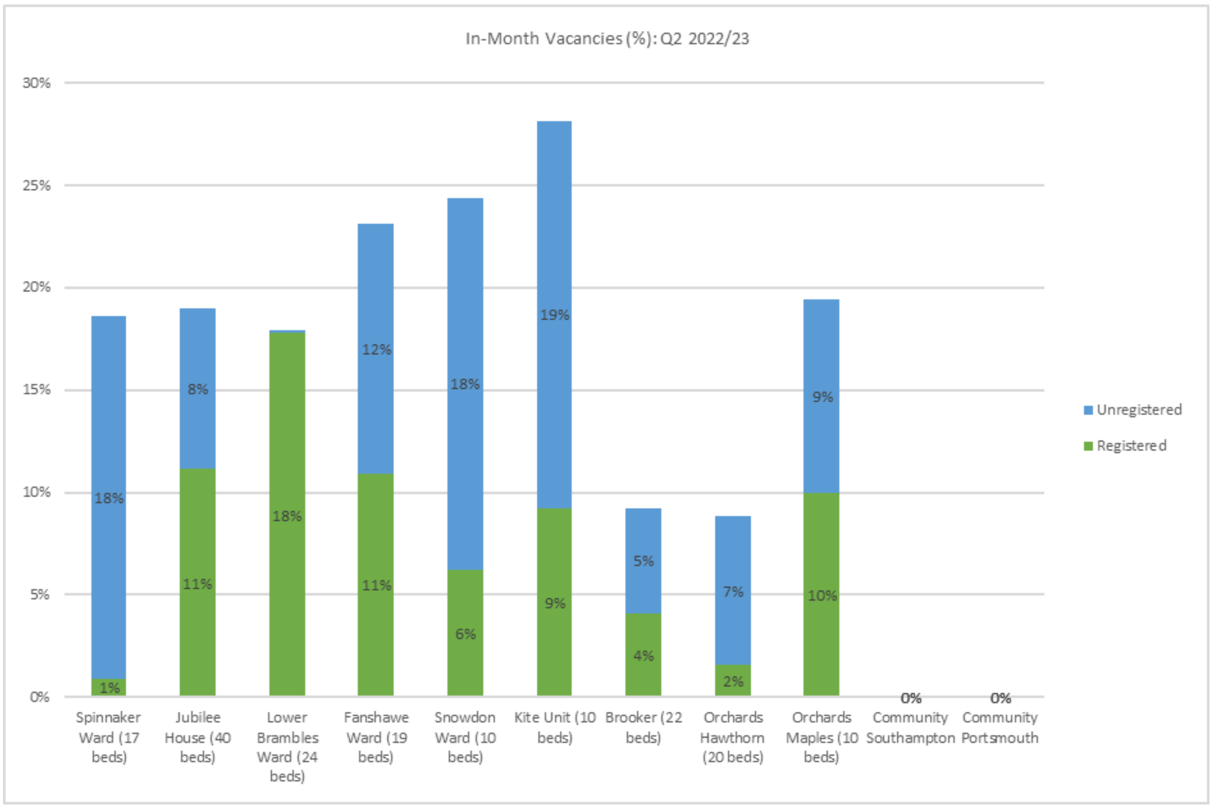


Table 5 Vacancies as a percentage by registered and non-registered staff for Q2 2022

7.0 Acuity & Dependency

7.1 Acuity and Dependency tools provide an evidenced based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure nursing establishments reflect patient needs. Within the reporting period, there has been further communication with national teams about acuity and dependency tools and licence.

7.2 It is anticipated within Q3 the Mental Health inpatient wards will receive the Mental Health Optimal Staffing Tool (MHOST) training and there is a programme of cascade training for the Community Nursing Safe Staffing Tool (CNSST) within Q3 /Q4.

7.3 Whilst there is a plan for the adult inpatient wards to complete the Safer Care Nursing Tool (SCNT) training, there is an update to the tool due imminently and therefore this will progress in Q4 and into Q1 of 23/24, dependant on progress by the national team.

8.0. Safety and Quality Incidents / Nurse Sensitive Indicators (NSI)

8.1 Nurse Sensitive Indicators (NSIs) refer to quality indicators that can be linked to nurse staffing issues, including leadership, establishment levels, skill mix and training and development of staff. This information can be used to further support ward staffing requirements identified through acuity and dependency measurement. The NSIs support identification of whether there has been any adverse impact because of below planned staffing numbers.

8.2 The NSIs / incidents are reported within the quarterly Patient Quality and Safety report and by individual services via their assurance framework. For the Safe Staffing report, incidents directly

relating to staffing levels affecting patient care and affecting staff will be identified. The tables below indicate the number of incidents within the reporting period.

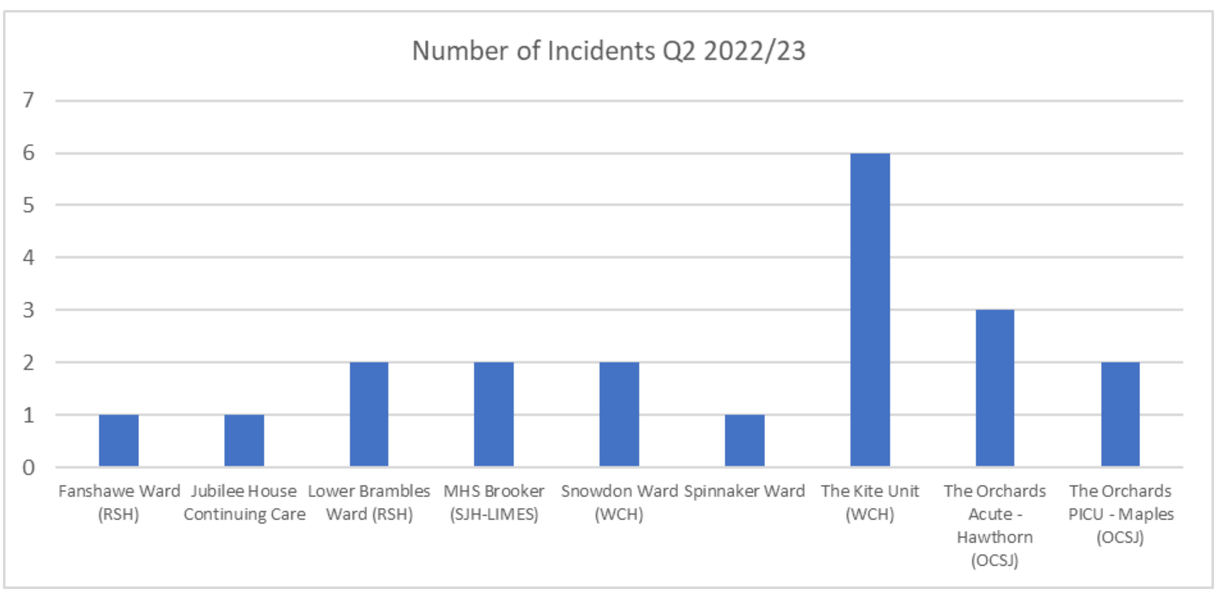


Table 6 Number of incidents for Q2 2022/23 citing staffing affecting care & staff

8.3 Of the incidents reported in relation to staffing levels, 5 were identified as having cause 2 as staffing levels affecting patient care. Three related to adult inpatient care within Southampton stating there was a reduced RN availability on a shift. Escalation and mitigation were in place and no further clinical incidents were reported with no significant harm identified as a consequence.

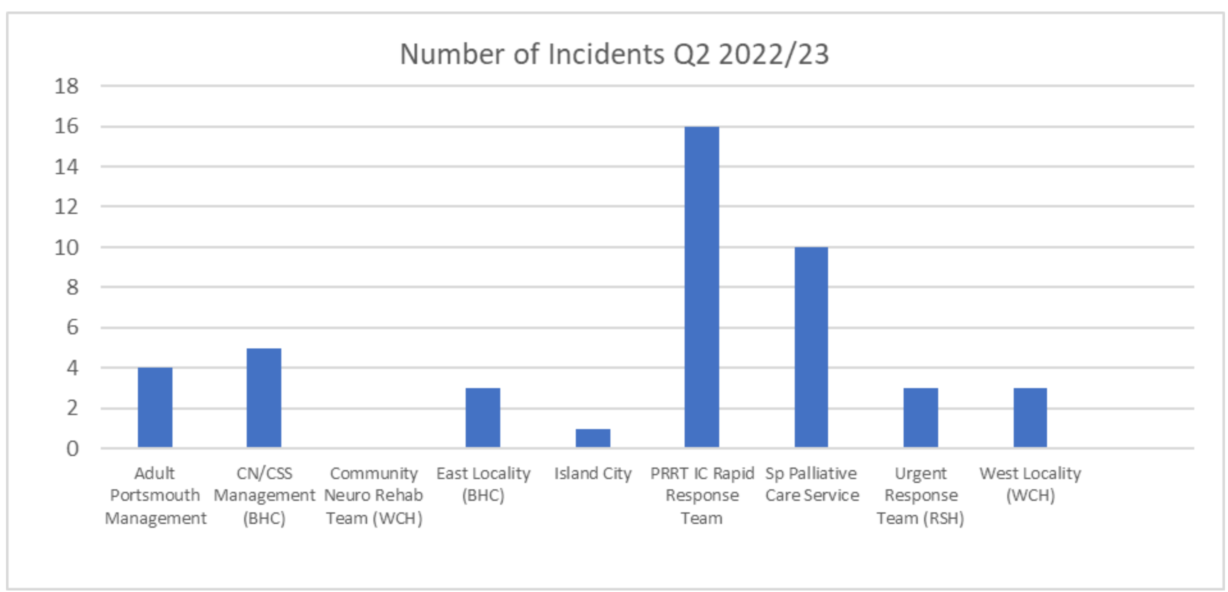


Table 7 Number of incidents for Q2 2022/23 citing staffing affecting care & staff within Community Nursing incidents

8.4 The incidents across the community teams directly stating staffing level affecting patient care and staffing total 22 across Q2. Of the incidents:

- 12 related to reduced staffing capacity and rescheduling visits across a week period
- 2 relate to challenging / understaffed shift
- 5 relate to breaches against target for AHP assessments
- 1 states recruitment delays
- 1 highlighting impact of admin shortage
- 1 highlighting query from family of patient re visit

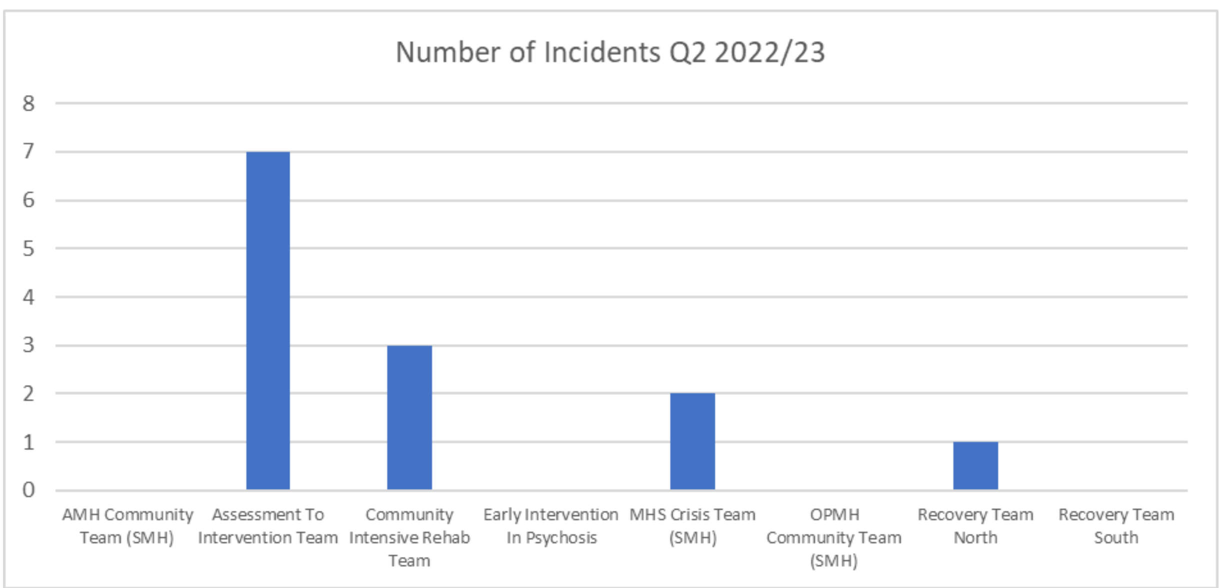


Table 8 Number of incidents within Mental Health Community citing staffing affecting care & staff within Q2 2022/23

8.5 Within the MH Community Teams four incidents were reported during Q2 that identified staffing levels affecting patient / staff by cause 1 and 2. All were reported by the Assessment to Intervention Team throughout August and related to reduced staffing capacity.

8.6 NSI – Infection

Within the quarter Solent NHS Trust has reported 0 incidents in relation to CDI & MRSA BSI

There were 4 outbreaks within the quarter within Brooker, Fanshawe, Lower Brambles and Spinnaker which affected staff availability, but services operated their business continuity plans and where necessary undertook soft redeployment. All outbreaks were supported by the Infection prevention & Control team and were well managed and contained by the clinical teams.

8.7 NSI – Nutrition

Whilst the Safer Care Nursing Tool (SCNT 2018) references Nutrition - number of patients having had nutritional screening per 1000 occupied bed days as an NSI, there have been no incidents reported within the quarter that identify nutrition as a cause, cause 2 and / or contributory factor.

It has been established that all inpatients' wards within Solent NHS Trust offer protected mealtimes and all patients have a MUST risk assessment on admission and every 7 days during their stay. This is audited on a six-monthly basis which identified Solent NHS Trust inpatient wards were compliant.

8.8 In summary, within future reports there will be further development to compare incidents across the reporting periods and identify where the impact of staffing levels has affected patient care and staff.

9.0 . Complaints and Service Concerns

9.1 In order to review the correlation between safe staffing, the receipt of complaints and service concerns, the SCNT (2018) recommends that official complaints about nursing / care staff received (per 1000 bed days) that identify three areas:

- Communication
- Patient care
- Values and Behaviours of Staff

9.2 Table 10 shows during the reporting period and in comparison, to Q1 ADP saw a slight decline in services concerns whilst a slight increase is seen in ADS, but significantly a 50% increase within Mental Health services is noted.

Number of Service Concerns	Q1	Q2
Adults Services (Portsmouth)	9	5
Adult Services (Southampton)	6	7
Mental Health Services	10	15
Total	**25**	**27**

Table 8 – Service concerns for Q2 2022/23

9.3 In Q2, it is noted there was a significant increase in complaints that were made within mental health services. The service saw their number of complaints increase from 1 complaint made in Q1 to 9 complaints made in Q2.

Due to the large increase in the number of complaints in mental health services, the PALs Team undertook further analysis to understand the themes for the complaints in the service. They were:

- 1 complaint related to access to treatment or drugs
- 3 complaints were related to admissions and discharge
- 3 complaints were related to patient care needs not identified and failure to provide adequate care
- 1 complaint was regarding use of restraints
- 1 complaint was regarding staff values and behaviours

With regards to the services, three of the complaints were residential and four were for the IAPT service and 2 for supporting services at St James Hospital.

The increase in both service concerns and complaints with the MH services correlates with the escalations in relation to concerns regarding culture and experience across the MH inpatient areas during this reporting period. A programme of work has been initiated to address these concerns and progress against the agreed actions will be monitored through a project management approach and reported through the formal Trust assurance processes.

10. Risks Escalated to Risk Register in Relation to Safe Staffing

10.1 In order to triangulate safe staffing, it is proposed within future reports to identify where concerns in relation to staffing have been escalated to the Solent NHS Trust risk register. The table below identifies the number of risks currently recorded, where staffing is reported as being below planned levels.

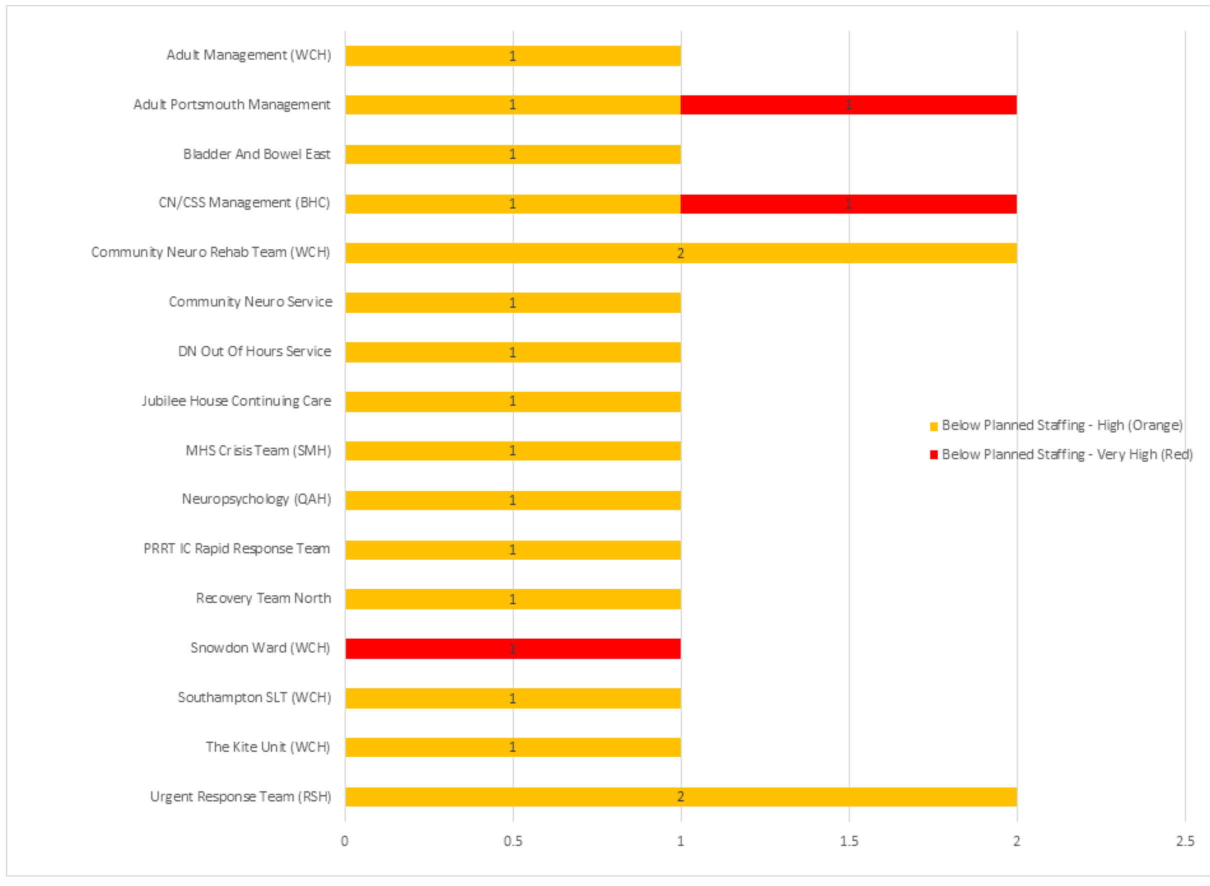


Table 9 Risks citing staffing levels within September 2022 impacting upon patient care / service delivery

10.2 The overarching theme in relation to risks relating to safe staffing are that staffing levels are below planned, potentially leading to sub optimal care. The mitigation is a reliance on both temporary staffing and existing staff undertaking excess hours to ensure the staffing numbers remain with the planned levels.

