Agenda

Solent NHS Trust In Public Board Meeting

Date: Monday 5 June 2023
Timings: 09:30 – 13:10
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**	Chief of Nursing and AHPs	To receive
3	10:05	30mins	**Staff Story** *Erin Power Co-Chair of Disability Staff Network and Elton Dzikiti*	Chief People Officer	To receive
4	10:35	10mins	**Reflection on Patient and Staff Stories**	Chief of Nursing and AHPs Chief People Officer	To discuss
5	10:45	5mins	• **Previous minutes, matters arising and action tracker**	Chair	To approve
Quality and safety first					
6	10:50	10mins	**Safety and Quality – contemporary matters including:** • **Board to Floor Year End Report** • **Freedom to Speak Up verbal update**	Chief of Nursing and AHPs Chief of Staff	To receive Verbal update
Items to receive					
7	11:00	20mins	**Chief Executive's Report**	Chief People Officer	To receive

Items to approve					
8	11:20	5mins	**2023/24 Financial Plan**	Chief Finance Officer	To approve
10-minute break					
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 (to include annual signing)*	Executive Leads	To receive
10	12:10	10mins	**Annual Review of Strategic Objectives**	Chief Strategic Transformation Officer	To receive
11	12:20	10mins	**Information Governance Annual Report**	Chief of Staff	To receive
12	12:30	10mins	**Safe Staffing- Quarter 4 Report**	Chief of Nursing and AHPs	To receive
13	12:40	10mins	**EDS Action Planning Update**	Chief People Officer	To receive
Governance					
Reporting Committees and Governance matters					
14	12:50	15mins	**Annual Review of Board of Directors Terms of Reference (and committees Terms of Reference)**	Chair	To approve
15			**People Committee -** *Exception report from meeting held 18 May 2023*	Committee Chair	To receive
16			**Mental Health Act Scrutiny Committee-** *No meeting held to report*	Committee chair	To receive
17			**Audit & Risk Committee –** *No meeting held to report*	Committee chair	To receive

18			**Quality Assurance Committee-** *Exception report from meeting held 18 May 2023* • *Research & Development Annual Report*	Committee chair	To receive
19			**Non-Confidential update from Finance & Infrastructure Committee–** *non confidential escalation report from meeting held 30 May 2023*	Committee chair	Verbal update
20			**Charitable Funds Committee –** *Exception report from meeting held 11 May 2023*	Committee chair	To receive
21			**Remuneration and Nominations Committee –** *no meeting held to report*	Committee chair	To receive
Any other business					
22	13:05	5mins	**Any other business and reflections including:**	Chair	-
23			• ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***	Chair	
24	13:10	---	**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:

- *7 August 2023*

SHE HER

Erin Louise Power BSc MCSP PG Cert BSL2
Clinical Workforce Development Team

NHS Solent NHS Trust

- Returned to Solent in OCT 2018 to work in student education, manual handling and preceptorship
- Completed PG Cert in Special and Additional Learning Needs
- **Workplace coaching identified undiagnosed Autism**

- **Diagnosed Autistic and BSL trained**
- Continual Professional Development Funding Lead

2019 2020 2021 2022 2023

- **Diagnosed Dyslexic in 2009 whilst at university**
- Trained Physiotherapist since 2011 who has worked in all specialities and Trusts across the Hampshire patch
- Specialised in Neurology, Oncology and Palliative Care

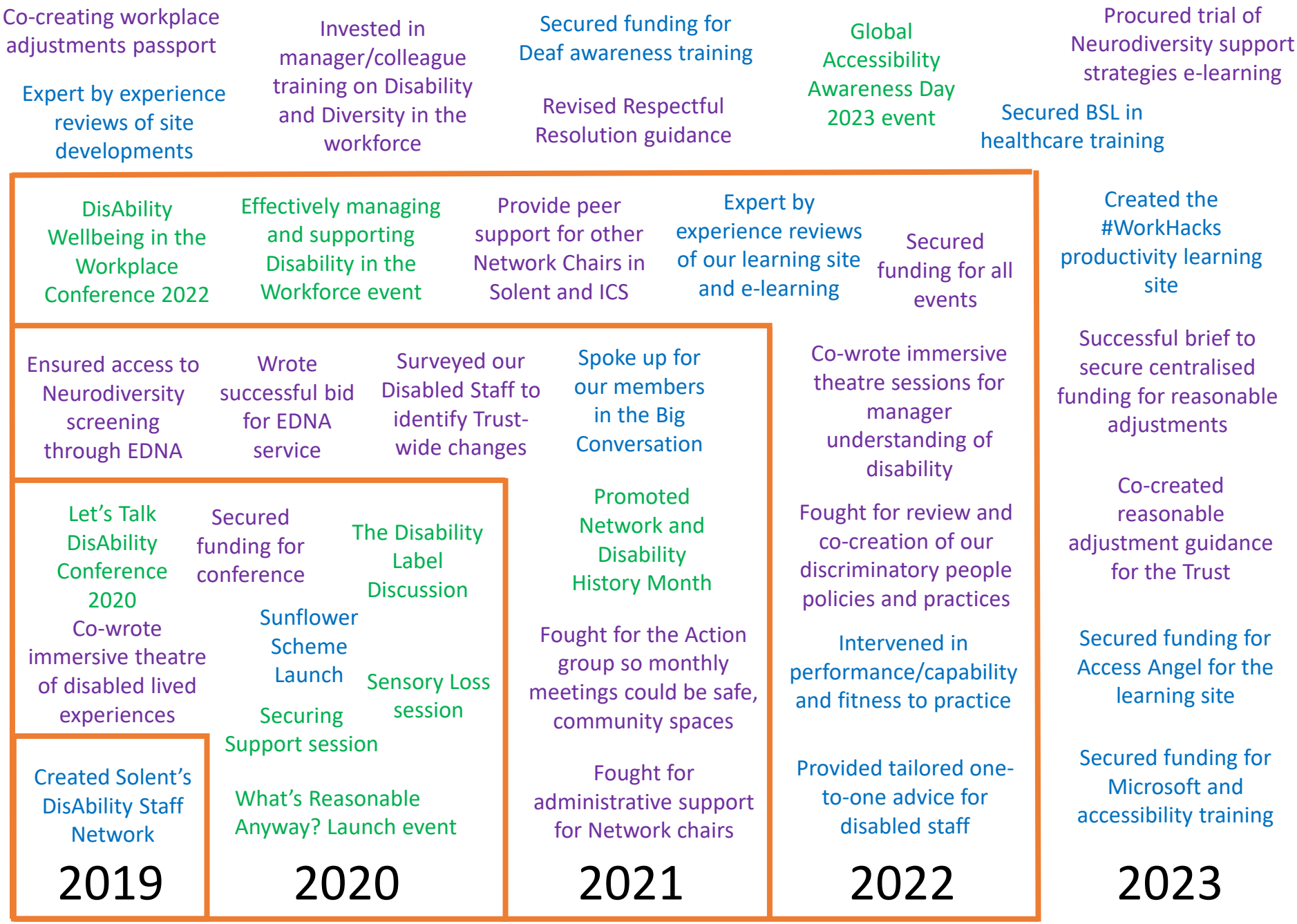
- Seconded to Trust-wide AHP Professional Lead during COVID pandemic
- Provided system-wide leadership on AHP job Planning and Clinical Placements Expansion
- **Diagnosed with long-term health conditions**

Availability: Tuesdays to Fridays with flexible hours

Location: Work from home with my support dog Penny

Contact: I have accessibility requirements for phone/MS Teams calls and in-person meetings so please contact me **by e-mail or MS Teams messages**.