There are three risks noted to be very high

Very High Risks	
Adults Portsmouth Management	Overarching whole service below planned staffing risk, controls and actions have a focus on staff wellbeing. Currently under review by the service with a view to splitting into two separate patient safety and staff wellbeing risks following discussion at July QIR and July & August QRMs.
CN/ CSS Management (BHC)	Community nursing below planned staffing risk. Daily capacity reviews at morning meetings and RAG rating caseloads and staffing. Recruitment review complete. International recruits expected to be substantive late summer 2022.
Snowdon Ward (WCH)	New inpatient below planned staffing risk. Use of bank and agency. Planning recruitment open day. Team building events for staff to maintain and retain existing staff.

Table 10 Very high risks relating to staffing affecting patient care / service delivery

10.3 The Head of Risk and Litigation meets monthly with Head of Quality & Professions to review current risks, determine mitigation and escalation / de-escalation. These are monitored within individual service line assurance frameworks.

11. Conclusion

In Q2 of 2022/23 workforce concerns relating to safe staffing is the top risk across the organisation.

During the reporting period the safe staffing escalation meetings have reverted to a monthly schedule. However, it was noted that should individual services be particularly challenged with regards to safe staffing and require additional support from the Chief Nurse Directorate, the HR Team and / or health roster team this would be supported. It is noted that within individual services, daily huddles with senior leadership to discuss staffing levels for the forward 24-hour period are in place.

During the reporting period weekly meeting with the Mental Health Crisis Resolution Home Treatment (CRHT) team discontinued however, there was a focus within Brooker ward for a defined period due to additional staffing challenges as a consequence of a Covid outbreak and higher than average levels of agreed annual leave.

Within the acute mental health inpatient ward (Hawthorn) during September, it was noted there were significant concerns raised via the senior leadership team with regard to quality of care and level of experience of both staff and the leadership team. A comprehensive review has been completed and actions are in place. The impact of the interventions will be monitored within Q3 Safe Staffing meetings.

Community Nursing services across both cities continue to be challenged and this has been escalated to the Chief Nurse and specific actions taken in response.

Additional bed capacity continued to be in use throughout reporting period particularly within the Portsmouth system and Quality Impact Assessments had been completed.

The planning continued for the closure of Jubilee House within Q2 and the uncertainty regarding the transfer to the new facility continued to be an area of concern particularly in relation to its possible impact on staff turnover, recruitment, and retention.

Item 7

CEO Report – In Public Board

Date: 23 January 2023

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.

Section 1 – Things to celebrate

Western Community Hospital demolition

Just before Christmas, demolition work started to make way for the new rehabilitation unit at Western Community Hospital in Southampton. The modern, purpose-built unit will replace two existing rehabilitation wards currently at the Royal South Hants Hospital in Southampton, will increase the number of beds available from 43 to 50, and will more than double the number of single rooms with en-suite facilities. Our Chief Executive, Andrew Strevens, and Chief Finance Officer, Nikki Burnett, donned their hard hats on site to mark the project milestone.

New digital service

An important first step towards transforming healthcare services is looking at how we can improve our digital experiences within Solent to make working lives easier and helping to release more time to care by providing a better IT service for our people and teams.

In late December, Solent welcomed the launch of its new digital service, supported by new suppliers; Atos and Exponential-E. To date the Trust has seen the introduction of a new helpdesk and service portal, with the imminent deployment of new networks, IT systems and tech bars across our sites.

Recruitment events

A range of recruitment events have taken place across Portsmouth and Southampton over the past few months, with more planned to attract people with a range of clinical skills and interests. Some of the events so far have been aimed at engaging with students who might be considering a healthcare career.

Frailty virtual wards pilot

In January we started a 6-month pilot which will trial digital technology for patients across Portsmouth and Southampton with frailty needs, delivering high quality, personalised care at home and helping reduce hospital admissions.

The pilot will focus on people aged 18 and over with suspected or known frailty, who are admitted on to the programme once they have been assessed by the Trust's urgent response teams.

Solent is collaborating with Doccla, who will provide various healthcare remote monitoring devices such as blood pressure monitors and pulse oximeters, tailored to each patient's clinical requirements.

Heart Awards

Since relaunching Solent's Heart Awards in November, there has been a fantastic response by colleagues to nominate individuals and teams for the work they are doing. To date, there has been hundreds of nominations, with the awards panel sitting regularly to decide winners each month, and occasions set up to present the winners with their certificates.

Pictured left - The Jubilee unit recently won the Heart Team of the Month (for November) award.

Section 2 – Internal matters (not reported elsewhere)

Board appointments

At the end of December 2022, we said farewell to our colleague and former Chair, Catherine Mason. Catherine joined us back on 1 April 2019 and brought a wealth of knowledge and expertise, leading the Board and supporting the Trust during what has been incredibly challenging times. Catherine remains the Chair of Community Health Partnership. I wish to personally convey my thanks to Catherine for her unwavering commitment to Solent during her tenure.

From 1 January 2023 we welcomed Mike Watts as our Acting Chair.

Mike was appointed in October 2016 as one of our Non-Executive Director colleagues and was previously our Deputy Chair. Mike went to school in Southampton, is a Hampshire resident and has an extensive and wide-ranging track record in organisational design and development that has driven business performance. Mike is currently the lead consultant with Capability and Performance Improvement Ltd of which he is a co-owner. He has previously held senior HR roles at Southampton City Council, and the Chartered Institute of Professional Development, Cabinet Office, Lloyds TSB and Scottish Widows. During his time in the Cabinet Office, Mike was recognised by HR Magazine as one of top 30 influencers of HR practice. He has also held a previous Non-executive Director role with the Scottish Executive. We warmly welcome Mike to his new appointment.

Great Care

Safety matters

Royal College of Nursing (RCN) industrial action- 18 & 19 January

Teams from across the Trust diligently prepared for the impact of c120 Solent members of staff taking part in industrial action as RCN members and supporters. It was important that the nursing voice was respected and heard, with staff welfare supported on the picket line at St Mary's as well as in the clinical areas across the Trust. At the time of writing the report no patient harm was identified. A verbal update will be provided at the Trust Board meeting.

Everyone's work ensured that Team Solent felt well informed and supported, and that the Trust's values really stood out – positive feedback was received. We now await the outcomes of further union ballots to see if Solent will be involved in future industrial action.

Demand and Capacity

Contemporary update urgent care and Winter pressures

Since the last report to Board there has been very little change to the system wide winter pressures. Over the Christmas period the HIOW System declared a Critical Incident twice in response to the number Critical Incidents called by individual Trusts (Acute and Ambulance). Solent's community services remain on Opel 4 with all its surge bedded capacity open, increased utilisation of virtual ward and urgent community response capacity and a higher that usual sickness rate. Community Services in both cities have had to refocus staff from scheduled specialist services (limiting contacts to those at most risk) to prioritise urgent on the day response services and keeping patients safe and well in their homes to prevent unnecessary admissions. Thoughts are now turning to how surge capacity can be de-escalated safely over the coming weeks.

Great Place to Work

Workforce matters

Cost of Living

We continue to provide a comprehensive offer to staff to support them through Cost-of-Living challenges through our Vivup portal which enables staff to access discounted food and household goods. Our Health and Wellbeing plan ensures that we offer proactive mental health support to people who work at Solent.

Vaccinations

Flu Vaccination compliance currently at 71%. The trust has achieved a high compliance percentage this year despite challenges experienced across wider trusts citing a high rate of declines, cancellations and demand pressures impacting on attendance. We continue to offer further clinics and a wide variety of flexible options to support staff to receive their Flu vaccine.

Workforce planning

The People team are working closely with services and finance colleagues to consider our workforce plans for the next financial year, which will include resourcing plans for different entry levels into careers in the NHS and further qualifications for our staff, e.g., advanced clinical practice. Focusing on retaining our talent and developing skills will be a key focus for us.

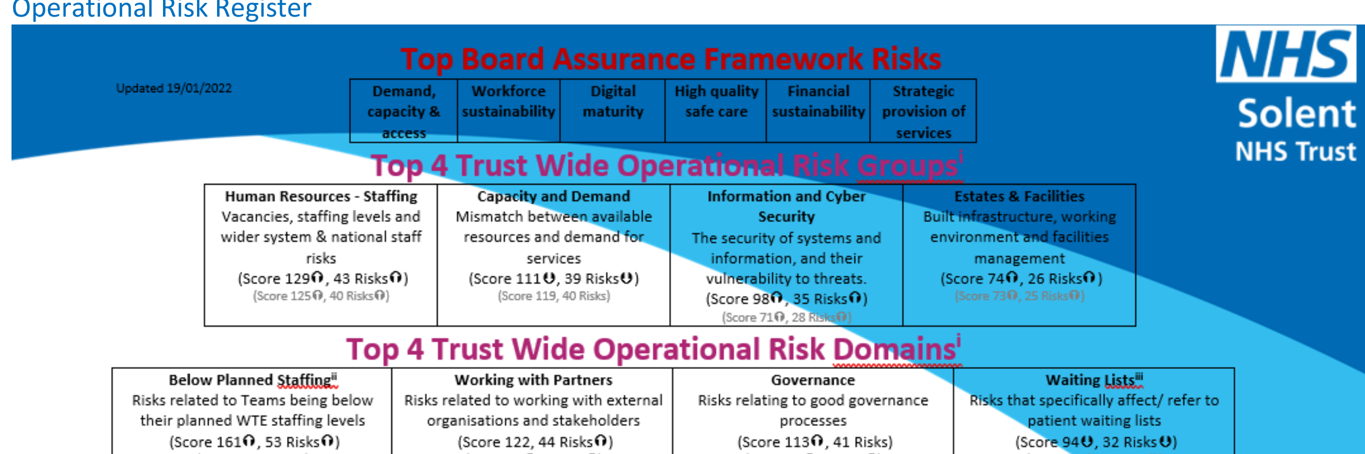
Great Value for Money

Estates and infrastructure

There are no additional matters to highlight to the Board – details can be found within the Performance Report

Our key risks

Operational Risk Register



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

1. Human Resources – Staffing
2. Capacity & Demand
3. Information and Cyber Security
4. Estates and Facilities

Our top Risk Domains are:

1. Below Planned Staffing - the most prevalent risk
2. Working with Partners
3. Governance
4. Waiting Lists

All operational risks are being actively managed through our care and governance 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	S5 x 4L = 20	S4 x L4 = 16 – by End July 2023
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 2022/23
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 L3 = 9 – by 1 April 2024
Risks removed from active BAF monitoring			
Strategic Partnerships	S5 x L4 = 20	S4 x L4 = 16	S4 x L3 = 12 **Risk suspended – incorporated into #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 **Target score achieved**

Section 3 –System and partnership working

Clinical Delivery Group Update

The Clinical Delivery Group (provider collaborative) met on 15 December and received an update on the No Wrong Door Programme, which focuses on the delivery and implementation of the National Community Mental Health Framework and were briefed on the complexities associated with progress within the Acute Mental Health Bed workstream. The group also acknowledged the current demand, capacity, winter and wider system pressures which are currently impeding the delivery of all clinical work programmes and potential risk for duplication of transformation work within the HIOW system.

Project Fusion

Project Fusion is progressing well. Partner Trusts are currently drafting the Strategic Case, which will set out the case for change, the options appraisal, the initial financial assessment, the clinical strategy and the benefits for patients, communities, our workforce and the system that could be realised by establishing a single, new community and mental health provider for Hampshire and Isle of Wight. A final version of the Strategic Case is due to be presented at all partner Trust Boards in March. This will enable partners to make the decision as to whether to invest in developing a full business case, which will include detailed plans for a new organisation. The Strategic Case is due to be considered by NHS England in April/May. Key to the work we are doing together now, and as we progress, is making sure patients are front and centre of our approach, which will be clinically-led, transparent, and inclusive. Detailed engagement will continue through finalisation of the strategic case and development of the full business case, to day one of the new organisation, and beyond. We will seek to understand more about what a great community and mental health organisation looks like for users of our services, their families and carers and now and into the future.

<table>
<tr><td>Item No.</td><td>8</td><td>Presentation to</td><td colspan="3">In Public Board</td></tr>
<tr><td>Date of paper</td><td>13 January 2023</td><td>Author</td><td colspan="3">Sandra Glaister, Head of Corporate Assurance</td></tr>
<tr><td>Title of paper</td><td colspan="5">Recent National Publications and Solent's Responses</td></tr>
<tr><td>Purpose of the paper</td><td colspan="5">The aim of this paper is to present recently issued national letters and guidance and the Trust's responses and actions and provide assurance to the Board that appropriate, proportionate action has been taken.</td></tr>
<tr><td>Committees /Groups previous presented and outputs</td><td colspan="5">This paper has not been previously presented.</td></tr>
<tr><td>Statement on impact on inequalities</td><td>Positive impact (inc. details below)</td><td></td><td>Negative Impact (inc. details below)</td><td></td><td>No impact (neutral) X</td></tr>
<tr><td>Action required</td><td>For decision</td><td></td><td>For assurance</td><td colspan="2">X</td></tr>
<tr><td>Summary of Recommendations and actions required by the author</td><td colspan="5">The Board is asked to;
• Review the details of the national letters and guidance and note the Trust's responses and actions.</td></tr>
<tr><td colspan="6">To be completed by Exec Sponsor - Level of assurance this report provides :</td></tr>
<tr><td>Significant</td><td>Sufficient x</td><td></td><td>Limited</td><td></td><td>None</td></tr>
<tr><td>Exec Sponsor name:</td><td>Andrew Strevens, Chief Executive</td><td>Exec Sponsor signature:</td><td colspan="3"></td></tr>
</table>

Background

The purpose of this paper is to present an overview of national publications, guidance and letters issued by NHS England to provide assurance to the Board that appropriate, proportionate action has been taken in response to these publications.

Two reports in the Nursing section of this paper (13 & 14), are reviews of maternity services that contained findings relating to organisational culture that are relevant to all providers. The remainder of the publications are concerned with winter planning for this year and the current industrial action.

The table in this paper presents a response to each publication, indicating where appropriate those that do not apply to the Trust. Confirmation of the Trust's responses and actions were provided by Executive Directors with responsibilty for the service areas addressed by the publications.

Publications and Solent's Responses

	Date received & Title	Implications of Notifications	Response / Action taken by Solent
	Operations		
1.	18 October 2022 Publication reference: PR2063 Going further for winter: Community-based falls response. NHSE Guidance	The Guidance sets out key principles and requirements for Integrated Care Boards (ICBs) to improve coverage of community-based falls response services across their footprint in preparation for winter.	Southampton & Portsmouth both have a Falls Service and we have submitted a self-assessment to the ICB against the 8 service principles.
2.	18 October 2022 Publication Reference: PR2090 **Going further on our winter resilienc** Plans letter from NHSE. .	The letter described key winter resilience support required including supporting patients in the community bed capacity and , ambulance services. (see also PR00007i 8 December)	Virtual wards opened across Portsmouth and Southampton to support patients in the community and address bed capacity, the Trust's contribution to reducing unwarranted variation in ambulance is via the Enhanced Care Home Team, in partnership with Primary Care in Portsmouth, In Southampton, this team is delivered by the Primary Care Alliance.
3.	18 October 2022 Publication reference: PR2084 Systems Control Centres NHSE Guidance.	The guidance describes the System Control Centres (SCC) aimed at providing visibility of operational pressure, action to address key systemic clinical and operational challenges, mutual aid and information flows. The guidance sets out the roles and responsibilities for SCC's and the requirement for the ICB's to ensure they set up and appropriately resourced.	The responsibility for setting up the SCC sits at ICB level.
4.	18 October 2022 Publication reference: PR2066 Supporting High Frequency Users (HFU) through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators. NHSE Guidance.	This guidance sets out the principles and recommended approach for offering proactive, personalised care for those at higher risk of hospital admissions due to psychosocial needs, as part of a broader strategy for ICBs and PCNs to tackle winter pressures and reduce unplanned admissions.	The Trust has not directly addressed this guidance as it is primarily aimed at ICBs and PCNs.
5.	18 October 2022 Publication reference: PR2064 Combined adult and paediatric Acute Respiratory Infection (ARI) Hubs NHSE Guidance	This document supports systems as they plan for the management of acute respiratory infections this winter and beyond, as COVID-19 and other respiratory infections persist throughout the year.	This guidance does not apply to the Trust.
6.	18 October 2022 Publication reference: PR2065 Going further for winter: Care homes ambulance conveyance avoidance NHSE Guidance	The document sets out the minimum requirements for reducing unplanned care home ambulance conveyance – deadline November 2022. Indicators: • Number of UCR contacts. • Rates of ambulance conveyances to emergency departments for care home residents. • A&E attendances via ambulances broken down by time of arrival • Analysis of NHS 111 and 999 call data for calls from care homes.	The UCR (Urgent Community Response) contacts are a constant focus for Southampton and Portsmouth, the remaining indicators do not apply to the Trust.

	Date received & Title	Implications of Notifications	Response / Action taken by Solent
	Operations		
7.	24 October 2022 Portsmouth & South-East Hampshire emergency patient care. Letter from Anne Eden, South East Region to the Chair and Chief Executive of Hampshire and Isle of Wight ICB.	The letter detailed the expected commitment, planning and partnership working from the ICB and Provider Boards to address excessive handover delays across the whole patient pathway.	The System responded with a Remedial Action Plan (RAP) to support an improvement trajectory which is monitored on a weekly basis and reported to the Learning Disability Service System Chief Executives meeting.
8.	4 November 2022 Portsmouth and South-East Hampshire Emergency Patient Care Letter to Anne Eden Presented to Confidential Board Monday 5 December 2022 Item 7.5. (H & IoW ICB responses to the Letter from Anne Eden dated 24 October)	Response to letter of 24 October 2022.	
9.	1 December 2022 Publication reference: PR2121 Help with validating waiting lists Letter NHSE	The national elective recovery and transformation team have developed a toolkit – saved on the NHS website and Future NHS – to support regions, systems and providers in implementing validation, with examples and case studies that focus on the value of digital validation.	This guidance is not applied specifically to the Trust's internal community waiting lists. It is more appropriate for elective waiting lists in an Acute hospital setting.
10.	1 December 2022 ii Publication reference: PR2121 Help with validating waiting lists Letter NHSE	This toolkit supports and explains to providers, systems and regions how best to implement validation through: 1. Defining validation. 2. Explaining why validation is important. 3. Sharing best practice guidance on validation, including digital opportunities.	
11.	6 December 2022 Publication reference: PR00028 Discharge Challenge for Mental H and Community Services provider NHSE Letter	The National Health and Social Care Discharge Taskforce has asked that Integrated Care Boards and providers of mental health and community inpatient services focus on ensuring that they have robust discharge processes in place, ensuring that patients who no longer need to be in an inpatient setting are discharged and cared for in more appropriate settings.	The Trust follows community discharge initiatives outlined by the document to ensure patients receive care in the most appropriate setting.
12.	8 December 2022 Publication reference PR00007i Going further on our winter resilience plans: more detail on mental health actions NHSE Letter	**Following on from PR2090** More detail on the priority actions that all systems need to take this winter to ensure the NHS can best support people with mental health needs. Further to the above, to support system-wide focus on reducing delayed discharges and avoidably long length of stay in mental health inpatient settings, a mental health specific discharge challenge has now been launched.	Optimising the flow through mental health inpatient Settings is a constant focus. To support this, raising the profile of 24/7 urgent mental health helplines for all ages has been included in targeted communications.

	Date received & Title	Implications of Notifications	Response / Action taken by Solent
Nursing & Medical			
13.	Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation Dr Bill Kirkup CBE October 2022	The Kirkup report identifies many opportunities that were missed at East Kent University NHS Foundation Trust where the managers and board could have acknowledged the concerns and issues raised about safe care and toxic culture. These were visible to Trust managers and board via several avenues and included internal reports, CQC, CCG and HSIB reviews, whistleblowing and inspections. Often the details and recommendations were met with defensiveness or false assurance that the trust was in a safe position in regard to national statistics. Governance assurance process and papers received by board did not reflect CQC findings on the ground, even where staff admitted to the CQC team that the service was unsafe. The findings of the report are relevant to all Trusts.	This external report was reviewed in order to identify potential areas that could impact on Solent, and as such the following are not statements that Solent are not achieving this, but suggestions where the trust could reflect on the recommendations. There is no reason to suggest that Solent NHS Trust has a default response to be defensive but must continue to have an open culture of learning from incidents and complaints. 1. Lessons learnt from both this, and the Morecombe Bay Report (2015) suggest that, in all trusts, difficult staff cultures, cliques, and professional disrespect should be addressed immediately should they occur. 2. Staff and patients should continue to be comfortable raising concerns about safety and encouraged to do so in the knowledge that they will be heard. 3. The Solent Freedom to Speak up service is essential in maintaining this. 4. Leadership in East Kent were unwilling to address issues seen to be reputational and in doing so ensured a culture of unsafe care and became a trust that no longer 'attracts quality staff'. 5.Solent must continue to ensure that it addresses poor culture where it may occur and maintain open, honest, and robust relationships with regulators. Assurance regarding the Solent's response to the recommendations is being overseen by the Quality Assurance Committee (QAC). A summary of the Kirkup investigation was presented to the QAC on 16.09.22.
14.	Independent Review of the Maternity Services at the Shrewsbury and Telford Hospital NHS Trust 30 March 2022 Chair: Donna Ockenden	The Ockenden report was originally commissioned in 2017 to review cases relating to deaths and serious injuries suffered by babies and mothers, and the safety of neonatal and maternity services at Shrewsbury and Telford Hospitals NHS Trust (SaTH). It investigated multiple, severe, and recurring clinical, leadership, governance, and cultural failures; these themes are relevant to all Trusts.	The Quality Assurance Committee has oversight of the Government Safety Reports Review Group formed by the Associate Medical Director and Head of Quality and Safety to consider the findings and share learning from the Ockenden review and other Government reports relevant to the Trust.
15.	BW2130 i Winter Regulations Letter – Nursing NHSE	The letters describe the responsibility of all providers commissioned by the NHS and healthcare leaders to ensure that all clinicians working in their organisations are well supported in their work. and that channels for raising and acting on concerns remain open and accessible to all staff.	Friday Focus – Trust wide messages from Jackie and Dan (Chief Nurse & Chief Medical Officer) provide channels of communication for staff to share their concerns during the winter and periods of change in the Trust (a new IT provider in December is an example of this). Staff receive acknowledgement, recognition and are offered support via these weekly communications, in line with the expectations of the Winter Regulation Letters issued by NHSE.
16.	BW2130 ii Winter Regulation Letter – Medical NHSE		
17.	BW2130 Winter Regulation Letter- AHP Publication Reference PR00045 NHSE		
People Services			
18.	B2109_Letter re Preparedness for potential industrial action in the NHS_011122	The letter emphasises the need for Trust's to prepare in readiness for industrial action and advises consideration of the checklist provided in the letter.	The Trust was undertaking preparations for industrial action prior to receipt of this letter and has since reviewed and addressed the requirements of the self-assessment checklist
19.	B2109_ii - Preparedness for potential industrial action in the NHS Self-assessment checklist November 2022	Checklist provided for consideration when industrial action is confirmed	

	Date received & Title	Implications of Notifications	Response / Action taken by Solent
20.	B2109_iii - Preparedness for potential industrial action in the NHS sitrep November 2022	Supporting documentation to monitor staff absence during industrial action.	The Trust has a situation report (sitrep) twice daily and plans to create a workforce sitrep on 20 January, the day following the planned strikes on 18 and 19 January 2023.
Corporate			
21.	COVID-19 Public Inquiry Questionnaire November 2022	The COVID-19 Public Inquiry will be sending out a questionnaire to all healthcare providers to record their experiences of the pandemic.	The questionnaire has not yet been issued; Trust will complete the questionnaire when received.

Board and Committees

Item No.	9			Presentation to	Trust Board – In Public		
Date of paper	27 January 2023			Author	Sarah Howarth - 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: • 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:			

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Trust Board Integrated Performance Report (IPR)
November – December 2022

Solent NHS Trust continues to move through a period of development with our Trust Board Performance Report, in line with the CQC Well-Led recommendations. We continue to use the utilise the NHS Improvement 'Making Data Count' methodology (where relevant and applicable) to add context to variation and trends seen within our data.

Our performance is summarised within this report using the following indicators. A more detailed explanation of the methodologies can be found 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

Target has been consistently failed, for more than 6 months

There is a variable and inconsistent performance against the target

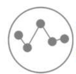
Variance Indicator

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 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 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

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


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

On 1 October 2022, the community ward located at Jubilee House in Portsmouth moved to a new facility in Harry Sotnick House. The new Jubilee Unit supports a wider range of patients requiring rehabilitation and reablement services and the admission criteria can be flexed to support the needs of the wider system if required. There are 30 standard beds and an additional 10 surge beds available for use.

The ward is staffed by the clinical team that previously ran Jubilee House, as well as staff that transferred from Portsmouth City Council (the previous provider of services at Harry Sotnick House). As with any new service, there is a period of bedding-in, and this is reflected in the data and narrative included within this report for the November and December period. During January, there have already been several process and quality improvements seen across the ward and this should be reflected within the next Trust Board Integrated Performance Report.

1. Safe

a. Performance Summary

	Indicator Description	Frequency	Internal /External Target	Target	Dec-22 Current Performance	Dec-22 Trending Performance	Dec-22 Variance	Nov-22 Current Performance	Nov-22 Trending Performance	Nov-22 Variance
Safe	Occurrence of any Never Event	Monthly	E	0	0	P	H	0	P	L
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	Monthly	E	0	0	P	L	0	P	L
	VTE Risk Assessment	Monthly	E	95.0%	89.0%	?		94.0%	?	
	Clostridium Difficile - variance from plan	Monthly	E	0	1	?	H	0	P	L
	Clostridium Difficile - infection rate	Monthly	E	0	1	?	H	0	P	L
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly	E	0	0	P		0	P	
	Escherichia coli (E.coli) bacteraemia bloodstream infection	Monthly	E	0	0	P		0	P	
	MRSA bacteraemias	Monthly	E	0	0	P		0	P	
	Admissions to adult facilities of patients who are under 16 yrs old	Monthly	E	0	0	P	L	0	P	L

VTE Risk Assessments

The completion rate for VTE risk assessments dropped in November and December. There was some reduction across all wards, however a reasonable proportion is attributable to the new Jubilee Unit. The data currently includes D2A (discharge to assess) patients, who are not routinely VTE assessed. This variation has occurred due to the new admission criteria in place on the Jubilee Unit, compared to the previous Jubilee Ward.

Clostridium Difficile

One case has been confirmed during December in a patient that was identified as high risk due to their ongoing and past medical history. The patient was admitted to the Lower Brambles ward, having acquired the infection elsewhere, and then transferred to the Fanshawe ward to facilitate isolation protocols. The Pharmacy team continue to investigate and any learning identified will be reported accordingly.

b. Key Performance Challenges

Incident Reporting

The chart below shows an upward trajectory in the number of incidents reported. Whilst data in November – December 2022 shows a potential movement down, when compared with previous years the number of incidents reported is significantly higher, and outside the upper control limit.

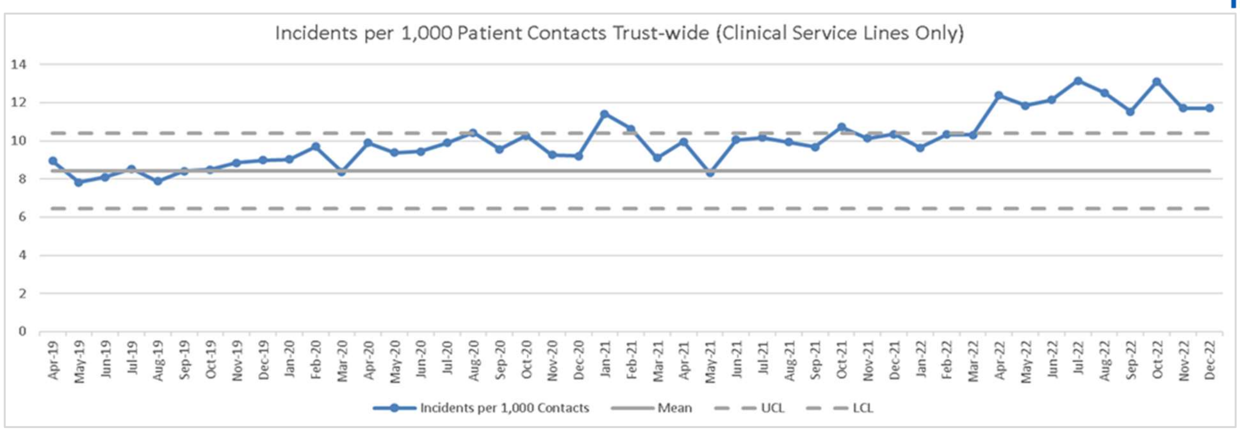


Figure 1: Incidents per 1000 patient contacts

The increase in reported incidents relates specifically to incidents of 'No Harm/Near Miss'. The overall reported increase is slightly masking a steady reduction in the number of instances of 'Low Harm or above'.

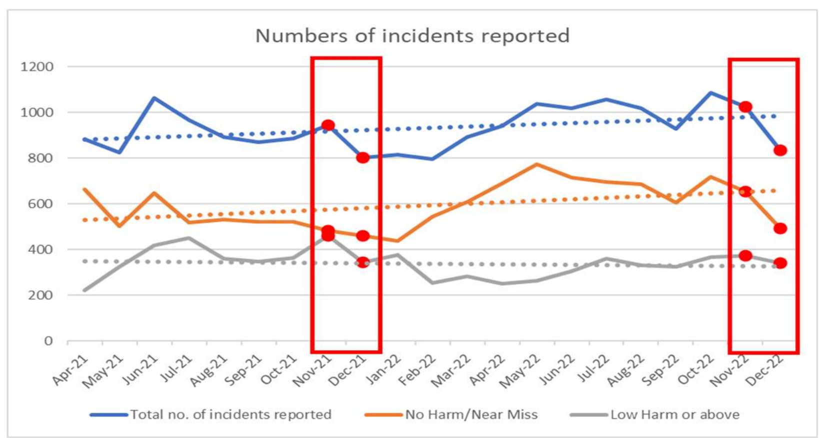


Figure 2: Number of incidents reported by harm type

This shift towards an increase in incidents of "No Harm/Near miss" being reported was particularly noticeable in November and December 2022/23 where we saw a 21.6% increase in the overall number of incidents reported alongside an 11.6% reduction in the number of incidents resulting in Harm, demonstrated below.

	Nov/Dec 2019/20	Nov/Dec 2020/21	Nov/Dec 2021/22	Nov/Dec 2022/23
No Harm/Near Miss	864	933	941	1144
Low Harm or above (incl Death/Fatality)	802	666	807	713
Total number of incidents	1,666	1,599	1,748	1,857

There is evidence that staff within Solent feel safe to report incidents, providing opportunities to learn and improve the services we offer to our communities, and that these improvements are resulting in a safer experience for staff and service users.

At the Quality Evidence Meeting in December an increase in the number of Slips, Trips & Falls reported on the new Jubilee Unit was noted, from a trust-wide average of 3 incidents per month to 17 in October and 19 in November (see Figure 4 below).

The Falls Lead is working with the staff at the Jubilee Unit to understand the increase in falls and the measures that can be put in place in the new unit to reduce them. Two formal complaints were noted where patients had experienced a fall. Both complaints were received directly from the Ward Service Manager on 8 December, enquirers will have the opportunity to discuss their concerns at a Local Resolution Meeting. The Quality & Safety Team, in collaboration with the Patient Advice & Liaison Service, will continue to monitor incident reports and complaints.

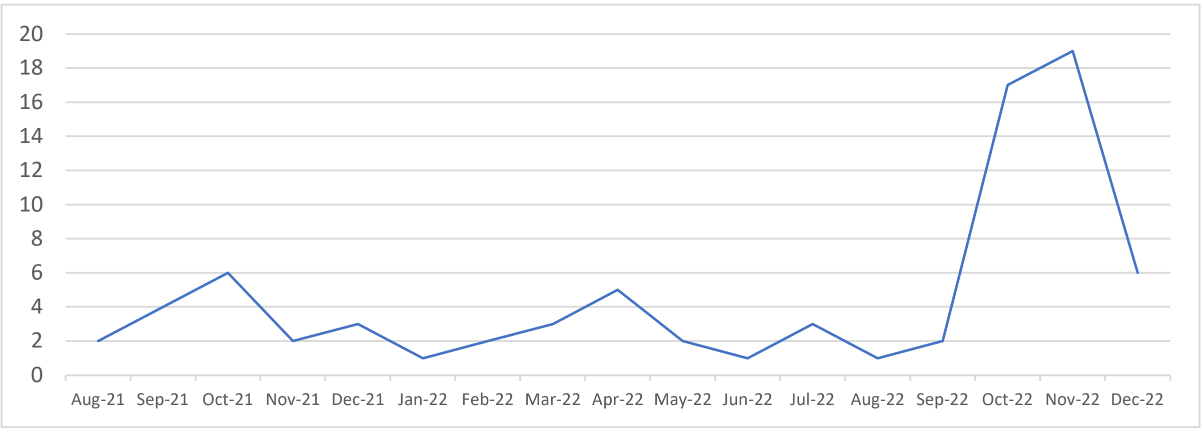


Figure 3: Number of reported slips, trips, and falls

c. Spotlight On:

Incidents in Community Mental Health

As outlined in the previous report, September and October 2022 saw a sharp increase in the number of deaths relating to suspected suicide in our Community Mental Health Teams. A review of the cases has been completed which included a comparison of Solent's cases against the 13 themes from the National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2022. The full report will be shared at the Learning from Incidents and Deaths panel and any specific trend or actions required as a result of the review will be considered in future reports.

Waiting List Risks

At the September Quality Improvement and Risk Group (QIR) there was a discussion around what evidence could be provided that risks associated with waiting lists were being identified and managed. Rather than holding a summit, a risk-based approach to review the top waiting list risks was proposed.

As the majority of risks scored as 'very high' were related to Children and Family services, a risk training session was delivered for Children and Family services leaders in mid-October 2022, followed by two review sessions to examine the risks in detail. Each risk was reviewed to ensure:

- All controls and mitigations were captured
- The current scores took account of the controls and mitigations in place
- The target scores were reasonably achievable
- Actions were in place to accomplish them

As a result of the review, the number of 'very high' waiting list risks reduced from 7 to 2 with the remaining 2 relating to wheelchair providers. The results of the review will be fed back to QIR for noting and a decision on the proposed next steps. The remaining risks will continue to be monitored and reviewed through the standard governance route.

2. Caring

a. Performance Summary

	Indicator Description	Frequency	Internal /External Target	Target	Dec-22 Current Performance		Dec-22 Trending Performance	Dec-22 Variance	Nov-22 Current Performance		Nov-22 Trending Performance	Nov-22 Variance
Caring	Community FFT % positive*	Monthly	E	95.0%	98.6%	●	P		99.1%	●	P	
	Mental Health FFT % positive*	Monthly	E	95.0%	95.7%	●	?		100.0%	●	?	
	People Pulse Survey - Advocacy Theme (Recommended for Care & Employment)	Quarterly	E	0	-				-			
	Mixed Sex breaches* (Submission recommenced October 20221)	Monthly	E	0	0	●	P		0	●	P	
	Plaudits	Monthly	-	-	44				77			

b. Key Performance Exceptions

Friends and Family Test (FFT)

During November/December 2022, there was a 36% increase in responses to the Friends and Family Test (5752 responses) from September/October (4215 responses). November saw the highest number of FFT responses received to date. This may be due to the postal strikes in the previous couple of months as large batches of results were being received and entered throughout November. The number of responses in December were also high compared to previous months, which may be linked to the loan of iPads to the Children and Family service to use for FFT.

c. Spotlight On:

Reporting of breached complaints

Historically complaints without an agreed response date have not been included in the breach data reported by Solent. Over the past two months, the PALS & Complaints team has assigned a response date on behalf of the service to try and ensure that all complaints have a due date. This move has been positively received by service lines.

In the short-term, the data will show that more complaints are breaching the agreed response times because they are now including complaints that would not have been previously included. This new approach provides a more accurate picture of the status of the complaints.

Most complaints will have a 30 -day response date with up to a maximum of 45 days for complex cases. This means that no complaint will be left for long periods without an allocated response date.

It should be noted that, with agreement of the complainant, cases can be extended. We are working hard with the services to ensure that the percentage of complaints closed within the agreed response times improves. This will provide assurance that not only are complaints investigated fairly and thoroughly, but they are also investigated in a timely manner and in accordance with the PHSO NHS Complaints Standards principles.