I WEAR THE SUNFLOWER
TO SHOW THAT I HAVE A HIDDEN DISABILITY

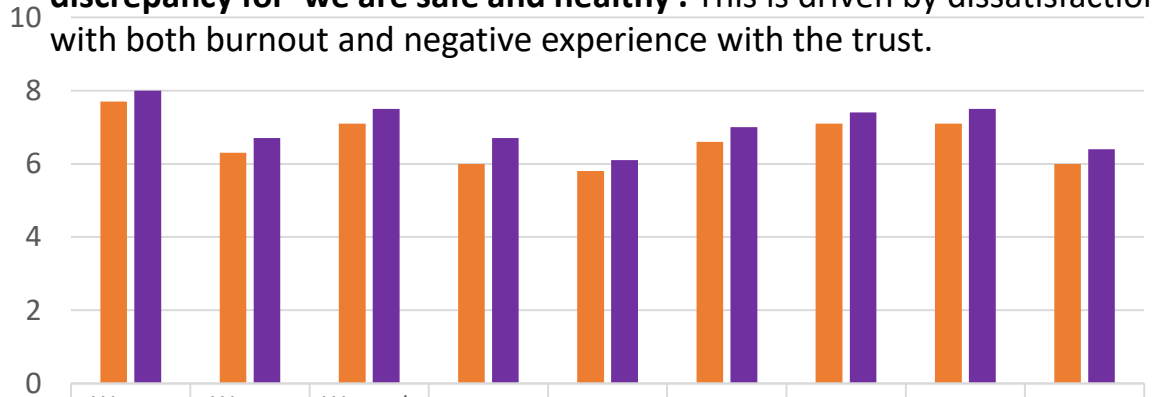

Co-creating workplace adjustments passport
Expert by experience reviews of site developments
Invested in manager/colleague training on Disability and Diversity in the workforce
Secured funding for Deaf awareness training
Revised Respectful Resolution guidance
Global Accessibility Awareness Day 2023 event
Procured trial of Neurodiversity support strategies e-learning
Secured BSL in healthcare training
DisAbility Wellbeing in the Workplace Conference 2022
Effectively managing and supporting Disability in the Workforce event
Provide peer support for other Network Chairs in Solent and ICS
Expert by experience reviews of our learning site and e-learning
Secured funding for all events
Created the #WorkHacks productivity learning site
Ensured access to Neurodiversity screening through EDNA
Wrote successful bid for EDNA service
Surveyed our Disabled Staff to identify Trust-wide changes
Spoke up for our members in the Big Conversation
Co-wrote immersive theatre sessions for manager understanding of disability
Successful brief to secure centralised funding for reasonable adjustments
Let's Talk DisAbility Conference 2020
Co-wrote immersive theatre of disabled lived experiences
Secured funding for conference
The Disability Label Discussion
Sunflower Scheme Launch
Sensory Loss session
Securing Support session
What's Reasonable Anyway? Launch event
Promoted Network and Disability History Month
Fought for the Action group so monthly meetings could be safe, community spaces
Fought for administrative support for Network chairs
Fought for review and co-creation of our discriminatory people policies and practices
Intervened in performance/capability and fitness to practice
Provided tailored one-to-one advice for disabled staff
Co-created reasonable adjustment guidance for the Trust
Secured funding for Access Angel for the learning site
Secured funding for Microsoft and accessibility training
Created Solent's DisAbility Staff Network
2019
2020
2021
2022
2023

I've always overcompensated to make sure I'm not seen as the weak link. I think this helped me have good credit with my team as my disability progressed. **I feel lucky that they accept me but I shouldn't have to feel lucky – being accepted, respected and valued is the every day experience of a non-disabled person and I deserve that too**. I don't feel safe to apply for a different role because I won't be as lucky.

It's a lottery out there and the odds are not in our favour. **We are surrounded by colleagues, managers and people practices which reinforce the disability equals weakness model, and if your reasonable adjustments don't 'fix' you to be like everyone else then you should do them a favour and quit seen as you 'don't pull your weight'.** Never mind that the patients think the care I give them is great because they can actually relate to me – apparently that doesn't matter.

I'm tired of explaining all the time, and **I'm really tired of you not believing me. Why won't you trust us,** why do you think we want to take advantage of things like disability leave?

Staff with disability rates Solent lower for all 9 measures, with the biggest discrepancy for 'we are safe and healthy'. This is driven by dissatisfaction with both burnout and negative experience with the trust.



	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Disability 2022	7.7	6.3	7.1	6.0	5.8	6.6	7.1	7.1	6.0
No Disability 2022	8.0	6.7	7.5	6.7	6.1	7.0	7.4	7.5	6.4

So many of our conditions are exacerbated by stress and anxiety, we don't need the extra stress of our workplaces not supporting us properly.

It's the first place I've worked where I can say it out loud, I trust you enough to be honest.

I feel that I shouldn't complain because it feels like a start, and that's better than the other trusts, but **is that really Solent's goal – to just not be the worst?**

It's good we can share this, because we feel you are capable of changing.

Take Action Now and for Fusion

Remove the barriers between us and our reasonable adjustments	**Reasonable adjustments guidance** for managers to follow and reduce inequity of experience
	Centralised funding for reasonable adjustments to reduce inequity of provision
	This is Possible – A Menu of Provision resource which lists what can be used in the trust and how compatible it is with our systems, not just software and apps but digital and non-digital equipment too.
	Clearly identified contact and pathway to get our digital needs met which includes procuring, installing and updating our software, apps and devices
Use our expert by experience to remove the discrimination in our workplace policies, practices and people	**Sickness/Absence policy;** The Bradford Index is discriminatory to disabled staff and we should be given automatic exemption. We should also be issued with disability leave for attending our medical appointments that is not taken from our annual or sick leave entitlement or asked to make up the hours.
	Disciplinary/Grievance policy; review of this policy and the new Respectful Resolution approach to ensure it is not unfairly applied to individuals due to their disability. As the Agile working guidance relates to workplace behaviours and practices this should be reviewed by lived experience staff too.
	Performance/Capability policy; must be completely re-written and co-created with the networks. Performance is capability and capacity, often capability measures aren't measuring what they intend to measure – unfairly focusing on the how – and fail to make reasonable adjustments for the capacity differences (time taken/caseload etc) of being disabled. **Once disability is declared or it is recognised that reasonable adjustments need adjusting, performance management must be stopped** (once addressed and if necessary then performance management should start from the beginning again).
	Case reviews with lived experience staff; Ensure people partners review cases of performance, disciplinary and sickness etc with the EDB team and staff with lived experience to ensure robust challenge of whether a disability or other protected characteristic is a factor.
	Allow emotional and communication needs advocates into performance, disciplinary, sickness review etc meetings of disabled staff, in addition to their trade union rep, and let them speak if the staff member has consented to this.
Support and involve your networks	**Protected time, responsibilities and investment in Staff Network Chairs;** Invest in us and value our lived experience voices as highly as the 'experts' in the room, tell the whole trust what our value is.
	Board to Belonging; The board is a decision making team and the networks will help you make effective decisions. We are the easiest to access sounding-board who are the most committed to improvement and you'll always get a balanced authentic response.

Item 5.1

Minutes

Solent NHS Trust In Public Board Meeting

Date: Monday 3 April 2023
Timings: 09:30 – 13:20
Meeting details: Kestrel, 2nd Floor- Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Chair: **Mike Watts,** Acting Trust Chair (MW)	
Members: **Andrew Strevens,** CEO (AS) **Dan Baylis**, Deputy CEO & Chief Medical Officer (DB) **Angela Anderson,** Chief of Nursing and Allied Health Professionals (AA) **Alasdair Snell,** Chief Operating Officer (ASn) **Rachel Goldsworthy**, Chief of Staff, Governance & Corporate Affairs (RG) **Nikki Burnett**, Chief Finance Officer (NB) **Debbie James**, Director of Strategic Transformation (DJ) **Shahana Ramsden**, Chief People Officer (SRa) **Gaurav Kumar**, Non-Executive Director (GK) **Stephanie Elsy,** Non-Executive Director (SE) **Vanessa Avlonitis,** Non-Executive Director (VA)	**Attendees** **Shani Davies**, Associate Director People (observing-virtually) **Andrea Hewitt**, Associate Director Communications (item 6 & 10) (AH) **Anastasia Mulenga-Lungu**, Head of Community Engagement & Experience (item 10) (AML)
Patient Story (item 19) **Linda Stephens**, Adults Portsmouth (LS) **Sue Bridge**, Patient (SB)	**Staff Story (item 3)** **Jacqui Wilkinson**, Schwartz Round Lead (JW) **Nicola Lowther**, Associate Practitioner, Lead for Health Care Support Worker Development (NL)

1	**Chairman's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declaration of Interests**
1.1	MW 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	***Previous minutes, matters arising and action tracker**
2.1	The minutes of the last meeting held on Monday 6 February were agreed as an accurate record, subject to minor amendment.
2.2	Action Tracker It was agreed that the following actions remain open on the tracker until confirmation of closure/discussions held: AC004997, AC004998, AC005062
3	**Safety and Quality – contemporary matters including:** • **Board to Floor feedback verbal update** • **Freedom to Speak Up verbal update**
3.1	DB briefed the Board on Junior Doctor Industrial Action taking place between 11-15 April 2023.