3. Effective

a. Performance Summary

	Indicator Description	Frequency	Internal /External Target	Target	Dec-22 Current Performance		Dec-22 Trending Performance	Dec-22 Variance	Nov-22 Current Performance		Nov-22 Trending Performance	Nov-22 Variance
Effective	Bed Occupancy - Community Wards	Monthly	-	-	94.8%			H	96.8%			H
	Bed Occupancy - Mental Health Wards	Monthly	-	-	69.5%				69.4%			
	Bed Occupancy - Neurological Wards	Monthly	-	-	93.9%				94.9%			
	Length of Stay - Community Wards	Monthly	-	-	25.1				31.8			
	Length of Stay - Mental Health Wards	Monthly	-	-	14.9				18.9			
	Length of Stay - Neurological Wards	Monthly	-	-	47.1				47.3			
	Delayed Transfers of Care [patient count]	Monthly	-	-	36				28			
	% clients in settled accommodation	Monthly	E	59.0%	66.9%	●	P	L	65.7%	●	P	L

Bed Occupancy

Bed occupancy rates have to date been calculated using an accurate number of available bed days each month, including any surge beds that may be open. It has been agreed that moving forward it would better demonstrate pressure on the wards to calculate occupancy using the available days based on the core bed base only. This would report an occupancy rate of greater than 100% if the core bed base was full and surge beds were in operation. The community wards in Portsmouth are shown below as an example.

	Occupancy Rate (all available beds)		Occupancy Rate (exc. surge beds)	
Ward	**Nov-22**	**Dec-22**	**Nov-22**	**Dec-22**
Spinnaker	95%	96%	113%	119%
Jubilee Unit	97%	97%	125%	128%

Delayed Transfers of Care (DTOC)

The number of patients on our Inpatient wards that are delayed continues to be higher than the usual expected trend. As reported last month, this is attributable to the increase in capacity at the new Jubilee Unit, and the flexible admission criteria in response to local system pressures. Several patients admitted to the ward have been homeless, which has contributed to the increase in delayed transfers of care. The benchmark has been removed whilst we monitor performance for a few months and identify what a reasonable target level of delayed patients should be.

b. Key Performance Exceptions

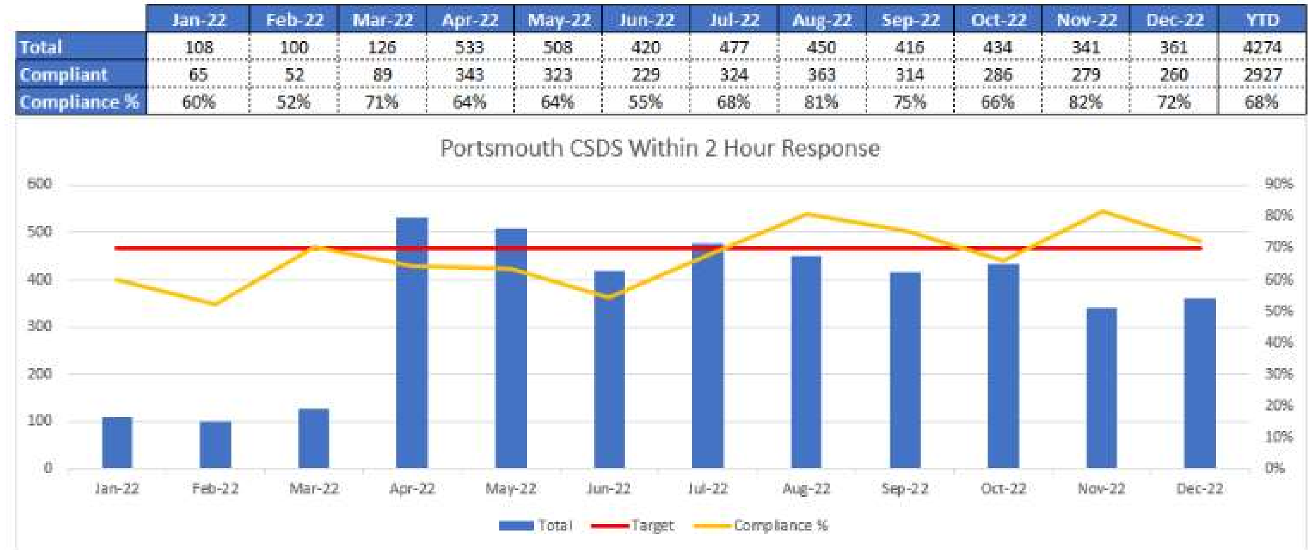
Urgent Community Response (UCR) – Data Quality

Data for the Urgent Community Response 2-hour target has been subject to further scrutiny as the figures published nationally, via the Community Services Dataset (CSDS), does not correlate with the data being presented internally. An investigation is underway to identify the cause for the discrepancy. Preliminary findings suggested the discrepancy may be linked to whether multiple urgent response requests can be counted per patient. Locally, we understood that the national methodology limits requests to one per referral, but it is possible NHS Digital are counting multiple. The Performance Team have received a patient level dataset from NHS Digital to enable validation of the records. This task is currently underway and findings will be shared in due course.

Further challenges have also been identified locally which impact the accuracy of reporting for both cities. The data recorded on SystmOne, and therefore included within our CSDS submissions, for the Portsmouth service does not accurately reflect the volume of referrals being received. Actions have subsequently been taken to improve the accuracy of the data recording, utilising Data Assurance resource to support this process. In Southampton, the overall number of referrals reported is accurate, however since October the validation of the time when patients are seen has not been completed due to capacity issues. The team have contacted their Data Assurance Officer to request support in validating the backlog of data.

Urgent Community Response (UCR) – 2-Hour Performance

Despite the critical incident pressures in both cities, the performance in Portsmouth was maintained during November and December. Increased sickness and absence within the teams due to COVID and flu, was managed by utilising support from PCAT and PRRT to support and supplement admission avoidance.

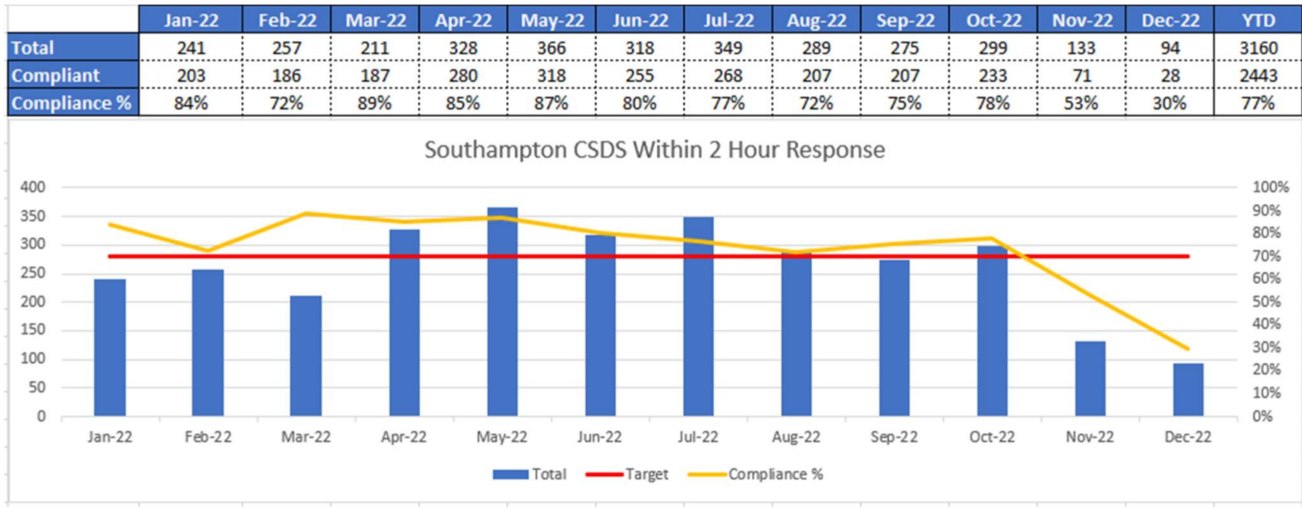


	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Total	108	100	126	533	508	420	477	450	416	434	341	361	4274
Compliant	65	52	89	343	323	229	324	363	314	286	279	260	2927
Compliance %	60%	52%	71%	64%	64%	55%	68%	81%	75%	66%	82%	72%	68%

Figure 4: 2-hour wait figures for Portsmouth UCR as reported in the CSDS (local data) Jan-Oct. Nov-Dec data reported from manually collected data

In Southampton, although the demand decreased significantly during the period, this correlated with the level of referrals received from SCAS (South Central Ambulance Service) significantly decreasing. The compliance against the 2-hour target is believed to be higher than reported for the reasons stated in the Data Quality section below.

The Urgent Reponse Service (URS) and Community Nursing teams during the critical incident were taking patients with more complex health needs into the community requiring increased care. This responsibility increased the flow of patients in the system but decreased the capacity of the team to meet the 2-hour target. Staff from URS, Community Independence Service (CIS), Bladder and Bowel team, Early Supported Discharge team, amongst others, flexed their criteria to accept patients with greater risk and redeployed resources to support greater system flow overall. Year-to-date, the service has met the 2-hour compliance target and expects performance to improve further after data validation.



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Total	241	257	211	328	366	318	349	289	275	299	133	94	3160
Compliant	203	186	187	280	318	255	268	207	207	233	71	28	2443
Compliance %	84%	72%	89%	85%	87%	80%	77%	72%	75%	78%	53%	30%	77%

Figure 5: 2-hour wait figures for Southampton UCR as reported in the CSDS (local data)

Sexual Health Reporting (SNOMED)

Reporting of activity data relating to the local authority Sexual Health contract was due to be completed by 23 January 2023, following a project to implement the new national SNOMED coding requirement. Following significant efforts from both service and the Performance & BI Team over the past three months, the work is very close to completion, however, to ensure the data provided is of the highest quality, a decision was made to request an extension to the deadline to allow further issue resolution and auditing of the data prior to submission.

School Aged Immunisations

In January 2023, Solent received a Contractual Performance Notice (CPN) for our School Aged Immunisation Service, following some issues with the accurate and timely provision of data to NHS England. A remedial action plan has been developed and accepted by NHS England, requiring multiple actions to be taken by service and the Performance and BI Team to ensure the issues are resolved, and data quality is assured to the highest level. The plan is expected to remain in place until the end of the academic year when the vaccinations programmes finish.

c. Corporate Business Review Meetings (CBRMs) – Key Areas of Exception

Seasonal Vaccinations Uptake

At the end of December, Solent had achieved 70.4% of staff vaccinated for Flu, which is above the 70% CQUIN target and highest across our neighbouring organisations. Solent are also higher than the regional

and national averages for both Flu and COVID Booster vaccination uptake. The trust is extremely proud of our staff taking the time to protect themselves and the organisation from these seasonal illnesses.

Other Exceptions

All other exceptions raised at this period's CBRMs will be addressed through the annual business planning process in January/February 2023.

4. Responsive

a. Performance Summary

				Dec-22				Nov-22			
Indicator Description	Frequency	Internal /External Target	Target	Current Performance		Trending Performance	Variance	Current Performance		Trending Performance	Variance
Patients waiting > 18 weeks	Monthly	-	-	4276				4105			
Accepted Referrals	Monthly	-	-	23843				29833			
Formal complaints per 1000 WTE	Monthly	-	-	2.0				5.1			
Number of complaints	Monthly	I	15	6				15			
Number of complaint breaches	Monthly	-	-	2				5			
RTT incomplete pathways*	Monthly	E	92.0%	82.6%				83.2%			
Maximum 6-week wait for diagnostic procedures	Monthly	E	99.0%	100.0%				100.0%			
Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	Monthly	E	0	91				55			
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Monthly	E	50.0%	50.0%				80.0%			
IAPT - Proportion of people completing treatment moving to recovery	Monthly	E	50.0%	53.7%				54.0%			
IAPT - Waiting time to begin treatment - within 6 weeks	Monthly	E	75.0%	91.0%				96.0%			
IAPT - Waiting time to begin treatment - within 18 weeks	Monthly	E	95.0%	100.0%				100.0%			
Data Quality Maturity Index (DQMI) - MHSDS dataset score*	Monthly	E	90.0%	90.6%				90.5%			

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

b. Key Performance Exceptions

Patients waiting > 18 weeks

Waiting lists continue to have special cause variation showing an increasing trend, reflecting the continued pressure on our services. Referrals continue to be high across the majority of services and capacity is stretched making it challenging for services to gain traction on the growing waiting lists.

RTT Incomplete Pathways

Performance for patients currently waiting for RTT eligible services continue to be below the 92% target and below the Lower Control Limit for the 5th consecutive month, highlighting this as a significant area of concern. This reflects the national and local issues surrounding waiting times.

The main service contributing to the reduction in performance is the Community Paediatric Medical Service, neurodevelopmental pathways in Southampton. All other RTT applicable services are maintaining achievement of the 92% target for completion of incomplete pathways within 18 weeks.

Priority continues to be given to Child Protection and Statutory Children Looked After referrals, however this takes clinicians away from seeing the high level of new referrals. Recruitment has been successful, with new starters planned for January and February which hopefully will alleviate some of the pressure and waiting lists will slowly start to reduce. The Clinical Delivery Group are reviewing the service model and looking at the sustainability of this service moving forwards.

RTT incomplete pathways*

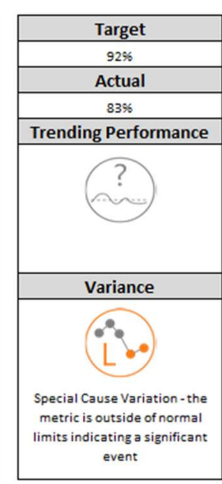


Figure 6: RTT Incomplete Pathways with significant variation highlighted

Inappropriate Out of Area Placements

There has been an increase in the number of inappropriate out of area placements for mental health patients, linked to the reduction in beds on the Hawthorns Ward. Further information on the changes on Hawthorns Ward can be found in the Service Line Performance Review Meetings (PRMs) – Key Areas of Exception (section 4c).

c. Service Line Performance Review Meetings (PRMs) – Key Areas of Exception

Adults Community Services (Portsmouth and Southampton)

System Pressures

System pressures continue to be the predominant focus for both the Adults Portsmouth and Adults Southampton service lines. In Adults Southampton there is growing concern of the detrimental effect this could be having on other services. Staff are being moved between routine services, such as case

management, to support high priority teams to improve patient flow and reduce pressure on our Acute partners, without sufficient consideration for the potential impact.

The focus for the teams in Adults Portsmouth has been to increase the flow from PHU into community-based services as a result of the critical incident. Surge beds have been operationalised to increase capacity, which has led to an increase in bank and agency usage and teams cross covering to provide support where necessary. The URS team have been in-reaching to SCAS to keep referrals flowing, as they have reduced in the past when SCAS are under pressure. The team have also been reviewing SDEC and OSDEC to identify patients suitable for the virtual wards, reducing pressure on PHU beds. Staff continued to demonstrate great resilience, despite reporting that they are exhausted.

Adults Community Services (Southampton)

Recruitment Success

A recruitment event was held in Southampton in December, with a view to promoting employment within the inpatient and community services. The event generated a much larger footfall than anticipated and generated 38 applications to roles within the service line. The event also improved the motivation of teams that were present, allowing them to meet each other and share good practice. The People services team helped to facilitate the event and are looking to recreate the event with other service lines.

Mental Health Services

Hawthorns Ward

Following the splitting of the Hawthorns ward there has been a reduction in incidents and medication errors and a reported improvement in staff morale, which is extremely positive. Further improvements are expected to be seen as work continues and the ward comes back together in January.

Out of area placements have been used to backfill some of the lost capacity in splitting the ward, and a further 4 beds have been secured at the Marchwood unit in Southampton from 9 January to use as required. This additional capacity will be used for a very specific cohort of low-risk patients, and only utilised if truly necessary to maintain a safe level of occupancy on the Hawthorns ward.

As part of the agreement to use beds at Marchwood, governance arrangements are being put in place to ensure patients receive the same standards of care, and the service receive the necessary information about each patients care whilst they are not residing on Solent premises.

Learning Disabilities Caseload

As previously reported, the caseload of the Integrated Learning Disability service continues to grow. There are now over 900 patients on the caseload, an increase of 20% in the past 3 years. Within the caseload, there has also been a proportional increase in the number of Complex Healthcare Cases (CHC). The service is funded to manage 35 CHC cases, but this has risen to 53 at present. There are also a higher proportion of transition cases (service users moving from Childrens to Adult services), and service users are having to wait longer to have their personal health budgets and case and support plans put in place.

The content of the agreement for LD services needs updating to better reflect the current model. Commissioners have been aware of the challenges faced by this service for at least a year. Service will meet with commissioning colleagues to set expectations if no further funding is available and will feedback at the next PRM meeting in two months.

High Intensity Service

Service Demobilisation

The High Intensity Service is transferring to Berkshire Health in April 2023. The service is working with Berkshire to understand the referral criteria of the new service model so that this can be applied to patients accepted into the service prior to April. The Peer Support Model currently provided is not being adopted by Berkshire, therefore leaving the staff from this team at risk. There have been several members of staff leave or find new roles already which is positive, however it has resulted in a reduction in operational hours, with weekend and evening cover no longer being provided. This poses a potential risk to the current patient cohort who are familiar with having access to these services at those times.

Specialist Dental Service (HIOW)

UDA Delivery

Progress towards the UDA target continues to be slow, with 40.3% of the target achieved for mainland and 42% for IOW. The service anticipates a year-end position of 55-60%, however the team are working up a more accurate trajectory, seeking additional capacity and considering different ways of working.

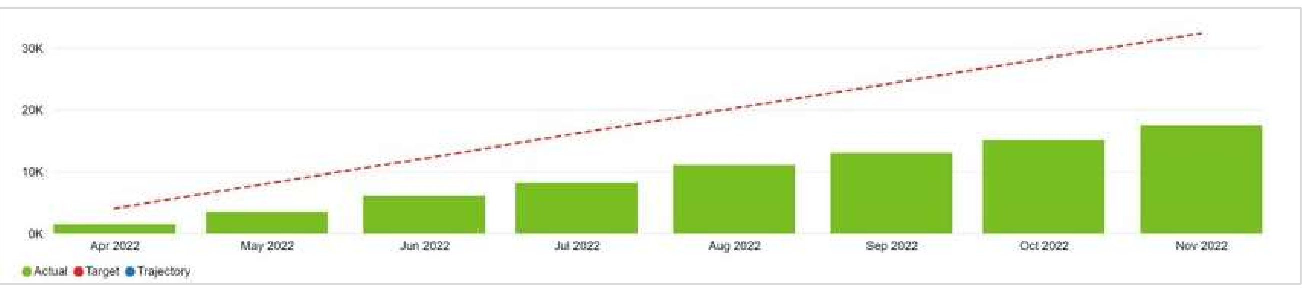


Figure 7: Cumulative UDA delivery against target

GA Delivery

Waiting times for GA procedures continues to be a concern for the service, with the longest waits at 70+ weeks for Children and 43 weeks for adults. A trajectory has been requested to detail when the Childrens waiting list is expected to drop below 52 weeks. The service report that patients are more complex and therefore, whilst the size of the waiting list is smaller, the patients they do see need more clinical input. The long waiting times are also contributing to the increasing acuity of the patient cohort.

5. People

a. Performance Summary

	Indicator Description	Frequency	Internal /External Target	Target	Dec-22 Current Performance	Dec-22 Trending Performance	Dec-22 Variance	Nov-22 Current Performance	Nov-22 Trending Performance	Nov-22 Variance
People	Sickness (annual)*	Monthly	I	4.5%	5.8%			5.7%		
	Sickness (in month)	Monthly	I	4.5%	7.4%			5.7%		
	Turnover (annual)*	Monthly	I	14.0%	14.5%			14.2%		
	Turnover (in month)	Monthly	I	1.2%	1.0%			0.5%		
	New starters (FTE)	Monthly	-	-	30.1			53.6		
	Proportion of Temporary Staff (in month)	Monthly	E	6.0%	4.3%			4.3%		

b. Key Performance Exceptions

Sickness

In-month sickness absence has seen a significant increase from 5.7% to 7.4%, reflective of the usual seasonal trend, with cold/cough/flu as the key reason for absence. This, paired with COVID sickness is increasing the reliance on bank and agency usage (and spend), to support safe staffing levels. The People services team are modelling sickness rates/reasons alongside key markers of the cost-of-living crisis to establish if there are any links between the two, i.e., correlation with sickness and/or stress/anxiety.

Turnover

Turnover is steadily increasing both annually and in-month, increasing demand for recruitment activity to fill vacant roles. Exit interview data continues to be reviewed with plans to include insights from this in the new workforce dashboards in development. The main reasons for leaving are personal development, working environment and work/life balance. A neighbouring NHS organisation remains the most common destination for leavers, highlighting the importance of ensuring clear and reassuring communications are shared with staff regarding Project Fusion.

Turnover (annual)*

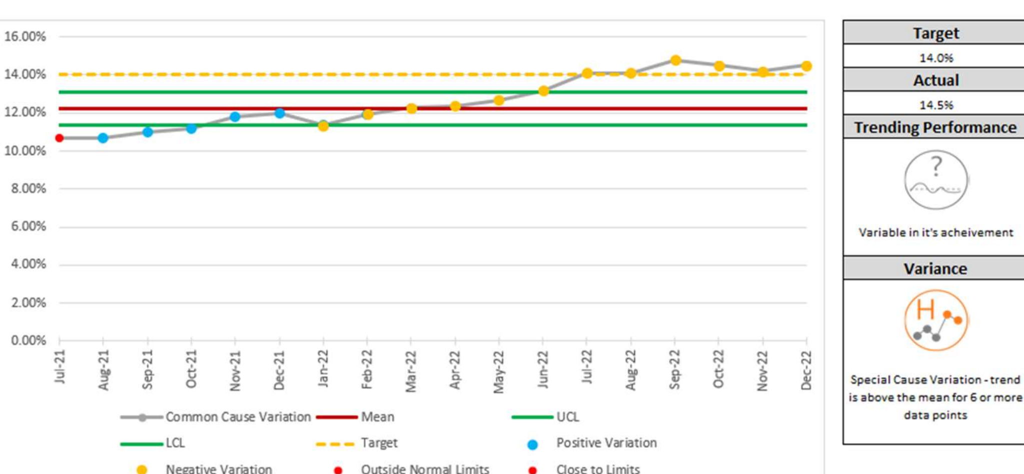


Figure 8: Trust annual turnover rates with significant variation highlighted

c. Spotlight On: Vacancy Rate

The overall vacancy rate continues to fall across the trust, but this is not reflected within all staff groups, as nursing and medical/dental staff continue to have increased vacancy rates. Whilst the medical and dental vacancy rate continues to climb, now up to 16.6%, it is a trend replicated across community and mental health providers in the region. Observing this trend, action was taking as part of early operational planning, where we held Workforce summits with all service lines along with the People Partner and Finance Teams throughout November to establish an accurate picture of vacancies across the Trust. International recruitment of mental health nurses continues, and we are now close to delivery of the final RMNs to meet the 2022/23 target. Whilst community nurse recruitment is now complete. We also continue to leverage the apprenticeship levy and the number of new starters for the year is currently at 55 (against a full-year target of 97).

6. Finance

a. Performance Summary

	Indicator Description	Frequency	Internal /External Target	Target	Dec-22 Current Performance		Dec-22 Trending Performance	Dec-22 Variance	Nov-22 Current Performance		Nov-22 Trending Performance	Nov-22 Variance
Finance	Year to date surplus/(deficit) Actual v budget	Monthly	-	-	0%				0%			
Finance	Agency spend % pay	Monthly	I	3.5%	3.8%				5.5%			
Finance	Cash balance	Monthly	-	-	£23.4				£25.3			
Finance	Aged debt (over 90 days)	Monthly	-	-	188				187			
Finance	Use of Resources Score	Monthly	-	-	2				3			

b. Spotlight On: Month 9 Results

Month 9 Results

The Trust is reporting an in month adjusted deficit of £109k, £37k favourable to plan, with a year-to-date adjusted deficit of £191k, which equals plan.

Forecast

At the end of December, the Trust is forecasting an adjusted underlying deficit of £4.4m, against a plan of breakeven. The position is predominately driven by the continuation of current spending levels, plus c£2.5m inflationary pressures unknown at the time of planning. The Trust is planning on mitigating this deficit with non-recurrent adjustments in the year and are therefore expecting to deliver a breakeven position.

Workforce

Pay savings targets of £5.2m have been allocated to operational and corporate service lines to support delivery. As at M9 savings of £5m have been delivered against a plan of £4.4m. The main drivers for over delivery of savings are: Childrens, Dental and Adults Southampton Services, along with Covid savings. It is expected the achievement of these savings will reduce in future months, with recruitment to key positions planned.

NHS Solent NHS Trust

Covid-19 Expenditure

The Trust continues to incur additional expenditure related to Covid-19 however this expenditure has dropped significantly since last year. In month expenditure was £0.2m, £0.1m lower than forecast due to lower IT costs. Year to date expenditure is £1.9m, which is in line with the forecast.

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. WCH bed optimisation has been approved by NHSE and works have started on site. Highclere is with NHSE for approval. Additional capital allocations need to flow from the ICS for both projects and the ICS have agreed this. The ICS support is due 2023/24 – 2024/25.

In month expenditure was £0.2m, £0.1m lower than forecast. Year to date expenditure is £1.3m, £0.4m lower than plan. Year-to-date underspends are due to timing and will be spent by the end of the year.

Cash

The cash balance was £23m on 31 December 2022, £1.8m lower than November due to expenditure exceeding income as per 2022/23 plan submission.

Aged Debt

The Trust's total debt was £5.6m, £0.4m debt 91+ days overdue, with no material movement from November.

7. Research & Improvement

a. Performance Summary

Research

Since April 2022, we have recruited 763 participants into 37 studies, with a further 6 new trials due to open. We have recruitment across all our service lines, with Children and Family services being our most research active.

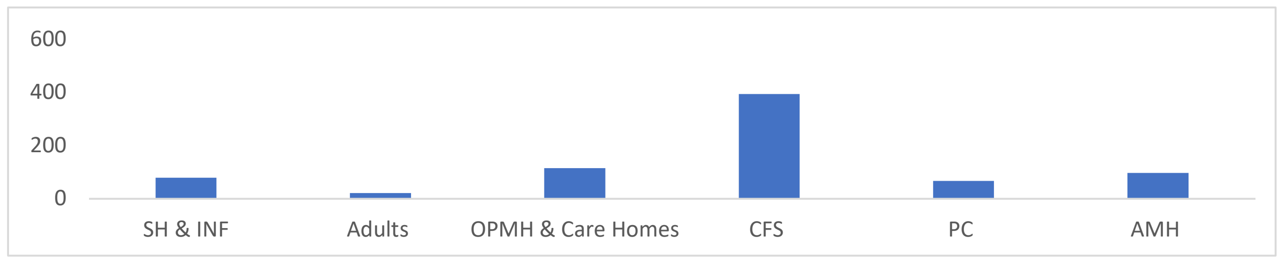


Figure 9: Participants recruited to research studies since April 2022

b. Spotlight On: Core Areas of Work

CAMHS Research

Prof Samuele Cortese, a consultant psychiatrist working in our CAMHS team has been appointed as the Wessex Research Speciality Lead for Mental Health Research. He will provide leadership and strategic

direction for Wessex partners on Mental Health Research (both adult and children). Sam leads a large programme of research both internationally and within Solent, and as a global expert on personalised targeted medicine for children with mental health disorders.

The OPEN Study

The aim of this study is to investigate the acceptance of Olanzapine in people with Anorexia Nervosa, to see whether participants take their olanzapine on a regular basis, for how long for, their experience of the treatment and to collect preliminary evidence on the effects of Olanzapine regarding anxiety, depressed mood, sleepiness, quality of life and physical and psychological consequences of Anorexia Nervosa.

The cross-sector pilot implementation of trauma-focused CBTs for children in care with post-traumatic stress symptoms

Care-experienced young people, carers, and services can often find it hard to get the help they need to support the young person to overcome their mental health difficulties. The goal of this project is to understand what mental health services need to deliver NICE-recommended mental health support to care-experienced young people.

The best evidenced therapy for children or teens with post-traumatic stress symptoms is called trauma-focused cognitive behaviour therapy. However, many services struggle to deliver this treatment for many different reasons. The study team aim to find out how services can be best supported to overcome barriers that might prevent use of these types of treatments. The study is offering clinicians, a 2-day training course on cognitive therapy for PTSD and so far, 25 of our clinicians have agreed to take part in this research.

OPTIMA- Online Parent Training for The Initial Management of ADHD Referrals

This is a study for parents of children who have recently been accepted onto the clinical waiting list for help with emotional or behavioural difficulties. The National Institute for Health and Care Excellence recommends that parents of children with these kinds of problems get support as soon as possible after they seek professional help. However, clinical services are overstretched, and traditional in-person parent training is expensive, so families often wait very long to receive this vital input.

The study team have created a digital parent training course - Structured E-Parenting Support (STEPS). It is delivered as a mobile app and provides low-cost support that can be easily accessed at parents' convenience. This study aims to test if STEPS helps parents reduce children's conduct problems during the waiting period for clinical assessment.

We have recruited 35 participants to this study across both our Southampton and Portsmouth sites.

The ATTENS project (ADHD trial of external trigeminal nerve stimulation)

The aim of this study is to test a new treatment for children with Attention-Deficit/Hyperactivity Disorder (ADHD). The best current treatment for children with ADHD is with stimulant medication. However, there are side effects and the impact of long-term use of stimulant medication is unclear.

This research is testing a new non-drug treatment, called external Trigeminal Nerve Stimulation (eTNS) that is applied during sleep. It is a randomised, placebo-controlled trial and the study will establish whether eTNS is effective in reducing symptoms of ADHD and other problems such as mood, concentration, memory, and sleep.

Annex A: Making Data Count Icon Crib Sheet

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

Solent NHS Trust - System Oversight Framework

The NHS System Oversight Framework is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance. The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

A set of oversight metrics are used to support the implementation of the framework at a system level. The metrics listed below are those which Solent contribute towards. It is worth noting that nationally a number of these metrics are linked to the provision of additional funding to support performance improvement, however, as a Community and Mental Health provider, Solent is not always eligible for these funding streams.

Metrics which have incentive funding for other providers are highlighted in blue below. We continue to monitor our contribution towards these targets, as a member of the local system, but acknowledge we are not given financial support to invest in additional improvements for this activity.

	Indicator Description	Internal /External Target	Target	Dec-22 Current Performance	Dec-22 Trending Performance	Dec-22 Variance	Nov-22 Current Performance	Nov-22 Trending Performance	Nov-22 Variance
Quality, Access & Outcomes	S038a: Potential under-reporting of patient safety incidents	E	100.0%	100.0%	?	H	100.0%	?	H
	S039a: National Patient Safety Alerts not completed by deadline	E	0	0	?	L	0	?	L
	S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	E	0	0	?		0	?	
	S041a: Clostridium difficile infections	E	0	1	?	H	0	?	L
	S042a: E. coli blood stream infections	E	0	0	?		0	?	
	S081a: IAPT access (total numbers accessing services)	E	366	349	?		520	P	H
	S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (3 months rolling)	E	0	146	F	H	55	F	H
	S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	-	-	100.0%			100.0%		
	S101a. Outpatient follow-up activity levels compared with 2019/20 baseline	E	75.0%	173.4%	F	H	90.7%	F	
	S105a. Proportion of patients discharged to usual place of residence	-	-	65.0%			64.9%		
	S107a. Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	E	70.0%	63.0%	?		74.0%	?	
	S007a: Total Elective Spells	-	-	Currently awaiting provision of guidance for measurements from NHS I&E					
	S009a: Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	E	0	0	?		0	?	
	S013a: Diagnostic activity levels - Imaging	E	545	391	F		352	F	
	S013b: Diagnostic activity levels - Physiological measurement	E	77	45			65		
Preventing Ill Health	S117a: Proportion of patients who have had a first consultation in a post-covid service more than 15 weeks after referral	-	-	0.0%		L	15.5%		L
Looking after our people	S071a: Proportion of staff in senior leadership roles who are from a BME background	-	12.0%	7.4%			7.4%		
	S071b: Proportion of staff in senior leadership roles who are women	-	62.0%	72.3%			72.3%		
	S071c: Proportion of staff in senior leadership roles who are disabled	-	3.2%	4.3%			4.3%		
	S067a: Leaver rate	I	14.0%	14.5%	F	H	14.2%	F	H
	S068a: Sickness absence (working days lost to sickness)	I	5.0%	7.4%	F	H	5.7%	F	H
Finance and Use of Resources	S118a: Financial Stability	E	-	Data not currently available					
	S119a: Financial Efficiency	E	-	2.3%			2.6%		
	120a: Finance – Agency Spend vs agency ceiling	E	100.0%	Data not currently available					
	120b: Agency spend price cap compliance	E	100.0%						

Solent NHS Trust - System Oversight Framework

Performance Summary:

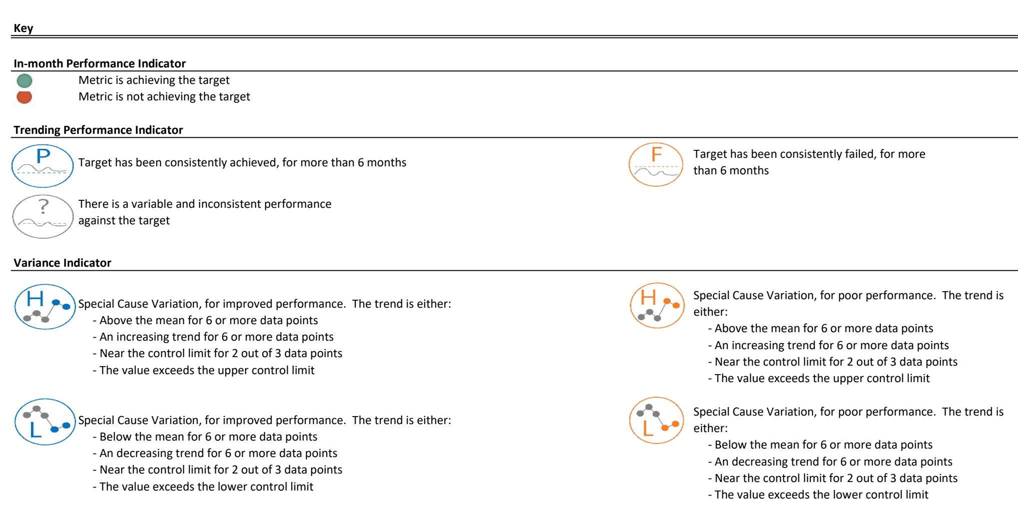
The majority of metrics showing a negative trend or variance are covered within the Trust Board Integrated Board Report. Other areas of exception worth noting are as follows:

Outpatient Follow-Up Activity

Numbers of follow-up contacts continue to be a higher proportion of all contacts than desired by NHS E/I. This is an area where acute trusts are receiving additional investment to increase diagnostics capacity, but this is not applicable to Solent.

Diagnostics Performance

Diagnostic performance levels are below target. This is an area where acute trusts are receiving additional investment to increase diagnostics capacity, but this is not applicable to Solent. There are no concerns about the levels of diagnostic activity being undertaken by Solent or our sub-contractors as all referrals are being managed within the nationally set timeframe of 6 weeks. Therefore, underperformance on this metric does not reflect any concerns about capacity within this service.



NHS Provider Licence – Self Certification 2022/23 – January 2023

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 NHSE.

Requirement

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 Remuneration 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.

Requirement

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. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls.

Requirement

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.

Succession planning arrangements for the Chair have been implemented commencing 1 January 2023.

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. Succession planning arrangements for the Chair have been for implemented , commencing 1 January 2023.

<table>
<tr><td>Item No.</td><td>10</td><td>Presentation to</td><td colspan="3">Trust Board</td></tr>
<tr><td>Date of paper</td><td>03/01/2023</td><td>Author</td><td colspan="3">Sadie Bell, Head of Information Governance & Digital Security / Data Protection Officer</td></tr>
<tr><td>Title of paper</td><td colspan="5">Information Governance Compliance Report July – December 2022</td></tr>
<tr><td>Purpose of the paper</td><td colspan="5">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</td></tr>
<tr><td>Committees /Groups previous presented and outputs</td><td colspan="5">N/A</td></tr>
<tr><td>Statement on impact on inequalities</td><td>Positive impact (inc. details below)</td><td></td><td>Negative Impact (inc. details below)</td><td></td><td>No impact (neutral) x</td></tr>
<tr><td>Action required</td><td>For decision</td><td colspan="2"></td><td>For assurance</td><td>X</td></tr>
<tr><td>Summary of Recommendations and actions required by the author</td><td colspan="5">The Board are asked to receive the report and in doing so:
- Note the risks identified and priority areas of focus for Q4, 2022/23</td></tr>
<tr><td colspan="6">To be completed by Exec Sponsor - Level of assurance this report provides :</td></tr>
<tr><td>Significant</td><td></td><td>Sufficient</td><td>x</td><td>Limited</td><td>None</td></tr>
<tr><td>Exec Sponsor name:</td><td>Rachel Cheal, Chief of Staff / SIRO</td><td>Exec Sponsor signature:</td><td colspan="3"></td></tr>
</table>

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 3rd October 2022, the Trust appointed a new Senior Information Risk Owner (SIRO), Rachel Cheal, Chief of Staff. 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.

2.2 **2022/23 Toolkit:** The publication of the 2022/23 DSPT, operates for the period July 2022 – June 2023. With the Trust's baseline submission due on the 28th February 2023 and final submission due on the 30th June 2023.