	The Board were informed of low community service impact and briefed on potential challenges, including out of hours cover. Potential strike action from the British Dental Association was explained and continued adherence to procedures was noted. Impact on dentistry waits were discussed and continued monitoring confirmed.
3.2	There were no matters of Freedom to Speak Up to raise.
3.3	<u>Board to Floor feedback</u> AA provided and overview of visits undertaken and themes identified. Positive areas such as wellbeing offers were noted. The Board were informed of areas for improvement/action, including, estate, staffing, IT and parking.
4	**Quarterly Safe Staffing Report**
4.1	AA presented the report and explained key items to note. • Continued challenges for services during quarter 3 were shared, however AA assured that safe staffing and patient safety were managed effectively by reviewing caseload and flexible working. • It was confirmed that, following review of workforce metrics, quality indicators and divisional commentaries, the staffing levels across the nursing & AHP workforce in Solent NHS Trust were maintained with no specific risks identified. • AA briefed on continuing development of the safe staffing report and the ongoing work to improve the approach to safe staffing and improve reporting matrix.
4.2	VA queried potential issues in relation to vacancies, skill mix and use of registered and unregistered staff. AA explained requirements for 2 registered nurses in most areas and confirmed that no issues had been identified.
4.3	RG commented on the high level of reporting required however queried clarity of safe staffing levels throughout the reporting period. AA assured of safe staffing levels maintained and explained methods, including use of temporary staffing.
4.4	RG asked about learning identified through recruitment events. AA reflected on further work required and review taking place, with reporting expected within the quarter 1 report.
4.5	DB commented on the positivity of work to review safe staffing for community nursing and emphasised the importance of consideration of how identify reasonable levels. AA confirmed deep dive being undertaken to define and plan workforce against.
4.6	VA asked about annual planning for recruitment including schemes and initiatives considered. AA informed of recruitment targets in place and oversight via the planning process. AA acknowledged areas requiring further review, including staff turnover. SRa commented on review within the Workforce Summit and highlighted progress being made. VA noted work with universities to encourage nursing opportunities and AA explained ongoing discussions in relation to student nursing.
4.7	AS reflected on additional surge capacity and level of assurance provided. AA emphasised continued monitoring in place.
4.8	The Board were briefed on intention to improve risks, however inclusion was noted to highlight key risks from the risk register.

	The Board noted the Safe Staffing Report.
5	**Staff Story- Schwartz Rounds**
5.1	SRa introduced JW and NL to the meeting. • JW provided an overview of the background of the Schwartz Rounds and importance of the initiative to provide a psychologically safe space for staff. • Process of the Rounds and offer across the Trust was explained, including alignment to the Ripple Model. • JW and NL shared their stories and experiences of the Rounds. Learning, rewards, and impact was highlighted. • An overview of challenges were shared including identifying story tellers, communicating, sharing understanding of the purpose of the rounds, ensuring used across all geographical areas and training facilitators.
5.2	SE asked about the communication used to engage across the Trust geographical areas. JW confirmed use of central communication team and recommendations. Review of models of delivery within care groups going forward to further awareness and accessibility was confirmed.
5.3	DB emphasised critical role of Schwartz Rounds within the new organisation and review of financial constraints. It was confirmed that a report would be submitted to the Clinical Executive Group (CEG) to ensure prominence and to maintain as a fundamental core element of wellbeing offers and the RIPPLE Model, whilst factoring in costs. Full support of the Senior Leadership Team was highlighted.
5.4	Regarding the recruitment of story tellers, RG commented on the importance of empowering staff to share their stories and remove barriers with clear engagement and potential use of Board level role modelling. JW agreed and highlighted usefulness of this level of support and advocacy.
5.5	AA asked about the follow up process in place for those that may have been effected by stories shared. JW explained protective measures in place to ensure staff safety and wellbeing both during and after the rounds.
5.6	GK queried potential challenge in relation to resource and demand. JW informed of increased demand for 'pop up' rounds and shared future planning as part of the care groups and system to increase capacity. GK asked about prioritisation of requests and JW explained allocation and lack of objective measures for prioritising. The need to broaden in terms of non-clinical rounds was recognised.
5.7	VA queried management of protected time for service line staff attending the rounds. JW acknowledged challenge and continued work to ensure allocation of time. DB commented on intention to ensure embedded within business cases and equity across the organisation. Importance of senior level advocacy was reiterated and ensuring priority aligned to Project Fusion was emphasised.
5.8	JW led the Board in a guided meditation session. The Board commended the work undertaken. *JW and NL left the meeting.*
6	**Annual Staff Survey Report**
6.1	AH presented the report. • Positivity of high response rate was noted. It was also confirmed that the Trust had maintained a strong performance in staff satisfaction during challenging times and was now top amongst peers for 5 of the 9 key measures.

	• AH briefed the Board on themes identified and shared planning for areas requiring improvement, with links to cultural analysis work. • Themes from a national perspective were highlighted, including decline in scoring for recommendation as a place to work. • Usefulness of prompt sharing of results for enabling quality discussions was discussed. • SRa informed the Board that workshops were being organised by People Partners to review, understand results, and consider learning to transpose into actions. • It was noted that a high-level Trust plan would be established following full review.
6.2	Regarding appraisal feedback, AA queried actions being taken to review across the organisation due to recurrent theme identified. SRa confirmed that a report would be submitted to the next People Committee to understand areas of support and learning required.
6.3	SE commended strong leadership and culture evident across the organisation. Continued work to understand, learn and improve was also commended.
6.4	AH commented on the usefulness of postal votes and WhatsApp to improve engagement in completing surveys.
6.5	NB asked about expected results following actions put in place after the last annual survey. AH informed of areas being reviewed and action plan metrics considered to provide clarity.
6.6	DB asked about considerations of staff reporting disabilities and potential statistical differences. AH reflected on further work required, together with the Equality Diversity and Inclusion team and the Disability Network. DB emphasised the importance of targeted interventions to ensure support and effective intervention. SRa commented on associated considerations with the Big Conversation and the People Strategy. Action planning and discussions within staff groups was noted.
6.7	AS highlighted the need for further considerations of bank staffing results to ensure bank staff feel inclusion and belonging to the organisation.
6.8	RG reflected on potential comparative data following move to a new organisation, as well as testing of transition of culture. The Board agreed importance of action planning and analysis as part of Project Fusion. DJ emphasised the importance of prompt review and joint learning, picked up via relevant groups. **The Annual Staff Survey Report was noted.** *AH left the meeting.*
7	**Chief Executive's Report**
7.1	AS provided an overview of the report. • Key changes to the Trust Board were shared and AS welcomed AA and ASn as Executive Board members. • A Contemporary update in relation to urgent care and Winter pressures was shared. • Development of Reverse Mentoring programme and positive response was highlighted. • The Board were also briefed on positive Department of Health and Social Care visit and progress in terms of the Western Community Hospital.
7.2	MW asked about QIA themes identified in terms of operational planning. NB confirmed that there were no specific issues identified and emphasised full process followed to ensure consideration of patient and organisational safety. Ongoing monitoring was confirmed and feedback at the Clinical Executive Group noted.

7.3	MW commended AS following nomination within the top 50 CEOs nationally. SE also commented on reflection of the strong organisation and importance of celebrating nomination across the Trust. **The Board noted the Chief Executive's Report.**
8	**Integrated Performance Report**
8.1	Key highlights from the report were presented. • ASn briefed the Board on statistical increase in relation to incidents. Potential reasoning was shared, including coding and classification changes. • The Board were informed of challenges regarding the Sexual Health Single Point of Access (SPA). Mismatch in demand and capacity was highlighted and ASn shared planning in relation to system consideration in business planning. • ASn commented on changes to reporting of SPC charts in order to see full breakdown. Challenge regarding national best practice and ongoing quality/system pressure discussions were noted.
8.2	RG acknowledged analysis and triangulation in terms of the number of incidents and asked about similar process for safe staffing and areas such as Freedom to Speak Up. AA assured of review across all areas, as detailed fully within the Patient Safety Report. Ongoing monitoring was confirmed and AA provided an overview of processes and escalations in place.
8.3	MW queried expected improvements within the Sexual Health SPA service following introduction of telephony system and asked about potential learning. ASn commented on usefulness of the system and data now provided, however shared continued effect of demand and capacity mismatch issues. It was confirmed that monitoring and oversight would continue and relevant feedback provided as available.
8.4	The level of risk for the Laboratory Information Management System Upgrade within sexual health was queried. AA confirmed current lack of clarity regarding the overall impact however noted ongoing monitoring.
8.5	Optimal bed occupancy targets were queried and ASn confirmed high special cause variation. Continued monitoring to ensure safety was emphasised and importance of maximizing proactivity shared.
8.6	In relation to the report, MW queried review to consider the entire organisational picture and a forward view of expectations. ASn commented on potential changes to the report and acknowledged the potential usefulness, although acknowledged challenges of reporting a forward view. **The Integrated Performance Report was noted.**
9	**Annual Audit Timetable and Delegations**
9.1	RG presented the report and explained requirement to consider governance arrangements associated with the approval of the Trust's Annual Report and Annual Accounts, due to the accounting timetable and planned absence of the Trust's Chair, and in consideration of the reduced NED cohort. **The Board acknowledged the timeline for the meetings to approve the Annual Report and Annual Accounts and agreed:** • **To co-opt NED membership to the Audit & Risk Committee on 21 June 2022**