Breakdown of the work required:

	Mandatory	Non-mandatory
No. assertions (top level requirements)	35	2
No. requirements (these sit under the assertions, break the assertion down into sections)	113	18

Focus: The Trust is currently focusing its attention on the mandatory requirements and assertions but will be reviewing the ability to meet non-mandatory requirements and assertions in May 2023, discussions around addressing non-mandatory assertions / requirements will be had with the SIRO in May 2023.

New Requirements & risks: This year has seen a number of new mandatory requirements introduced, mainly surrounding Cyber Security and Medical Devices. Cyber security assurance & prevention is considered a significant risk to the organisation, alongside cyber security business continuity.

	Cyber Security	Medical Devices
Mitigations	Being address by recruitment to Cyber Security Manager and Digital Security Business Support Officer. Additionally, the Trust's new ICT contractors are contracted to ensure that the Trust meets compliance with all mandatory technical cyber security requirements, by June 2023. This will be monitored through the newly re-established Information & Cyber Security Group (Part A – Contractors Assurance), which is due to recommence in February 2023.	A joint project involving Cyber Security, the Information Governance Team and the Trust's Medical Devices Lead, is due to commence in January 2023, with approximately 313 devices having through Security and Data Protection Impact Assessments conducted. In addition, whilst undertaking this project, the project leads are working closely with the Trust's Chief Nurse Information Officer (CNIO), to use this as an opportunity to assess if any Patient Safety Assessments are required on these medical devices; findings are then to be feedback to the CNIO, for them to undertake assessments where required.

A breakdown of the Trust's current compliance with the mandatory requirements, is shown below;

Compliance Status	No. Requirements
Compliant	20
Compliant, but require some additional work, in order to strengthen compliance	5
Compliant, but require an annual review	34
Partially complaint	22
To address with new contractors	23
Non-compliant (newly mandatory or changes to requirement compliance)	9

Further information relating to the Trust's current 2022/23 DSPT status can be found in Appendix A.

3. Summary of Information Governance's Legal Requirements Compliance (Freedom of Information and Subject Matter requests) Q1-Q3 2022/23

* as of 30th December 2022

Concerning	Summary
SARS	• 10% decrease in the average number of requests per quarter • Overall compliance to date: 96.4%, which is also above the mandatory compliance rate of 95%. Compliance rate for Q1 was below mandated 95% compliance rate, due to staff training / process issues, which have now been addressed. Compliance improved Q2 and Q3 above the mandated compliance rate. • Currently 53 requests (Q3) have not been released, however are also currently not due to be released (legal deadline); therefore, figures are subject to change.
FOIs	• 4.6% increase in the average number of requests per quarter. • Overall compliance to date: 94.1% compliance. This is due to a dip in compliance within Q3, as a result of staffing pressures and turnover. • In Nov 2022 a session was held with services, who receive frequent FOI's, to assess how we can proactively address FOIs
Overall support	• Changes within the IG Team made to strengthen legal compliance – inc. recalibration of compliance focus and enhanced internal monitoring processes.

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

4. Information Governance Incidents/Security

* as of 30th December 2022

4.1 ***IG Incident Summary***

Concerning	Summary (Q1 – Q3, 2022/23)
No. Incidents reported	• 641 Information Governance Incidents were reported • 246 (38% of the reported incidents) 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. • 395 incidents, within Solent NHS Trust's control were reported within Q1 – Q2, 2022/23. • Compared to the same period of time 2021/22, it identifies that the Trust is reporting a similar number of incidents

Most Common type of reported incidents	• Top two most common reported IG incidents, make up 64.1% of the Trust's total IG Incidents (within our control)
	  ○ PID sent to wrong person / address (131)
	  ○ PID in wrong record / record error (122)

2021/22 & 2022/23 comparison	Following changes to the types of incidents reported have been identified; • Decrease in the number of non-encrypted email used for PID incidents; which is believed to be as a result of awareness raising • Increase in the number of PID Saved / Stored Insecurely incidents; it is important to note that this is the category used for PID printing to the wrong printer and being left on the printer (until discovered). These types of incidents have been identified as an ICT System issue and ICT are working with services / staff who experience this issue when printing, to provide education on ensuring the correct printer is selected.

Actions update from 2021/22 deep dive: Any outstanding actions will aim to be addressed in Q4, 2022/23 and therefore no further actions have been identified at present.

Completed Actions	*Actions outstanding, to be completed in Q4*	*Ongoing actions, now part of BAU practice*
• 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. • Undertake 3-month, 6 month and annual reviews of service engagement vs impact / change in practice (reduction in incidents)	• 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

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

5. Information Management, Information & Cyber Security Assurance

5.1 The Trust is currently on its cyber security journey, implementing greater governance, monitoring and oversight of its cyber security compliance and controls in place, to ensure that it can strive to achieve cyber security protection, resilience and the ability to respond in the unfortunate event of a cyber incident.

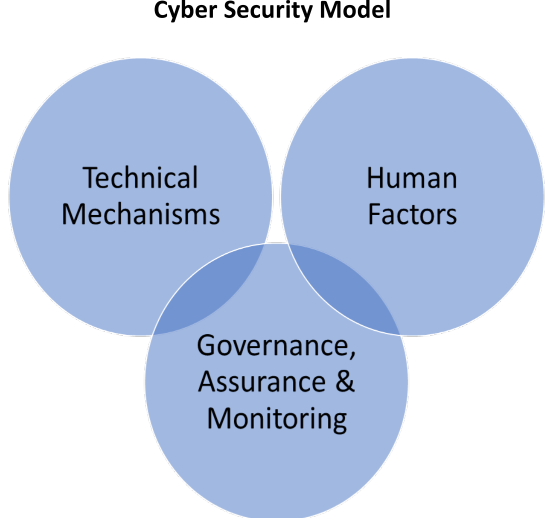
5.2 As part of this journey the Trust has established an Information Management & Cyber Security Strategy; which is a sub-strategy of the Trust's Digital Strategy. This strategy has outlined a number of key deliverables and achievements.

5.3 **Information Management & Cyber Security Assurance Strategy – Cyber Security Priorities**

Cyber Security Assurance, Assessment and Monitoring	**Training and Education**	**Culture: Creating an Environment of Digital Ownership & Accountability**
➢ Understanding of technology dependency and governance of technology risk ➢ Cyber security strategy (understanding of cyber security risks) ➢ 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	➢ Staff education reference Cyber Security ➢ Evaluation of staff's understanding of Cyber Security ➢ Staff education reference information management standards and requirements ➢ Monitoring and assessment of staff's understanding and adherence to information standards and requirements ➢ Develop a Trust-wide knowledge bank and the sharing of best-practice	➢ Develop a culture of individual and service ownership of data; ensuring the confidentiality, integrity, and availability of data ➢ Develop a culture of individual ownership over the security and safeguarding of the Trust's information security and awareness ➢ Develop a culture of reporting and learning from information related incidents ➢ Develop a culture of information and digital maturity; as well as an understanding of the value of digital information.

5.4 This strategy is underpinned by the Trust's new Cyber Security Model, which requires the Trust to look at cyber security through three lenses, instead of the standard "technical" lens. The benefit of this model is that it allows the Trust to protect, defend and asses its cyber security position from multiple mechanisms, meaning that the Trust is not reliant on one approach nor vulnerable by not assessing other mechanisms; providing greater protection against cyber security. This model has been recognised as a best practice model by NHS Digital and now shared with the wider Hampshire & Isle of Wight ICB / ICS.

Cyber Security Model



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 elements 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; 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.

[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.

5.5 **Key Tasks:** The following key tasks and activities have either commenced or been completed, since the last report, in order to continue strengthening the Trust's cyber security compliance.

Technical	Human Factors	Governance & Assurance
• Development of a Future Operating Model (new ICT contracts) Cyber Security Road Map, outlining key milestones of implementation and greater cyber security assurance and resilience. ***Commenced in January 2023*** • IT Health Checks have been undertaken by our new ICT suppliers, outlining any gaps and remediation work; this work will also support the Trust in achieving secure email accreditation. ***Completed in December 2022 – Actions and remediations to be discussed at January 2023 Information & Cyber Security Group*** • New patching model has been implemented across our infrastructure. ***Commenced in January 2023***	• Development of a Cyber Security Communication, Education and Awareness Plan. ***In development*** • Develop a culture of individual ownership over the security and safeguarding of the Trust's information security and awareness. ***In development*** • Develop a culture of reporting and learning from information related incidents. ***In development*** • Testing of cyber security capability through simulated attacks. ***Currently in consultation with NHS Digital***	• Connect with the Hampshire & IoW's ICB Cyber Lead and other Trust Cyber Leads to discuss cyber security assurance models currently in place and the possibility of a unified approach moving forward. ***Completed*** • The Trust's Head of IG & Security is to work in collaboration with the Trust's CNIO, EPRR and Cyber Security Manager, to support services HQP's and Corporate Heads in undertaking an assessment of their services existing BCP's and assess if they effectively cover how the service will operate in the event of a cyber-attack. Drawing on the impact of the OneAdvanced cyber-attack. ***In development*** • Continual progression of the Trust's access control projects. ***Ongoing***

5.6 **Resources:** Additionally, the Trust has also identified the need for the appointment of a full-time Cyber Security Manager, which is currently out for advert.

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 Solent NHS Trust is leading on the Hampshire & Isle of Wight Supporting Families Health Information Sharing Agreement. It is also working closely with Southern Health NHS Foundation Trust and Isle of Wight NHS Trust, in sharing the governance and security due diligence with regards to the newly establishing Overseas Working / Workers Policy and SoP.

7. Top Three Security Risks (Taken from the December 2022 SIRO Risk Register (Cyber security, IG, ICT and Information Management))

1. **Risk 1849: End of Life Hardware (Score 20 – Accepted Risk):** Increased end of life infrastructure equipment, impacting upon security patches being available. This is an accepted risk, due to up-and-coming ICT contract changes. New equipment, within patching support, is to be rolled out by the Trust's new ICT contractors in Q4, 2022/23. ***This risk is linked to Risk 2192, which also has a score of 20 and Risk 2192 & 2193 which has a score of 15.***

2. **Risk 2141: Service Level Business Continuity Plans (Score 15 – Active Risk):** There is a risk that services business continuity plans do not have plan in place, in the event of a cyber-attack. There is however an overarching ICT Infrastructure Business Continuity Plan, which acts as a mitigation to this risk. Service level Business Continuity Plans are currently being reviewed, to address this risk.

3. **Risk 2194: Cyber Exposure Score (Score 15 – Active Risk):** There is a risk that the Trust is vulnerable to a cyber-attack, as its security exposure score is above 29 (recommended level). The consequence is that the Trust could have a cyber-attack, impacting its network and infrastructure and access to critical systems. The Trust is in the process of appointing a new Cyber Security Manager, with one of the main responsibilities being to assess, monitor and address the Trust's Cyber Exposure Score.

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.

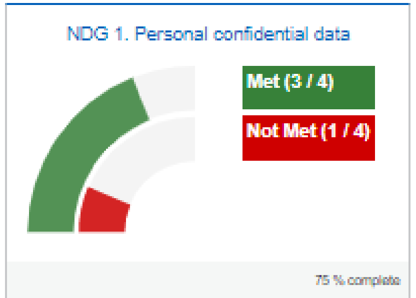
The Information Governance Team continue to focus on improving compliance, creating a learning culture and working collaboratively. The following are identified as priorities over the next quarter;

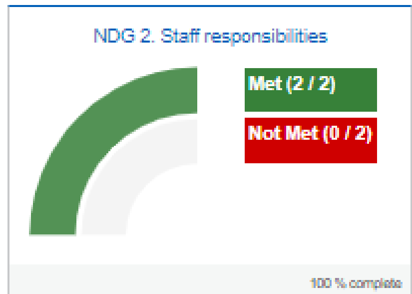
- Continual improvements in FOI & SAR Practices
- Collaborative working with the Trust's new ICT contractors, to assess the Trust's cyber security position and identify / address gaps in practice.
- Implementation of an Information Management & Cyber Security Strategy

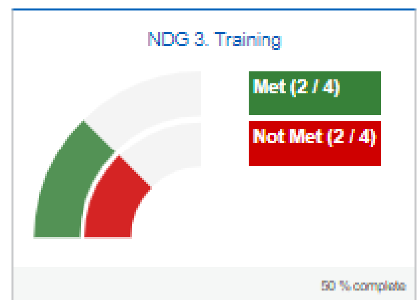
Appendix A: DSPT 2022/23 Compliance Status * as of 30th December 2022

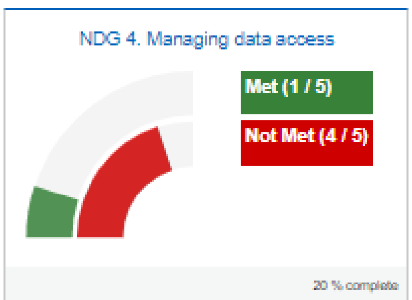
National Data Guardian Standards

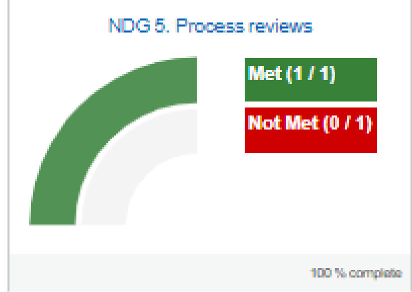
The National Data Guardian (NDG) standards have been calculated for your organisation based on the responses provided in your organisation profile.

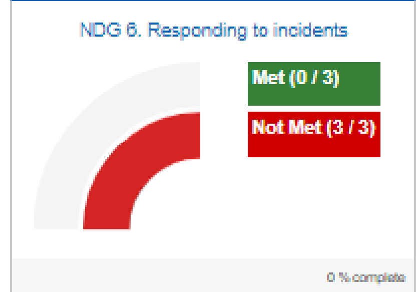


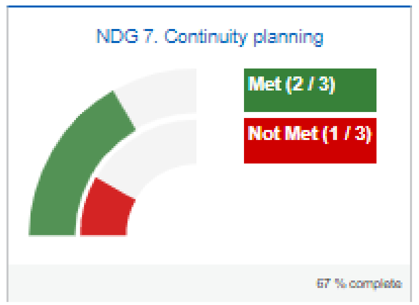


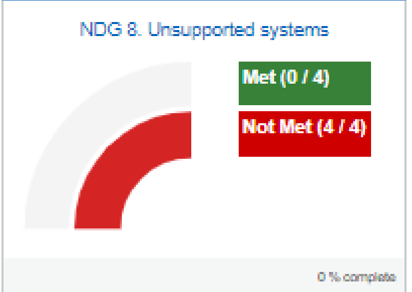


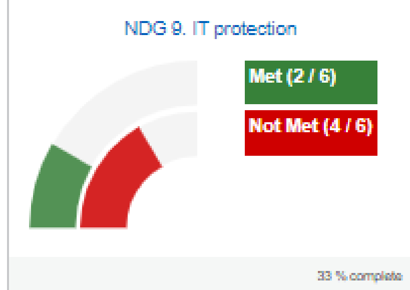


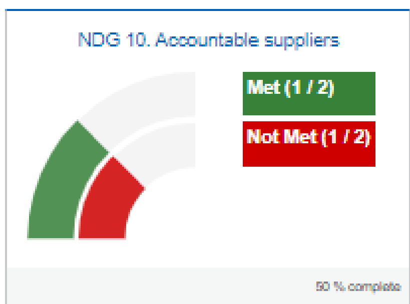












Appendix B: Information Request Compliance Breakdown * as of 30th December 2022

Subject Access Requests – Quarterly Breakdown

	2021/22				2022/23		
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
No. requests received	312	291	321	333	287	315	247
No. requests responded to within 21 days (best practice)	282	270	286	245	219	243	166
No. requests responded to within mandated timescale (one calendar month)	29	20	27	64	53	64	22
No. breaches within (legal deadline)	1	1	8	24	15	8	6
% Compliance – Legal Requirement (approx. 30 days)	99.7%	99.7%	97.5%	92.8%	94.8%	97.5%	96.9%
Not Due	-	-	-	-	-	-	53

Freedom of Information Requests – Quarterly Breakdown

	2021/22				2022/23		
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
No. Requests	98	103	94	91	83	118	102
No. Responded within 20 working days	94	95	87	79	82	112	75
No. Breaches	4	8	**7**	12	1	6	10
% Compliance – Legal Requirement (21 days)	95.9%	92.2%	92.5%	86.8%	98.8%	94.9%	88.2%
No. Not Due	-	-	-	-	-	-	17

Appendix C: Information Governance Incident Report – Q1 – Q3, 2022/23* as of 30th December 2022

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 – Q3, 2022/23, to date (April 2022 – December 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 – Q3, 2022/23, a total of 641 Information Governance Incidents were reported. However, out of them 246 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 38% of the reported incidents. Therefore 395 incidents, within Solent NHS Trust's control were reported within Q1 – Q3, 2022/23.

With regards to the remaining 395 incidents (62% 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 – December 22
PID in Wrong Record / Record Error	131
PID Sent to Wrong Person / Address	122
PID Saved / Stored Insecurely	67
Inappropriate Access / Disclosure	25
Non-Encrypted Email Used for PID	22
PID Found in Public Place	18
Other IG	8
Lost / Missing PID	2
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 64.1% 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.

Additionally, when compared to data from the previous year, there have been the following changes to the types of incidents reported;
- Decrease in the number of non-encrypted email used for PID incidents; which is believed to be as a result of awareness raising
- Increase in the number of PID Saved / Stored Insecurely incidents; it is important to note that this is the category used for PID printing to the wrong printer and being left on the printer (until discovered). These types of incidents have been identified as an ICT System issue and ICT are working with services / staff who experience this issue when printing, to provide education on ensuring the correct printer is selected.