	• **Designate a NED colleague to Chair the In Public Board meeting on 21 June 2022– to be decided outside of the meeting.** • **Ensure that the Trust Chair pre-agrees to sign (via e-signature) the Annual Report (opening statement), subject to approval of the annual report content at the meeting on 21 June.**
10	**Creation of a New Trust for Community, Mental Health and Learning Disability Services Across Hampshire and the Isle of Wight Integrated Care System** Including: • Strategic Case • Comms and Engagement Plan • Programme update
10.1	*AH and AML joined the meeting.* AS informed that the Strategic Case had been approved by all four Trust Boards (Solent, Sussex Partnership, Southern and Isle of Wight) at the March 2023 Board meetings and a letter of support sent by the Integrated Care Board (ICB). It was confirmed that the next phase of the Programme and the Communications & Engagement Plan was now presented for review and approval.
10.2	SE commented on ambitious timescales for approval of the full business case and potential impacts of national political activity. AS reported ongoing work on due diligence and risks, with articulation of potential issues being reviewed.
10.3	<u>Communication & Engagement Plan</u> The Board were briefed on the collaborative plan and an overview of the outline approach and principles were shared, with iterative engagement activity plan explained. AML informed of engagement held with community partners and key groups to ensure strength-based discussions and engagement at all points of the programme. Ongoing work to ensure support and transparency, particularly in relation to assurance of effect on services was highlighted. Alignment to the Clinical Delivery Groups was noted and continued engagement confirmed. The need for consideration of formal messaging from the Clinical Delivery Groups was discussed.
10.4	AS reflected on discussions with the regional teams and commended communication work undertaken to involve community and local partners.
10.5	SE emphasised the importance of consistent and honest approach of the Board, particularly when communicating directly with staff in areas such as Board to Floor visits. AML agreed and commented on the need to be honest surrounding lack of clarity at the current time. DB acknowledged consistent approach required, however emphasised that that Project Fusion was not a method for changing clinical pathways but for ensuring less barriers and improved access to care.
10.6	AA shared further key work required in relation to engagement with staff as well as service users. Joint virtual communications were highlighted and AA informed of planning to ensure further engagement.
10.7	ASn reiterated the importance of joint communications with a universal approach to ensure consistency. AH agreed and confirmed ongoing collaborative discussions. **The Board approved the Communications & Engagement Plan and noted next steps for the next phase of the Programme**. *AH and AML left the meeting.*
Reporting Committees and Governance matters	
11	**People Committee - *Exception report from meeting held 16 March 2023***

11.1	Key escalations were shared, particularly in relation to equality delivery system, HR Audit Process and ongoing work regarding talent and appraisals. **The People Committee Exception Report was noted.**
11.2	**The Board approved the People Committee Terms of Reference.**
12	**Mental Health Act Scrutiny Committee- *Exception report from meeting held 16 February 2023***
12.1	The exception report was presented and an update on Mental Capacity Act Training and alignment of processes with Isle of Wight NHS Trust ahead of Project Fusion were shared. **The Board noted the Mental Health Act Scrutiny Committee Exception Report.**
13	**Audit & Risk Committee – *Exception report from meeting held 9 February 2023***
13.1	Key discussion areas were noted, specifically agreement to amend June Committee date to align with account timetables. **The Audit and Risk Committee Exception Report was noted.**
14	**Quality Assurance Committee- *Exception report from meeting held 23 March 2023*** • ***Patient Safety Quarterly Report including Learning from Deaths, Serious Incidents and Complaint – Qtr 3***
14.1	VA shared the report and explained pressures within the Safeguarding team and requirements for FIT testing. **The Quality Assurance Committee Exception Report was noted.**
14.2	**The Board noted the Patient Safety Quarterly Report.**
15	**Non-Confidential update from Finance & Infrastructure Committee– *non confidential escalation report from meeting held 27 March 2023***
15.1	There were no items of escalation to report.
16	**Charitable Funds Committee – *Exception report from meeting held 9 February 2023***
16.1	Committee activity was reported and the Board were informed of Charity Lunch event being held, with attendance encouraged. **The Board noted the Charitable Funds Committee Exception Report.**
17	**Remuneration and Nominations Committee – *Non-confidential update from meeting held 24 March 2023. (Exception report presented to Confidential Board)***
17.1	A verbal update was provided on key discussions held by the Committee, including changes to Board composition, portfolio amendments, Provider Licence Gap Analysis, and compliance against the NHS Constitution. It was confirmed that minor amendments had been made to the Pension Policy. **The Remuneration & Nominations Committee verbal update was noted.**
18	**Board Effectiveness Review**
18.1	The Board reviewed the results from the recent Board Effectiveness Review Survey. MW commented on considerations for ensuring a system integrated view and potential actions required to improve. AS agreed and explained importance of systems perspective evident at Board level, including collaborative working with partner organisations.
18.2	SE reflected on Board values and potential work required in terms of behaviours. The Board discussed challenging and contentious discussions held over the last year and areas of complexity.

18.3	Potential review of Board reports was discussed in order to ensure clarity of key escalation areas and appropriate oversight of areas for discussion. RG emphasised the need for oversight of strategic objectives, particularly within the Integrated Performance Report. **The Board Effectiveness Review was noted.**
19	**Patient Story**
19.1	AA introduced LS and SB to the meeting. SB shared her experiences of the Oxygen Service and issues raised in relation to staff behaviour and contact details. The Board were briefed on resulting Information Governance breach and complaint raised. SB shared rapid and efficient resolution held and importance of ensuring such issues were not repeated.
19.2	DJ asked about potential ways that the situation could have been managed differently, to ensure learning going forward. SB commented on the need for clarity in relation to information/leaflets provided by services and double-checking contact details logged.
19.3	AS reflected on positivity of prompt and efficient complaint handling. AS queried correct tone used and level of service since resolution. SB shared prompt visits and local resolution meetings held, with the Trust taking concerns seriously and dealing with all aspects of the complaint thoroughly.
19.4	SE requested clarity on handover between Solent and Southern services, following address change. LS explained issues in this case, largely due to communication and error in recording details.
19.5	NB queried assurance that issues had been resolved appropriately and learning undertaken to ensure this was not repeated for other service users. AA briefed on learning applied and continued monitoring. LS informed of service changes in relation to how contact information was provided and DJ commented on the importance of learning across the entire organisation.
19.6	VA asked about handover processes in place between organisations and LS explained de-briefings held and outlying aspects of this case. The Board thanked SB and LS for attending the meeting. *SB and LS left the meeting.*
20	**Reflection on Patient and Staff Stories Joint Summary Report**
20.1	SRa briefed the Board on review undertaken of all patient and staff stories from 2022-23 in order to consider the 'so what' elements and ensure implementation of learning. The value of stories to Board was emphasised and the recommendations were presented. The importance of considering expectations and ensuring cascade of learning at service level was noted.
20.2	RG reflected on the disconnect of learning and queried review of parameters used as a baseline within other organisations to consider potential structure, without losing the personable nature of the stories. SE agreed and commented on the value as a Non-Executive Board member to connect with the reality of services provided. SE suggested discussions with Health Watch to consider stories presented and the triangulation of themes.

20.3	SRa commented on potential use of the strategy to identify stories and the Board discussed challenge of potentially losing purpose, value and learning by restricting selection of stories by using a strategy/framework. AS reflected on balance of positive and negative stories and suggested usefulness of review by Health Watch and the Disability Network. GK also suggested use of patient surveys to identify stories.
20.4	The importance of oversight and closure of learning was noted and review/update on a 6 monthly basis was suggested. It was agreed to review further outside of the meeting**. The Board noted the Reflection on Patient and Staff Stories Joint Summary Report.**
Any other business	
21	**Any other business and reflections including:** • ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***
21.1	AS commented on strong discussions held. SRa agreed and reflected on the importance of patient and staff stories to ensure experiences were heard at this level. It was agreed to cascade messaging in relation to the Staff Survey.
21.2	The date of the next meeting was confirmed as follows: • *Monday 5 June 2023*
22	**Close and move to Confidential meeting**

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	**Closed. On-going system work now in place.**
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	The Workforce Data and Metrics report has been re-designed to support alignment of data and will be presented to People Committee on 26th January.
On Target	Board meeting - In Public	06/02/2023	9.2	AC005062	In Public Board- Integrated Performance Report	Safe- Regarding incidents outside of their allocated range, MW asked about potential need to reassess. The importance of continuing strong reporting culture was emphasised, however the Board acknowledged potential change in boundaries required. **Action- AA to consider further outside of the meeting.**	Angela Anderson	

Item 7

CEO Report – In Public Board

Date: 25 May 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

New mental health phoneline

Along with other partners of Health and Care Portsmouth (HCP), we created and launched a new phoneline for Portsmouth residents to get the most appropriate mental health support they need before they reach a crisis point. The phoneline, which will be known more widely as the Portsmouth Mental Health Hub, is available to people aged 16 and over and carers, who can call 0300 123 6621 from Monday to Friday, between 8am and 6pm. Fully trained call handlers will either arrange an appointment with services such as Talking Change, offering support to connect with local organisations including HIVE Portsmouth, social support or substance misuse. The phoneline comes directly from feedback gathered during events run by HCP with local voluntary groups and people with lived experience of mental health throughout last year.

Support Colleague Awards

We held our first Support Colleague Awards to recognise the amazing skills, work and dedication of colleagues who are not necessarily clinical or frontline. The awards ceremony and lunch was held in April and celebrated the nominees and winners of Outstanding Innovation Award; Inspiring Leader; Outstanding Team Award; Rising Star Award; Outstanding Colleague Award; and The Partnership Award. It was a great celebration - take a look.

Southampton Football Club

We have worked closely with Southampton Football Club to promote our children's and young people's services, alongside those of our city partners at their home football matches recently, both on their big screen before and mid- game but also in their match day programmes and online. You can view their webpage here: SOUTHAMPTON FC | Official Website of Saints – latest news, photos and videos and view the video via No Limit's Twitter feed here.

Improving Solent's ICT infrastructure

A lot of work has been taking place to modernise and improve Solent's ICT infrastructure for the benefit of service users and staff. Currently a rollout of new laptops is taking place across the Trust. The new laptops are more secure, faster, and reliable; bringing with them a range of positives for members of Team Solent to work in agile ways.

Commemorative tree planting

We continued to forge strong relationships with members of our communities, seen with a local Girl Guide group planting a tree in our memorial garden at the Western Community Hospital in Southampton in recognition of King Charles III's Coronation.

Freedom to Speak Up national call

We organised and held first ever National Freedom to Speak Up Guardian call with Dr. Jayne Chidgey-Clark, who represented the National office and spoke to new guidance and mandatory training, which Solent is leading on pushing through. Over 50 colleagues joined the call, and we will be following up with a case study on our work for the national office.

Staff recognition

I'm delighted to highlight the following;

- Project Management Degree Apprentice Rochelle Sampson-Clarke is a finalist in the Apprentice of the Year category at the 2023 Our Health Heroes Awards. Joining Solent in 2019, Rochelle was part of the first cohort of Project Management Degree Apprentices for the Trust, working in the estates management team. In just over three years, she has made a tremendous impact, despite having no prior project management experience. Winners are being announced on 7 June 2023
- In recognition of her outstanding work whilst deployed with the Royal Navy, the Army in addition to the exemplary work that Beth Carter has been a part of across the Trust during the pandemic and most recently as our Lead Freedom to Speak Up Guardian, we are delighted that Beth has been shortlisted for the Military Values in Business Award. The winners will be revealed at the world's largest celebration of veterans in second careers, the British Ex-Forces in Business Awards gala ceremony, on 29 June 2023.

Section 2 – Internal matters (not reported elsewhere)

Board news

Rachel Goldsworthy, Chief of Staff, Corporate Affairs and Governance

Following a successful recruitment process, Rachel Goldsworthy, Chief of Staff, Corporate Affairs and Governance has been offered a brilliant new role with Sussex Partnership NHS Foundation Trust as Chief of Staff.

Rachel has worked in Solent, and its predecessor organisations, for over 20 years and has been a huge part of the Trust's journey. Under her leadership, we have had incredibly sound corporate governance and corporate affairs and her support to the Executive team and Trust Board has been second to none. She has been a big part of Solent and I know she will be missed, both personally and professionally. I'm sure you will join me in wishing her well in her future endeavours.

Rachel is due to leave Solent at the end of July, following the completion of the Project Fusion due diligence process. I am currently considering how we continue providing leadership in the corporate governance space in Solent and where Rachel's exec responsibilities will sit going forward.

David Kelham, Non-Executive Director

At the beginning of May, David Kelham was appointed as a Non-Executive Director on the Solent Trust Board. Bringing his wealth of experience in financial management, David's role includes chairing the Audit and Risk Committee, as well as being the lead Non-Executive for security management. David is also a non- executive director on Southern Health's Trust Board. The joint appointment to both Solent and Southern Boards will support the development of the new community and mental health provider for Hampshire and Isle of Wight as we bring together four organisations into one.

You can find out more about David, his experience and skills here.

Great Care

Safety matters

In April 2023, all Covid restrictions in relation to IPC were removed and all national guidance has reverted to business as usual in line with the National Infection Prevention and Control manual for England and supported by the updated IPC Board Assurance Framework. All services are currently updating their position against the latter.

Great Place to Work

Workforce matters

Industrial Action

Two periods of industrial action have taken place in recent months; Junior Doctors (11 – 14 April) and Nurses (30 April & 1 May). The April junior doctor action saw a maximum of 21 colleagues take action at any one time with minimal impact and only one COPD clinic cancelled on the first day to allow the doctor (who is a shared resource with UHS) to return to UHS to support them. Further action has been announced between the 14 - 17 June. Notification from the BMA of further balloting of the Consultant workforce took place from 15 May.

The Nurses action in May had little impact as it was taken over a bank holiday weekend and we saw a maximum of 15 colleagues, mainly community nurses, take action on those days with mitigations ensuring no impact on patient care. Further balloting by the RCN is underway.

We saw incredible work from the teams in preparation for, and during the strikes and in particular the leadership of the Head of Quality & Professions (HQPs) enabled the process to run smoothly and without incident.
Services are reporting by exception via QIR and will escalate should any impact as a consequence of past industrial action become apparent.

Operational Workforce Planning 22/23

Our workforce plan includes a 0.5% growth, which is focused on clinical roles. We will continue with investments and a realistic recruitment plan to grow our establishments in Nursing by +4.8% and AHP by +3.5%. Recognising the priority in supporting the stability in mental health roles nationally.

We are continuing conversations as an ICS to support the financial position in the HIOW system. We have plans to manage our establishment position through controls on recruitment, and adoption of shared opportunities ahead of Project Fusion.

Reverse Mentoring

There has been a successful engagement with the programme with 17 pairs matched across Solent and Southern Health. The pairs are already in the process of meeting and will continue through the Summer until September with their meetings. We very much look forward to the insight, reflections, and lessons from this important programme.

Great Value for Money

Estates and infrastructure

ICT Future Operating Model

Following the major transition between networks at the end of March the team have been working through compatibility issues experienced by some of our operating bases located on third party sites. For a short period business continuity plans were enacted by impacted teams to minimise patient impact. The device replacement programme has commenced with all eligible staff expected to have refreshed devices by the end of June completing the transition programme. Post device replacement the project will move from implementation phase to optimisation to support colleagues in maximising the opportunities afforded by the new operating model.

Western Community Hospital

The Western Community Hospital scheme continues to progress on plan with no major issues or concerns to report. Ground works are close to completion ready to move into the next stages of the programme with the ground floor slab pour due to commence early June.

As part of the wider Western campus development the Trust has entered a lease within the Oakley Road site in May, with reconfiguration works due to complete early summer, to facilitate the co-location of Health and Social Care teams across Adults Southampton. The co-location is anticipated to further strengthen the partnership working across the city, improving the teams resilience and the experience of our resident patient population. An exciting step towards the future vision for the Western Community Campus.