Human Error vs Process
- 64.8% of the IG incidents reported were in connection with Human Error

- 20.5% of the IG incidents reported were in connection with Processes (Failure to follow, Lack of and Unaware of)
- 8.9% of the IG incidents reported were in connection with ICT / System Errors
- 3.8% of IG incidents reported were in connection with staff being unaware of processes
- 1% of IG incidents reported were in connection with lack of training
- 1% of IG incidents reported were in connection with lack of process

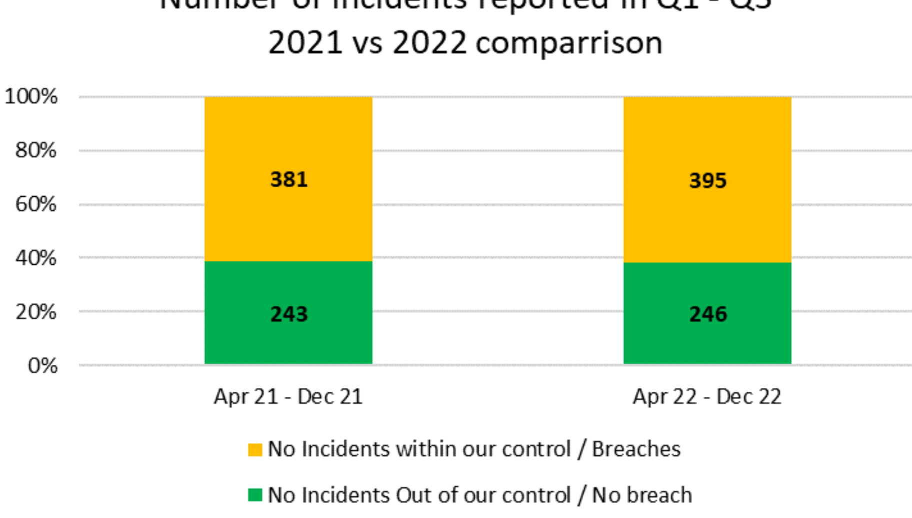
These findings indicated that the root cause of the majority of incidents are not to do with the processes in place currently within the Trust, but the human elements of working practices. That being said, Human Error should not be dismissed as something we cannot reduce, but something we need to understand, 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 32%.

IG Incidents vs No Breach / Out of Our Control

An assessment of the number of IG incidents reported (395) Within our control / Breach vs the number of incidents reported that either Out of our control / No Breach (246), show an approx. 60%/40% split between incidents resulting in Trust breaches and those that were not Trust breaches. 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.

When compared to the same period of time 2021/22, it identifies that the Trust is reporting a similar number of incidents and the ratio of Within our control / Breach vs Out of our control / No Breach remains an approximate 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

- 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

Actions outstanding, to be completed in Q4

- 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.
- Undertake 3-month, 6 month and annual reviews of service engagement vs impact / change in practice (reduction in incidents)

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 Q4, 2022/23 and therefore no further actions have been identified at present.

Report: In-Public Board Meeting

<table>
<tr><td>Item No.</td><td colspan="2">11</td><td>Presentation to</td><td colspan="3">In-Public Board Meeting</td></tr>
<tr><td>Title of paper</td><td colspan="2">People Committee Exception Report</td><td>Author</td><td colspan="3">Tina King, People Services Assistant</td></tr>
<tr><td>Purpose of the paper</td><td colspan="6">To summarise the business transacted at the People Committee held on 26 January 2023</td></tr>
<tr><td>Committees /Groups previous presented and outputs</td><td colspan="6">N/A</td></tr>
<tr><td>Statement on impact on inequalities</td><td>Positive impact (inc. details below)</td><td></td><td>Negative Impact (inc. details below)</td><td></td><td>No impact (neutral)</td><td>X</td></tr>
<tr><td>Action required</td><td>For decision</td><td colspan="2"></td><td colspan="2">For assurance</td><td>X</td></tr>
</table>

Summary of Recommendations and actions required by the author

The following reports were noted by the Committee:

Sub-Committee Exception Reports:

- **People Forum** - No meeting held to report
- The committee noted the received **Joint Consultative Negotiating Committee Report.**
- The committee noted the received **Wellbeing Oversight Meeting Exception Report**.
- The committee noted the received **Joint Local Negotiating Committee (formerly DDNC) Exception Report**. It was noted that Pension Recycling was agreed at Exec and a policy is now being developed which will be presented back to JLNC.
-

Annual Effectiveness Review: including Terms of Reference

We discussed the review and made a number of recommendations for improvement.
The final TOR will be shared with the Solent Board for sign off.

Chief People Officer Report:

- The Committee received a verbal update on current strategic matters including The People Team structure, Industrial action, The 6 people priorities, Oleeo and Project Fusion. The learning from industrial action was discussed and Solent's compassionate approach was commended.
- The 'Ask the People Team Service' is being developed which will provide a single point of access to HR services.

Workforce Performance and Workforce Metrics Report:

- A new style of report was presented, and feedback requested.

Important to get a balance between the insights the report is giving us and the assurance we can provide to demonstrate that issues are being addressed.

Board Assurance Framework:

- The BAF and its commentary was agreed.

Internal Audit and HR Self Audit:
- The Internal Audit has been completed apart from one action relating to BI which is being picked up by Execs.
- The HR self-audit is completed but discussions in place to commission a separate PWC audit.

Health and Wellbeing Plan update:
- The update was noted.
- The Committee was assured that all is on track and going to plan.

Employee Relations Assurance report / Industrial Action:
- People Partners Team were recognised for the efforts put into ensuring the Industrial Action ran smoothly.
- Length of time taken to resolve some older cases was discussed.
- Case revisions will now regularly be taking place to try to decrease timescales.
- Additional investigators are being recruited on bank to help with demand.
- Increase in complex medical cases was also noted as taking longer to resolve.

Staff Survey:
Ian Ralph – analytics lead will be leading this work….to support greater insights into data returns and associated actions.
- Limited discussion on this as results are still embargoed.
- Initial Results are looking positive.
- More detailed results will be shared at the next meeting/ followed by update to the board.

Reverse Mentoring:

- An overview of the programme was presented.
- The committee were asked to sponsor this, volunteer to take part and ask managers to support to allow people to take part.
- It was noted that the time required to be part of this should be taken into consideration.
- Training is available before the programme commences.

Workforce Planning Update:
- Workforce Planning Template is developed and will be shared next meeting.
- Operational workforce planning template from NHSE received and submission due to ICB on 23 Feb.

Digital Workforce Update:
- The report was noted. Discussion about more defined targets to measure progress on digital was discussed.
-

Apprentice Update:
- 15 new registered nurses and 2 Nursing Associates have completed apprenticeship programmes and secured roles in Solent.

	• Retention rate of 90% since 2019 was noted and praised. • Learning from this retention and recruitment success is to be considered to encourage and embed across the Trust. For cascade: thanks to the People Team for their excellent support for Industrial Action

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:	

Board and Committees- In Public Board Exception Report

Item No.	14.1			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 26 January 2023.						
Committees /Groups previous presented and outputs	N/A						
Statement on impact on inequalities	Positive impact (inc. details below)			Negative Impact (inc. details below)		No impact (neutral)	X
Action required	For decision			For assurance		X	
Summary of Recommendations and actions required by the author	The Board is asked: • To note the report from the Committee						
To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient	X	Limited		None	
Sponsor name:	Vanessa Avlonitis, Non-Executive Director Committee Chair			Exec Sponsor signature:	*V.Avlonitis*		

Summary of business transacted:

- There were no **Freedom to Speak Up Concerns, Urgent Matters of Safety or Partnership Governance Arrangements** to report.
- The Committee **noted** the following standard reports presented:
  - **Patient Safety Quarter 2 Report**- Review of ongoing activity was shared, including diagnostic phase of implementation of the Learn from Patient Safety Events System, Patient Safety Incident Response Framework and ongoing support for implementation of the RIPPLE Model. Continued work to embed Patient Safety Partners was noted and involvement in the Wards Environmental Falls Audits explained. Increase in moderate and above incidents was reported and assurance from thematic review provided. A contempory update in terms of Duty of Candour regulation was shared. *(included with Board papers- item 15.2)*
  - **Safeguarding Quarter 2 Report**- Continued high level of safeguarding activity and pressures within the team were highlighted. Increased collaborative work across the system was discussed, including ongoing activity in relation to Domestic Abuse Statutory Guidance. Work to address training compliance was noted.
  - **Infection Prevention & Control Q2 Report-** The Committee were informed of challenges in relation to training compliance and FIT testing requirements. Ongoing considerations and provision of bespoke training was shared. It was agreed to discuss training compliance in depth at the next Quality Improvement and Risk (QIR) Group.
  - **Professional Leadership and Engagement 6-month update**- An overview of professional activities across the Trust were provided, including an update on the newly appointed Head of Allied Health Professionals (AHPs) and AHP Conference. Progress in relation to international recruitment, clinical placement capacity and apprenticeships was discussed, with emphasis on links to safe staffing. The importance of system level and collaborative working was reviewed.
  - **Safe Staffing Quarterly Report** *(formally 6-monthly)*- An update was provided regarding response to staffing challenges in inpatient areas, monitoring of high level of turnover and increased use of agency staffing.

- The **Performance & Quality Exception Report** was **noted**.
    - The Committee were informed of increase in Slips, Trips & Falls reported on the Jubilee Unit and work to address was noted.
    - Continued work to support service lines in delivery of safe quality care on Hawthorne's ward was explained, with reflection/learning considerations being held.
    - A contemporary update on recent Industrial Action was provided.
- Key highlights were provided from the **Community Engagement Group Exception Report**.
    - An update on delivery of the annual plan was provided, with confirmation that 59/64 deliverables/actions were on track.
    - Continued use of community partners networks were shared and ongoing work across the system highlighted.
    - The Committee agreed critical support and Board level advocacy required.
- The **Payment Guide for Working with Patients and People** was presented. Comments were made and it was agreed to review at the next meeting, with relevant leads in attendance, to address queries.
- There were no **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)** to report.
- **Ethics and Caldicott Panel Exception Report**- There was no panel held since the last meeting.
- The **Committee Effectiveness Review** was **noted.** Consideration of wider learning and seeking assurance was discussed.
- The **Board Assurance Framework (BAF) consideration and oversight of risks Report** was presented. No comments were raised and the report was **noted** by the Committee.

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.

PATIENT SAFETY QUARTERLY REPORT INCLUDING, LEARNING FROM DEATHS, SI'S, AND INCIDENTS
QUARTER 2, 2022-2023

The report covers the period
01/07/2022 – 30/09/2022

This report brings together information from the following sources:

- Incidents
- Serious Incidents (SI)
- Learning from Deaths
- Patient Safety Strategy

1.1 The Quality and Safety teams focus for Quarter 2 has continued to be one of supporting staff to deliver safe care. There has been support to staff through de briefs and the RIPPLE model. Bespoke Incident Reporters and Reviewers training has also been provided.

1.2 In addition there has been a focus on the revised application of Duty of Candour, the Learn from Patient Safety Events (LFPSE) and changes to assigning the levels of harm to incidents.

2.0 Insight

2.1. Incidents reported across the trust in Quarter 2 2022/23 are up 9.2% compared with Q2 2021/22 and 22.1% compared with Q2 2020/21. This is shown below in figure 1.

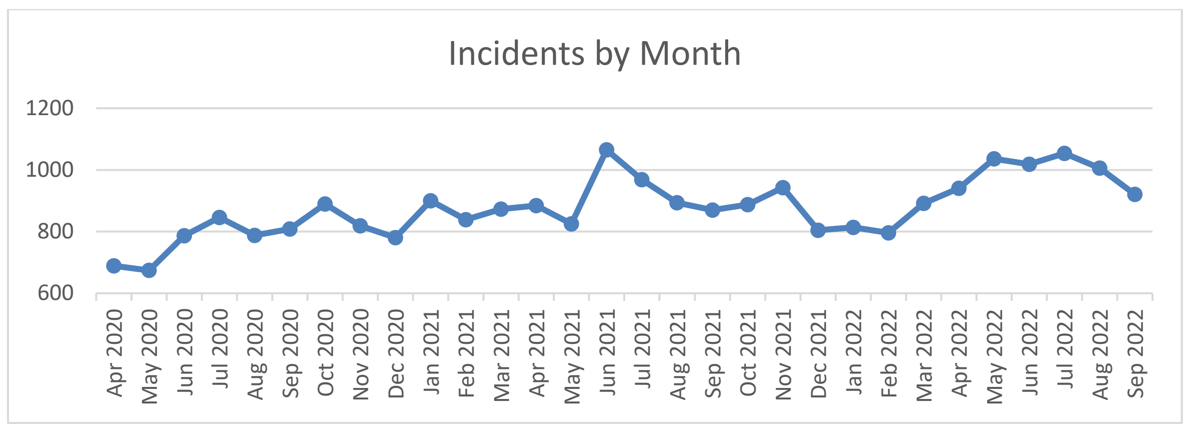


Figure 1 - Incident Reporting Trend – Trust Wide

2.2 Overall incident numbers and incidents per 1,000 contacts (as shown in figure 2) continue to show a steady increase compared with previous years.

2.3 Incident reporting and reviewing training continues to run each month, with bespoke sessions provided to Primary Care and Sexual Health which supports the strengthened reporting culture within Solent. Bespoke sessions are also planned for Adult Services Southampton in-patient units.

2.4 There continues to be an increased level of Near Miss and No Harm incidents which provides further evidence of a strong safety culture (as shown in figure 3).

2.5 Figure 3 displays an increase in the number of Moderate Incidents reported during Quarter 2 in 2022/23 when compared to Quarter 2 in 2021/22. This is mainly driven by a 62% increase in Category 3 or above Pressure Ulcers occurring within Solent care during this period. This increase is mainly attributable to Adults Services Portsmouth and a Trust-wide deep dive has been undertaken to review this trend. Further information will follow in the Q3 2022/23 Patient Safety Report.

2.6 In addition there were 6 deaths and 7 self-harming incidents in Mental Health, as detailed in section 2.9. These were graded as moderates and above. Section 2.11 details the Serious Incidents raised in this period.

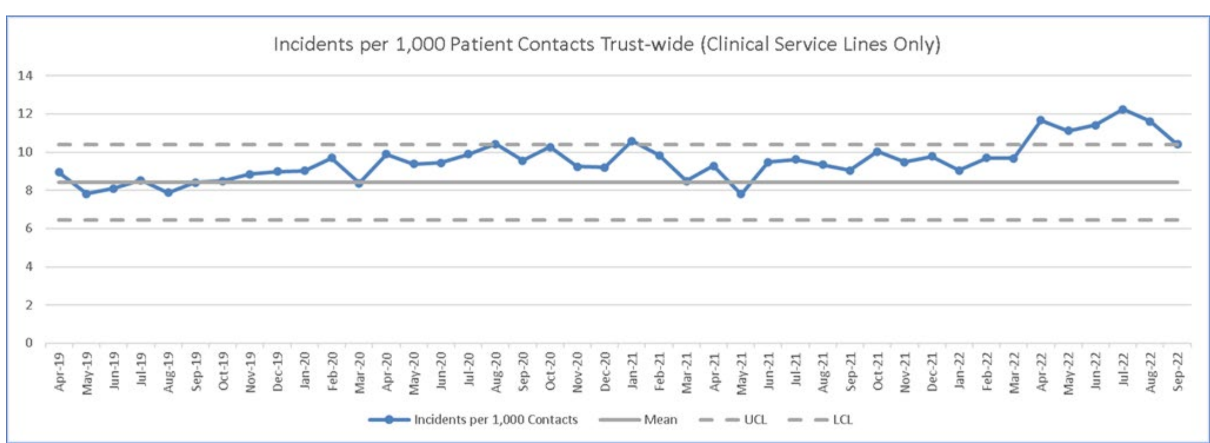


Figure 2 – Incidents reported per 1,000 Patient Contacts

Year (Q2)	Number of incidents reported	No Harm or Near Miss		Minor or Low Harm		Moderate or above Harm	
		% of overall incidents	Total	% of overall incidents	Total	% of overall incidents	Total
2020/21	2443	60.5%	1478	36.7%	896	2.8%	69
2021/22	2732	57.6%	1573	40.7%	1113	1.7%	46
2022/23	2983	66.3%	1976	30.2%	898	3.5%	105

Figure 3 - Incidents breakdown by Actual Impact during Quarter 2

2.7 Duty of Candour Regulation

2.7.1 In June 2022, the Care Quality Commission issued updated guidance on the application of Duty of Candour. The changes clarified how the term “unexpected or unintended” should be applied to decide if something qualifies as a “notifiable safety incident”.

2.7.2 A notifiable safety incident must meet all 3 of the following criteria:

- It must have been unintended or expected.
- It must have occurred during the provision of an activity CQC regulate.
- In the reasonable opinion of a healthcare professional (the incident) already has, or might, result in death, or severe or moderate harm to a person receiving care.

2.7.2 This identified a change to the Trust’s current process whereby only if there had been a presence of fault it was determined a notifiable safety incident and duty of candour was undertaken.

2.7.3 Following the release of the guidance. The Quality and Safety team reviewed the Incident Review meetings held in July/August 2022 to ensure that any “notifiable safety incidents” had been identified and acted on.

2.7.4 In addition a review of the way Solent manages its Duty of Candour led to the following actions:

- A learning poster outlining the key points was distributed to all staff.
- The structure of Incident Review Meetings (IRMs) was changed to include:
  1. A clear reference to Being Open and Duty of Candour
  2. A decision whether an incident meets the criteria for “notifiable safety incident”

3. Discussion about whether an incident was unexpected

- IRM chairs received a briefing on the changes.
- A working group was established to look at policy, audit, training, and compliance. The policy is to include reference to Duty of Confidentiality when consent to share has been withdrawn by the patient.
- A survey of staff on their knowledge and competence around Duty of Candour will take place in Q4 2022/23.
- A workshop will be held at the Quality Improvement and Risk Group on 12th December to focus on Duty of Candour.

2.8 Levels of Harm

2.8.1 The CQC guidance also provided updated definitions of Moderate and Severe Harm which the Quality & Safety Team reviewed in conjunction with the definitions of Harm produced as part of NHS England's Learn From Patient Safety Events (LFPSE) project. Both sets of guidance were compared with the current way in which Solent grade incidents. The review highlighted that the internal guidance used to review the harm was misleading and was not being consistently applied.

2.8.2 Therefore, from 1st October 2022, the assessment and assigning of Actual Impact has been changed to provide detailed guidance to reporters and reviewers, who are better placed to make the judgement, on how to grade incidents, and responsibility for the assessment will be with these individuals from 1st April 2023. The Quality and Safety team have also clarified that where patients or staff are involved, the Actual Impact will be based on the harm to the individual. The Quality and Safety Team will be providing support and guidance to staff to support the assigning of the level of harm.

2.8.3 As a result of this, it is not anticipated the overall number of incidents where No Harm/Near Miss has occurred will change. However, the proportion of incidents in the Minor, Moderate and Severe categories may show some slight adjustment which will be reflected in the Q3 data.