Our key risks

Operational Risk Register

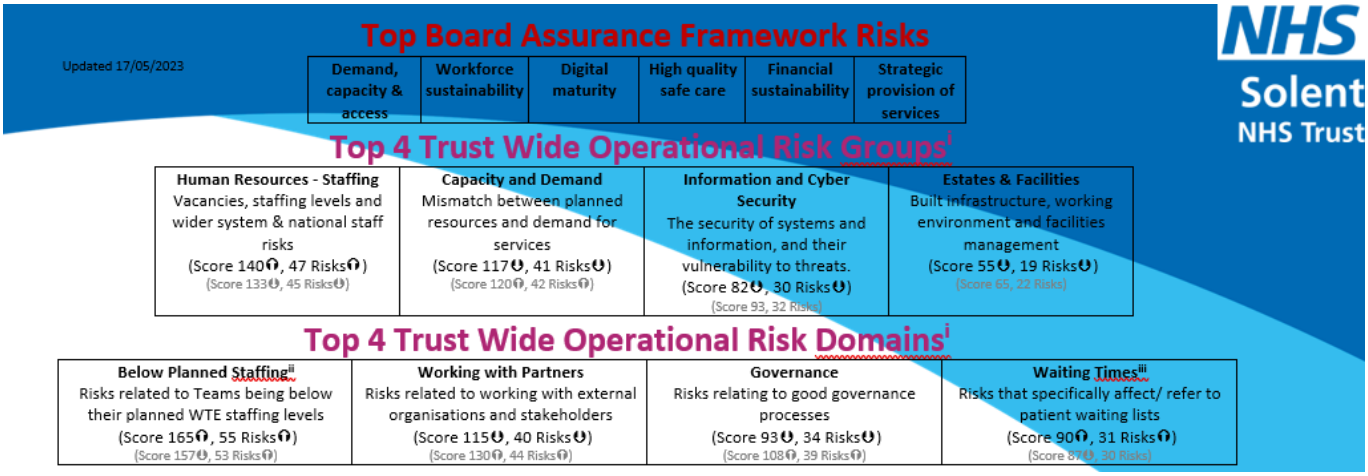
The risk pyramid summarises our key strategic and trust wide operational risks. Our top risk groups are:

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 Times

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)

During April 2023, the Executive team reviewed the entire BAF, risk descriptions gaps and mitigating actions. This was presented to the Board workshop on 15 May where the Board acknowledged the update. The Board's Committees will now reflect on the BAF entries as part of their assurance process of managing associated risks The BAF is summarised as below;

BAF Risk	Raw Score	Residual Score	Target and date
Demand, capacity and accessibility	L5 X S4 = 20	L4 X S4 = 16	L3 X S4 = 12 End Q4 2023/24
Workforce sustainability	L4 X S5 = 20	L3 X S3 = 9	L2 X S3 = 6 End Q4 2023/24
High quality safe care	L4 X S5 =20	L3 X S4 = 12	L3 X S3= 9 End Q4 2023/24
Financial Constraints	L4 X S5 = 20	L3 X S5 = 15	L2 X S4 = 8 October 2023
Strategic provision of services	L4 X S5 =20	L3 X S4 = 12	L3 X S3 = 9 End Q4 2023/24
Digital maturity	L4 X S5 = 20	L3 X S4 = 12	L3 X S3 = 9 End Q4 2023/24

Section 3 –System and partnership working

Project Fusion

The strategic business case for the proposed new community and mental health provider for Hampshire and the Isle of Wight has now been considered by NHS England and we are expecting notification of the outcome of their review shortly. Meanwhile, teams from across our partner organisations have been planning the next phase of the programme, which will include detailed due diligence to understand the way things work and the outcomes we are achieving currently across the partners – and to identify the potential risks and opportunities for improvement that we must consider when planning the integration. We are also planning development of the Full Business Case and Patient Benefits Case which will set out the proposals in greater detail. These will need to be approved by our Trust Boards and NHS England before we can proceed with the transaction. We are also continuing with our programme of engagement with our staff, communities and other stakeholders, to help shape the proposed new Trust

HIOW ICS

The financial plans submitted from all partners across the ICS are in excess of national expectations and conversations are ongoing as to how the system can close the gap. Significant support as well as challenge is being offered by the national team to the system.

Part of the solution will be the 4 significant transformation schemes, being Discharge, UEC, Elective and Local and Primary Care, which are being led by CEOs of provider organisations. I am the CEO lead for Local and Primary Care.

Board and Committee Summary Report

Title of Paper	23/24 Financial Plan				
Date of paper	23rd May 2023				
Presentation to	Public Board				
Item No.	8.1				
Author(s)	Nicola Burnett – Chief Financial Officer				
Executive Sponsor	Nicola Burnett – Chief Financial Officer				
Executive Summary	Summary of the trusts financial plan for 23/24 to include details of the £23.4m efficiency programme. The plans set out demonstrates the component of the plan to deliver a £2.2m deficit in the financial year including key features of the operating environment that have been assumed.				
Action Required	For decision?	Y	For assurance?	Y	
Summary of Recommendations	The Board is asked to: • Approve the 23/24 plan to deliver a £2.2m deficit recognising the high risk of contractual terms restoration • Note the scale and risk of the efficiency programme within the plan				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) x
Positive / negative inequalities	Through the trusts planning process all decisions have had scrutiny by clinical colleagues to mitigate any negative impacts on quality or access				
Previously considered at	Iterations of the plan and recovery actions have been considered at the December 22, January 23, March 23, May 23 Confidential Board Meetings				

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services		8. Looking after our people		12.Digital transformation	
2. Alongside Communities		9.Belonging to the NHS		13. A greener NHS	
3. Outcomes that matter		10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature	 Nicola Burnett, Chief Financial Officer							

23/24 Business Planning Update

May 2023

Context

Initial draft plan submissions covering activity, finance and workforce were submitted by the ICS to the national team on 23rd February 2022, consolidating all providers and the ICB position inline with the national guidance with subsequent submissions made 30th March and the 4th May to include the impact of transformation scheme developments and further clarification of income available.

The Solent position has improved from the initial snapshot position of a £16.4m deficit position to the current plan to deliver an in year deficit of £2.2m and a cost neutral run rate by the end of the financial year.

National sign off of the ICS collective plans remains outstanding at the time of writing and may drive the need for further consideration of the options available.

ICS Efficiencies

Overall the ICS has plans to save circa £331m in 23/24 or 4.3% of the relevant allocation.

In November 2021 Solent set an internal ambition to strive for a 5% CIP in order to balance cost growth against inflation whilst also improving the trusts underlying deficit of £13.4m. The majority of organisations across the ICB are now meeting this ambition however Solent have further stretched the goal towards a return to run rate breakeven by March 2024 further.

The HIOW system recovery director, supported by CF, and the newly appointed ICB CFO have reviewed the system cost base to identify common savings to be delivered across the board. Examples include a reduction in criteria to reside proportions and a return to 19/20 levels of temporary staffing.

The South East Region have also produced a model to highlight benchmarked efficiency opportunities using model hospital data. Key opportunities highlighted for Solent include ICT (£6.7m), HR (£2.4m), Governance & Risk (£2.1m) and Property maintenance (£0.9m)

A system recovery board is due to meet for the first time in May to monitor progress across all of the system plans and to support with mitigations should slippage against delivery begin to emerge.

Trust Recovery Acton Plan

Through the 23/24 planning round bottom up plans have been built alongside service leads to incorporate efficiency schemes within baseline budgets. The majority of those schemes are profiled to commence delivery within the initial quarter of the year and will e routinely monitored through Service Line Performance Review Meetings and Corporate Review Meetings in addition to the board level scrutiny to the programme as a whole via Finance and Infrastructure Committee and operationally through the Finance and Commercial Group.

To support the improvements across the planning submissions a number of organisational wide decisions have been made to improve the trusts expenditure profile whilst protecting access to and the quality of services delivered to our population cohorts. Each of these workstreams has an executive lead with clear timescales set in order to monitor progress and delivery. Fully delivery of these additional schemes is due to commence in the latter half of the financial year.

As part of the Trusts commitment to continuous improvement a rolling 12 month planning process will be in place throughout the year with a continuation of the Quality Impact Assessment (QIA) process being core to scheme sign off to ensure patient care remains the centre of all of the trusts improvement schemes and that the impact of any internal changes are considers through the eyes of the other service providers in the system to prevent unintended consequences.

Key operating conditions

In order to reach a finalised plan the trust has reviewed each service area to understand the impact of financial recovery actions on service performance, the key operating conditions assumed within the plan for 23/24 are summarised below:

Mental Health
- Expansion of substantive workforce to deliver newly commissioned services and reduce agency reliance.
- Inpatient length of stay and occupancy to remain static
- No use of out of area bedded capacity
- Talking Therapies trajectories will remain inline with 22/23 rather than reflect the expansion anticipated in prior system strategies

Adults Portsmouth
- Capacity of 40 to be mainstreamed within Jubilee Unit
- Surge capacity to be stood down with no capacity to re-instate
- Virtual Ward capacity to be expanded to 20
- Expansion of substantive workforce to reduce reliance on high cost agency

Children's
- Cessation of subcontract of Solent activity
- Deterioration in assessment waiting lists
- Expansion of substantive workforce to reduce reliance on high cost agency

Adults Southampton
- Virtual Ward capacity to tb expanded to 22
- Reduced resilience to respond to system pressures
- Expansion of substantive workforce to reduce reliance on high cost agency

Key operating conditions

Primary Care
- Reduced reliance on temporary staffing to
- Increased partnership with Southern Health and PCN to model best practice
- Increased efficiency in job planning to maximise capacity within resource available
- Maintain QOF performance and delivery of enhanced services

MPP
- Continued recruitment to improve podiatry performance metrics
- Removal of MSK backlog across Portsmouth locality
- Maintain MSK backlog across Southampton locality
- Increased performance against RTT activity units
- Reduction in follow up ratios

Sexual health Services
- Active management of vasectomy waiting list
- Clinical triage of incoming calls to reprofile activity profile
- Continuation of increase in demand for termination of pregnancy services
- Increased performance against Local Authority performance targets
- Funding toward national pay award by LA commissioners

Specialist Dental Services
- Continuation of current block funding arrangement
- Increase in performance against contractual targets
- Reskilling of workforce to reprofile activity

Key operating conditions

Facilities Management & Estates
- Continued investment into Green initiatives to reduce the operating cost of the estate
- Expansion of substantive workforce to reduce reliance on private contractors
-Increased commercialisation of the estate to exploit income opportunities
- Increased bias to public sector estate to reduce reliance on private hire and freehold arrangements.

Corporate
- Increased collaboration with Fusion partners and wider ICS colleagues to exploit synergies through collaboration
- Closer departmental collaboration to drive enhanced insights

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Solent Financial Plan on a page (£)

Solent NHS Trust

ServiceLine	Pay Expenditure Plan £m Substantive	Agency	Third Bank	Party	Total Pay	Non Pay	Total Gross Expenditure Plan	Income £m Recurrent	Non Recurrent	Total 23/24	23/24 Net Expenditure Plan	Efficiency within plan £m Recurrent	Non Recurrent	Total 23/24
Mental Health Services	26.1	1.1	0.6	0.5	**28.2**	2.7	**30.9**	21.8	2.8	**24.6**	(6.3)	1.1	-	**1.1**
Adult Srvs Portsmouth	21.9	0.5	0.3	0.9	**23.7**	1.9	**25.7**	19.5	1.6	**21.0**	(4.6)	1.7	-	**1.7**
Childrens Services	41.7	-	0.2	0.5	**42.4**	2.1	**44.5**	35.3	4.1	**39.4**	(5.1)	0.3	-	**0.3**
Adult Srvs Southampton	24.9	0.5	0.3	0.2	**25.9**	2.5	**28.4**	22.8	1.9	**24.6**	(3.8)	1.8	-	**1.8**
Primary Care	3.5	-	1.1	-	**4.6**	0.5	**5.1**	2.8	0.2	**3.0**	(2.1)	0.6	-	**0.6**
MPP	11.6	-	0.2	0.0	**11.8**	1.7	**13.5**	10.3	0.8	**11.1**	(2.4)	0.0	-	**0.0**
Sexual Health Srvs	9.4	-	0.1	0.1	**9.6**	16.6	**26.2**	21.2	-	**21.2**	(5.0)	0.1	-	**0.1**
Specialist Dental Srvs	7.7	-	0.0	-	**7.7**	1.9	**9.5**	9.3	-	**9.3**	(0.2)	0.0	-	**0.0**
Total Operations	**146.9**	**2.1**	**2.7**	**2.3**	**153.9**	**29.9**	**183.8**	**143.0**	**11.2**	**154.3**	**(29.6)**	**5.6**	**-**	**5.6**
FM & Estates	8.9	-	-	-	**8.9**	12.4	**21.3**	28.9	-	**28.9**	7.5	2.3	-	**2.3**
ICT	2.4	-	-	-	**2.4**	10.0	**12.3**	10.0	-	**10.0**	(2.3)	0.2	-	**0.2**
Total Infrastructure	**11.3**	**-**	**-**	**-**	**11.3**	**22.4**	**33.7**	**38.9**	**-**	**38.9**	**5.2**	**2.5**	**-**	**2.5**
Trust Board	2.5	-	0.0	-	**2.5**	1.9	**4.4**	4.7	-	**4.7**	0.2	0.0	-	**0.0**
Finance	1.6	-	-	-	**1.6**	0.5	**2.1**	2.2	-	**2.2**	0.0	0.2	-	**0.2**
Performance & BI	1.4	-	0.0	-	**1.4**	0.0	**1.5**	1.5	-	**1.5**	0.1	0.0	-	**0.0**
Human Resources	5.5	-	-	-	**5.5**	1.5	**7.1**	8.0	0.0	**8.0**	0.9	0.0	-	**0.0**
Medical Director	1.5	-	0.0	-	**1.5**	1.0	**2.5**	3.9	-	**3.9**	1.3	0.0	-	**0.0**
Quality & Risk	5.6	-	0.1	-	**5.7**	0.5	**6.1**	7.0	-	**7.0**	0.9	0.2	-	**0.2**
Commercial Team	1.1	-	0.0	-	**1.1**	- 0.0	**1.1**	1.1	-	**1.1**	0.0	0.1	-	**0.1**
E and T Income	-	-	-	-	**-**	0.1	**0.1**	3.9	-	**3.9**	3.8	-	-	-
Chief Operating Officer	0.7	0.0	0.0	-	**0.7**	0.0	**0.7**	0.8	-	**0.8**	0.0	0.0	-	**0.0**
Solent Pharmacy Service	2.9	-	-	0.0	**2.9**	0.3	**3.2**	4.0	0.0	**4.1**	0.9	0.2	-	**0.2**
Single Point Of Access	0.6	-	0.0	-	**0.6**	-	**0.6**	0.6	-	**0.6**	0.0	0.0	-	**0.0**
Total Corporate	**23.5**	**0.0**	**0.2**	**0.0**	**23.7**	**5.8**	**29.5**	**37.7**	**0.0**	**37.8**	**8.3**	**0.7**	**-**	**0.7**
Commissioner Income	-	-	-	-	**-**	-	**-**	1.8	-	**1.8**	1.8	-	-	-
Financing & Reserves	1.8	-	-	-	**1.8**	0.4	**2.2**	17.4	1.2	**18.6**	16.4	7.9	6.8	**14.6**
Solent NHS Trust	**183.5**	**2.1**	**2.9**	**2.3**	**190.7**	**58.5**	**249.2**	**238.9**	**12.5**	**251.4**	**2.2**	**16.6**	**6.8**	**23.4**

In concluding the 23/24 planning process final budget statements have been issued and accepted by service leads to support moving the process into the in-year monitoring and rolling forecasting methodology.

23/24 Efficiency Schemes

Name of Scheme	Category	Recurrent/Non Recurrent	FY 23/24	1st month of impact
Car Parking	Income	Recurrent	167	M4
Mileage Reduction	Non Pay	Recurrent	87	M6
Temple Car Park	Non Pay	Recurrent	19	M6
Balance Sheet Releases	Non Pay	Non Recurrent	2,588	M1
ICT Efficiency	Non Pay	Recurrent	305	M1
Human Recourses Efficiency	Non Pay	Recurrent	114	M1
Q&R Efficiency	Non Pay	Recurrent	100	M1
Subscription lapses	Non Pay	Recurrent	98	M1
Estates spend review	Non Pay	Recurrent	873	M1
Lapse shadow membership	Non Pay	Recurrent	9	M1
Subscription lapses	Non Pay	Recurrent	80	M1
SAI transformation	Non Pay	Recurrent	154	M1
Phlebotomy ceasing	Non Pay	Recurrent	155	M1
VAT Review	Non Pay	Recurrent	200	M1
Strategic transformation savings	Non Pay	Recurrent	68	M1
Performance spend review	Non Pay	Recurrent	34	M1
Enhancement Review	Pay	Recurrent	113	M6
Safer Staffing review	Pay	Recurrent	600	M4
Agency Usage Reduction	Pay	Recurrent	5,628	M1
Agency Rate reduction	Pay	Recurrent	400	M5
Bank Usage Reduction	Pay	Recurrent	1,836	M1
Corporate Review	Pay	Recurrent	1,680	M4
Infrastructure Growth	Pay	Recurrent	1,943	M6
Community Nurses Growth	Pay	Recurrent	788	M6
Infrastructure stretch	Pay	Recurrent	1,181	M6
Total Identified Schemes			**19,220**	
Unidentified	Non Pay	Non Recurrent	4,204	M1
Total Shemes			**23,424**	