2.9 Incidents in Community Mental Health

2.9.1 In September 2022 there was a significant increase in the number of deaths relating to suspected suicide in our Community Mental Health teams as illustrated in Figure 4

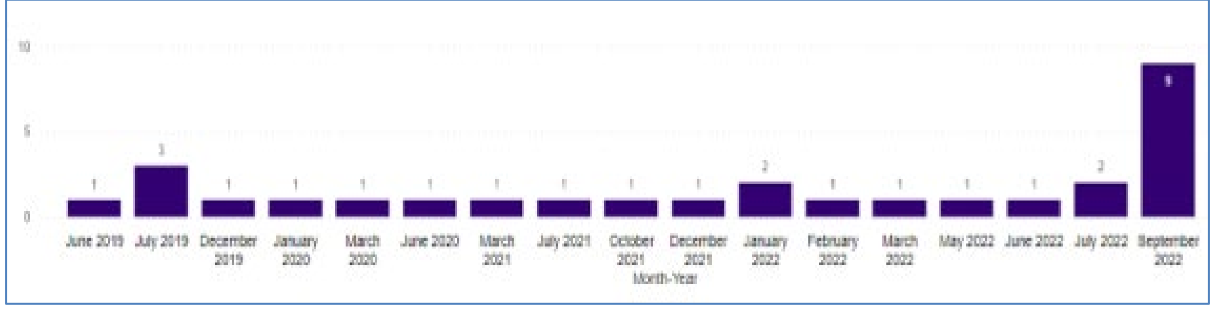


Figure 4 - Unexpected deaths in the Assessment to Intervention (A2i), Crisis and Resolution Home Treatment (CRHT) & Recovery Teams

2.9.2 An initial review of the eight cases was undertaken, and a thematic analysis commissioned, which will review and analyse each case individually to establish any themes or trends which may link the incidents. At the time of writing this report seven clinical case reviews have been undertaken. So far there has been no clear learning from the reviews, although some have noted missed opportunities.

2.9.3 Included in this review is an incident of suspected homicide and subsequent suicide which is being investigated as a Serious Incident.

2.9.4 The Mental Health service currently remains under a high level of pressure. Staff in the teams have been supported both collectively and individually under the staff support RIPPLE Model. Feedback was exceptionally positive from those involved and the Quality & Safety Team will continue to publicise the RIPPLE model, along with other support available to staff, when dealing with challenging or traumatic events.

2.10 Incident Cause Groups

2.10.1 The top 10 cause groups for incidents reported remains largely unchanged from previous quarters. These are shown in figure 5.

2.10.2 Medication incidents remain the most reported incident. It is anticipated with the continued implementation of Electronic Prescribing and Medicines Administration (EMPA) on the wards and the introduction of the EPMA Medication Safety Nurse Specialist this will reduce.

2.10.3 As detailed in section 2.6.4 the pressure ulcer trust wide deep dive will provide explanation and learning for the number of pressure ulcers being reported.

2.10.4 Clinical Delays in care and staffing issues are intrinsically linked and are detailed on the Trust risk register. They are discussed at the Safe Staffing meetings and at the Quality Risk and Improvement Group. There are specific actions in place to increase the recruitment of clinical staff. However, it is recognised this is a nationwide problem.

2.10.5 The level of physical assaults remains a concern and although these are mainly attributed to Mental Health Services, the review of the cause of these incidents and support for staff continues to be a high priority.

2.10.6 The environmental falls audits for the wards continue with the Falls Project Lead, Patient Safety Partners, and Patients. Learning has been identified and actioned at the end of each audit. The audits will continue into Q4 2022/23.

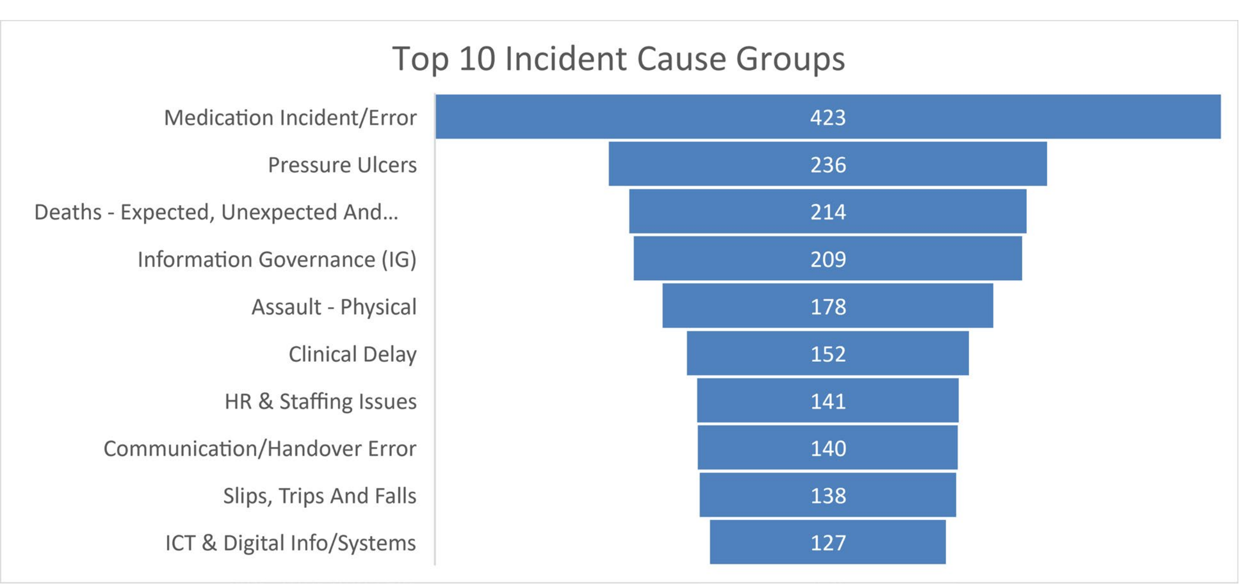


Figure 5 - Incidents by Cause Group

2.11 Serious Incidents

2.11.1 Six Serious Incidents were declared in Quarter 2. These are being investigated and the learning from them will be discussed at future Learning from Incidents and Deaths Panels. See figure 6.

Service	Description
Adult Services Portsmouth	A palliative patient developed a wound on his spine that was initially categorised as shearing. The wound subsequently developed into an unstageable PU.
Adult Services Southampton	A community patient required escalation for the treatment of a hypoglycaemic event.
Mental Health Services	Between September 2021 and July 2022 there have been 32 separate incidents reported for a patient with a diagnosis of Emotionally Unstable Personality Disorder, including 2 overdoses and 11 instances of self-harm, including 3 while an in-patient.
	A patient of the Crisis Resolution Home Treatment Team is thought to have committed a homicide before taking his own life.
Special Care Dental	A formal People Services investigation, which started in March 2022, has identified potential patient harm in at least 5 cases, including instances of missed dental decay, delayed referrals, and incomplete notes.
	A young patient attended a community dental clinic where they had 7 teeth extracted. However, in total 8 teeth required extraction resulting in an additional procedure, under general anaesthetic, being necessary for the patient.

Figure 6 – Serious Incidents declared in Q2 2022/22

2.12 High-Risk Incidents

2.12.1 All high-risk incidents are investigated by the Service lines and the learning presented as a poster at future Learning from Incidents and Deaths panel. Figure 7.

Service	Description	Cause Group
Mental Health Services	A patient on Hawthorn was administered Quetiapine in error.	Medication Incident/Error
	A patient on Hawthorn Ward was placed in tertiary seclusion after their behaviour was not de-escalated correctly.	Clinical Management
Adult Services Southampton	Patient experienced a Deep Vein Thrombosis (DVT) whilst admitted to Lower Brambles Ward, RSH	Venous Thromboembolism

Figure 7 – High-risk Incidents declared in Q2 2022/23

2.13 Learning from Deaths

2.13.1 During Quarter 2 2022/23 444 people in receipt of services provided by Solent NHS Trust have died. In 74 cases the patient's death was reviewed using a Structured Judgement Tool (SJT), Investigation or a Multi-Disciplinary Team (MDT) discussion. The breakdown by Service Line is shown in Figure 8.

Service line	Number of deaths reported	Reviewed via SJT, MDT, or Serious Incident Investigation	Reviewed by another provider	Total Reviewed (% of cases reviewed)
Adult Services Portsmouth	193	32	0	32 (16.6%)
Adult Services Southampton	172	18	9	27 (15.7%)
Child & Family Services	3	0	0	0 (0%)
Mental Health Services	45	11	1	12 (26.7%)
Primary Care	28	0	0	0 (0%)
Sexual Health	3	3	0	3 (100%)
Total	444	64	10	74 (17.3%)

Figure 8 – Reviews of patient deaths completed in Q2 2022/23

2.13.2 Of the 64 reviews undertaken by **Solent**, 56 used an SJT to determine the Quality of Care provided and Preventability of the death. Of these 94.6% of cases were either Not Preventable or only Slight Evidence of Preventable whilst 98.2% rated the Quality of Care provided either Good or Excellent.

2.13.3 The Quality & Safety Team recognise that Solent's Mortality Reporting has scope to be improved and are working with colleagues at Southern Health Foundation Trust to both

update and align our policies and processes, capturing the best aspects of both. Work will continue in Quarter 3 and Quarter 4 of 2022/23 before a new Learning from Deaths policy is released in Q1 of 2023/24.

3.0 Involvement

3.1. Patient Safety Strategy update

3.1.1 During Quarter 2, the Patient Safety Incident Response Framework (PSIRF) was published by NHSE. In addition, NHSE also released further information on the Learn from Patient Safety Events (LFPSE) Service. The update will focus on these areas but also provide an update on the implementation of the Patient Safety Partners and the Patient Safety Syllabus.

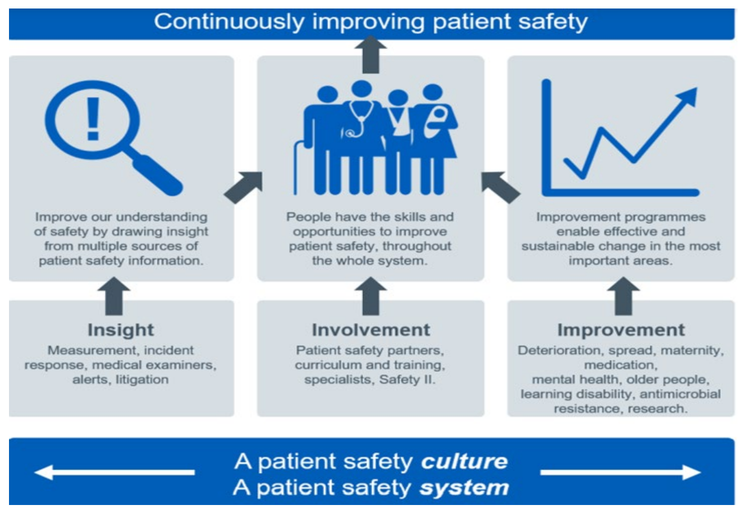


Figure 9. Patient Safety Strategy elements

3.1.2 In September an induction workshop was provided to all four of the Patient Safety Partners. This provided an opportunity to get to know each other and receive training on Patient Safety, Psychological Safety and Just Culture. The Heads of Quality and Professions also provided an overview of their services.

3.1.3 A draft remuneration policy was shared for comment and the Patient Safety Partner Policy commenced along with an evaluation of the role. These will be completed by Quarter 4. Solent continue to work with NHSE as part of the early adopter's group.

3.1.4 The compliance of level 1 and 2 Patient Safety training continues to be monitored and is discussed with each Service line at their monthly Quality Review meetings. Solent remain on target of 85% compliance of level 2 by Quarter 1 2023/24. Figure 10.

Training	Q2 Level of Compliance	Q1 Level of Compliance
Level 1 – Essentials of Patient Safety	87%	84%
Level 1 – Essentials of Patient Safety for Boards	89%	90%
Level 2 – Access to Practice – Patient Safety	68%	39%

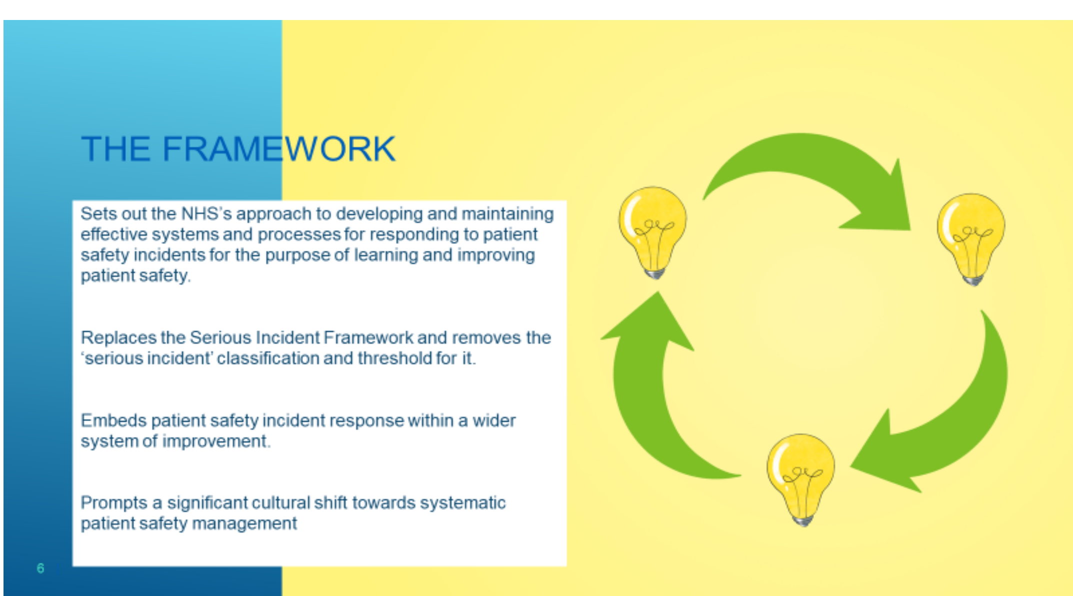
Figure 10 - Patient Safety Training Compliance levels 30th September 2022

3.1.5 The National Reporting Learning System (NRLS) will be replaced in March 2023 by the LFPSE System. NHSE have been developing the system with feedback from Organisations. Solent continue to provide feedback and engage with services on how the changes will affect staff, reporting, and the validation of incidents. Further information will be shared in Quarter 3.

3.1.6 Following an evaluation of the implementation of PSIRF by early adopters, the revised version of the framework was released in August 2022. Considering Project fusion, Solent's implementation is in collaboration with Southern, Sussex Partnership and the Isle of Wight. Solent are in the orientation phase and are engaged in the NHSE PSIRF webinars and NHS Futures Platform.

3.1.7 NHSE have produced this timeline for its implementation.

3.1.8 The Framework will radically change the way we respond to patient safety events as detailed below. Further information will follow in the Quarter 3 report.



3.2 The RIPPLE model

3.2.1 The RIPPLE model, launched in April 2022, has been designed to offer staff appropriate and timely support following an incident.

3.2.2 An initial evaluation has now been completed which identified that, to date, 72 incidents reported requested additional support via the RIPPLE model (see figure 11 for a breakdown by Service Line). The incidents requesting additional support were across several cause groups, with 14 incidents following an Assault and 6 due to HR or Staffing issues.

3.2.3 The evaluation found the following.

- The Quality & Safety Team have, on occasion, provided emotional support to reporters which may not always be appropriate.
- The Quality & Safety Team have been too helpful in taking on work rather than signposting reporters to more appropriate areas.
- Links have also been established with colleagues across the Trust, including Occupational Health, to ensure a co-ordinated and supportive signposting for staff when in need of additional support.
- The recording of information relating to outcomes has been reviewed and updated.
- To inform reporters, an explanation of the RIPPLE Model has been added to the Trust's Incident Reporting System, Ulysses.
- The Team have been publicising the Ripple model to staff. The model has also shared with other NHS Trusts outside the region.

Service Line	Q1	Q2	Grand Total
Adult Services - Portsmouth	3	3	6
Adult Services - Southampton	7	11	18
Child & Family Services	5	6	11
Corporate Services	1	0	1
FM And Estates	1	1	2
Mental Health Services	8	5	13
Primary Care	4	2	6
Sexual Health Services	4	3	7
Specialist Dental Services	2	6	8
Grand Total	**35**	**37**	**72**

Figure 11 – Incidents requesting support via the RIPPLE Model

3.2.4 Following the increase in deaths experienced in Mental Health Services in September, a series of facilitated peer support sessions (often referred to as "de-briefs") have been held with the Teams involved, facilitated by the Quality & Safety Team. These have proved extremely beneficial to the staff involved with feedback being received that they were a fantastic source of support. As the uptake increases, the resource required to effectively facilitate the RIPPLE Model will be reviewed. We will explore options for upskilling staff in Trauma Risk Management (TRiM) training to facilitate these "de-briefs".

4.0 Next Steps

The Quarter 3 report will provide further information on the following:

4.1 The commissioned review of the process of the Quality Improvement and Risk Group.

4.2 The Freedom to Speak up Lead and the Interim Associate Director of Quality and Governance plan on how Safety Chats will be implemented in more services.

4.3 A Safety, Excellence, and Improvement forum (postponed from September) planned to take place on Fanshawe Ward at the Royal South Hants Hospital in November and will include sessions on Safety Chats, the RIPPLE model, and Patient Safety Partners.

4.4 The Quality Evidence meetings held by the Quality and Governance team development to include Audit and the Clinical and Organisational Assurance team.

4.5 The Patient Safety Incident and Response Framework move into the Diagnostic and Discovery phase.

4.6 The release of the training and communication plans for the implementation of Learn from Patient Safety Events.

4.7 The Rescheduled Medication without Harm Conference (postponed from September) with the keynote speaker being Dr Chris Turner presenting Civility Saves Lives.

4.8 The Learning from Deaths Policy review in collaboration with Southern Health Foundation Trust.

4.9 An update on the Mental Health Deaths Thematic Review, scheduled to be presented at QIR in Quarter 4 2022/23.

Item No.	15		Presentation to	In-Public Trust Board – February 2023		
Title of paper	Finance and Infrastructure Committee exception report					
Purpose of the paper	The aim of this paper is to update the In-Public Trust Board on key items discussed at the January 2023 Finance and Infrastructure Committee.					
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: • Note the exceptions from the January Finance and Infrastructure Committee					

To be completed by Exec Sponsor - Level of assurance this report provides:							
Significant		Sufficient	X	Limited		None	
Exec Sponsor name:	Stephanie Elsy, Non-Executive Director & Committee Chair			Exec Sponsor signature:	[signature]		

For approval

No items require Trust Board approval.

For noting

1. **Month 9 financial position including ICS update** - The committee received a high-level summary of the M9 financial position; discussions focussed on agency spend, CIPs and the overall ICS system challenges.
2. **Budget and Business Planning update**- The committee were informed of the Business Planning, Support and Challenge sessions scheduled for week commencing 30 January 2023, outcomes to be presented at an executive meeting on 03 February 2023, with an update due to Trust Board on 06 February 2023.
3. **ICT update –** The committee received an overview of the ICT highlight report, noting the key achievements and planned works.
4. **Finance and Commercial Group Escalation Report –** The committee noted the Finance and Commercial Group escalation report.
5. **BAF update –** The committee noted the BAF update, focussing discussions on risk 5, financial sustainability.
6. **Internal Audit Recommendations**- The committee noted the Internal Audit Recommendation update report.
7. **Finance and Infrastructure Committee Agenda Cycle** – The committee approved the F&IC agenda cycle, subject to agreement on submission dates for the Corporate benchmarking updates.