70% of the years efficiency programme is profiled to commence from M1 with a further 12% in Q2 and the residual 18% into Q3 which will release full year impacts into the 24/25 financial position

Solent Financial Plan on a page (WTE)

ServiceLine	Pay Plan WTE Substantive	Agency	Bank	Third Party	23/24 Plan
Mental Health Services	552.93	8.33	14.45	10.30	**586.01**
Adult Srvs Portsmouth	541.63	4.03	7.00	18.40	**571.05**
Childrens Services	889.55	-	4.05	8.25	**901.85**
Adult Srvs Southampton	567.02	3.81	6.60	4.70	**582.13**
Primary Care	67.36	-	27.09	-	**94.46**
MPP	232.28	-	3.94	1.40	**237.62**
Sexual Health Srvs	175.94	-	1.63	1.00	**178.57**
Specialist Dental Srvs	146.96	-	0.13	-	**147.10**
Total Operations	**3,173.68**	**16.16**	**64.90**	**44.05**	**3,298.79**
FM & Estates	276.50	-	-	-	**276.50**
ICT	48.90	-	-	-	**48.90**
Total Infrastructure	**325.40**	**-**	**-**	**-**	**325.40**
Trust Board	32.70	-	0.43	-	**33.13**
Finance	30.22	-	-	-	**30.22**
Performance & BI	28.96	-	0.14	-	**29.10**
Human Resources	120.70	-	-	-	**120.70**
Medical Director	27.92	-	0.98	-	**28.90**
Quality & Risk	105.46	-	1.73	-	**107.19**
Commercial Team	19.35	-	0.02	-	**19.37**
E and T Income	-	-	-	-	-
Chief Operating Officer	9.72	0.15	0.26	-	**10.12**
Solent Pharmacy Service	62.09	-	-	-	**62.09**
Single Point Of Access	16.45	-	0.12	-	**16.57**
Total Corporate	**453.57**	**0.15**	**3.68**	**-**	**457.39**
Commissioner Income	-	-	-	-	-
Financing & Reserves	-	-	-	-	-
Solent NHS Trust	**3,952.65**	**16.31**	**68.58**	**44.05**	**4,081.58**

The trusts WTE plan for 23/24 reflects the challenging plan set internally to minimise reliance on high cost agency workforce and to invest into the substantive workforce.

Item No.	9.1	Presentation to	Trust Board – In Public
Date of paper	26 May 2023	Author	Sarah Earl - 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:			

Table of Contents

Trust Board Integrated Performance Report (IPR)
March – April 2023

Our performance is summarised within this report using the following NHS Improvement 'Making Data Count' methodology (where relevant and applicable). A more detailed explanation of the indicators 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

There is a variable and inconsistent performance against the target

Target has been consistently failed, for more than 6 months

Variance Indicator

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

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

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

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

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

1. Safe

a. Performance Summary

	Indicator Description	Internal /External	Target	Apr-23 Current Performance		Apr-23 Trending Performance	Apr-23 Variance	Mar-23 Current Performance		Mar-23 Trending Performance	Mar-23 Variance
Safe	Occurrence of any Never Event	E	0	0		P		0		P	
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	0		P	L	0		P	L
	VTE Risk Assessment	E	95.0%	100.0%		?		99.0%		?	
	Clostridium Difficile - variance from plan	E	0	0		?		0		?	
	Clostridium Difficile - infection rate	E	0	0		?		0		?	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	E	0	0		P		0		P	
	Escherichia coli (E.coli) bacteraemia bloodstream infection	E	0	0		P		0		P	
	MRSA bacteraemias	E	0	0		P		0		P	
	Admissions to adult facilities of patients who are under 16 yrs old	E	0	0		P	L	0		P	L

b. Key Performance Challenges

Incident Reporting

The number of incidents reported continues to be above the upper control limit, however this has not translated to higher reporting of harm.

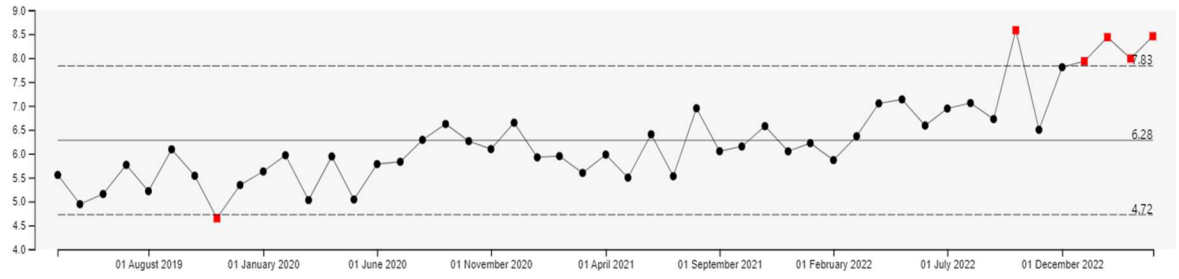


Figure 1: Incidents per 1,000 patient contacts

There has been a 9.5% increase in the overall number of incidents reported in March/April 2023 compared with the same period in 2022 and 14.5% more when compared to 2021. This relates to an increase in incidents relating to ICT (see section 4c. Performance Review Meetings – Key Areas of Exception) and on the new Jubilee Unit. As the ICT cutover closes and the staffing model on the Jubilee Unit has stabilised, it is expected that the number of incidents will reduce back to normal levels during quarter 2.

The level of incidents, excluding ICT and Jubilee Unit related incidents, continue to be on a stable, but gradually increasing trend, demonstrating a positive safety reporting culture within the organisation. The reporting culture continues to be encouraged across all service lines and puts the organisation in a strong position in relation to learning from incidents and safety improvements.

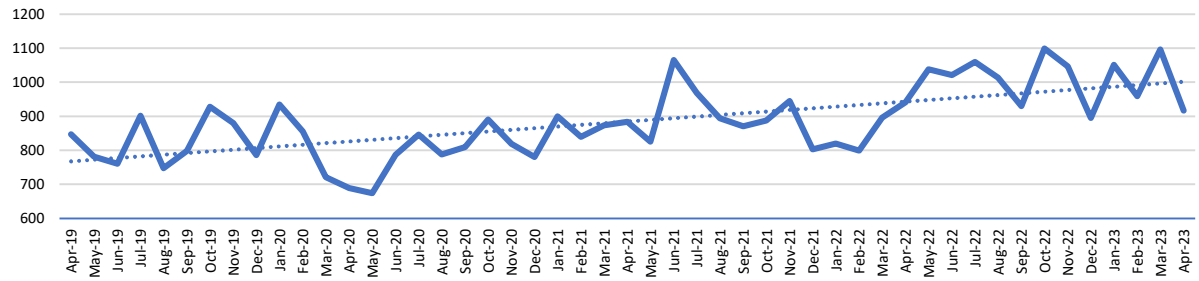


Figure 2: Total number of incidents reported

Incident Management Performance

The average number of days taken to close an incident in the last financial year 2022/2023 was 44.4 days. In March and April 2023 this figure dropped to 11 days. It has been noted that better visibility of this data, due to the Quality Data Library, has led to several teams making concerted effort to close open incidents.

Despite this, there remains 6,180 open incidents, awaiting or under review. The Quality and Safety team can provide assurance that no incidents of significant concern, or that resulted in serious harm, were missed, for incidents reported prior to April 2023 as these have all been reviewed. The team are considering how non-current incidents can be closed in the most efficient manner whilst ensuring relevant learning is captured. This is however considered within the context that an average of 1000 incidents are reported per month.

Initial investigation suggests that some historical incidents which were closed have not been effectively captured within the system. The Quality and Governance team are reviewing these anomalies, and there will be a task and finish group set up to close these outstanding incidents. This task is important in the context of the transition from the NHS Serious Incidents Framework 2015 to the new Patient Safety Incidents Response Framework (PSIRF), and also Project Fusion. It is anticipated that the average time to incident closure will be down to the target 7 days by the end of Q3 2023/24. This metric will be subject to ongoing review at service line performance review meetings.

c. Spotlight On: Learn from Patient Safety Events (LFPSE)

As noted in the last report, a review of the way level of harm is determined and recorded when reporting incidents has been undertaken and aligned to the guidance provided by NHS England as part of the Learn from Patient Safety Events (LFPSE) project. The LFPSE service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare replacing the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS).

A key aspect of this review was to give responsibility for grading harm to staff who are reporting and reviewing incidents instead of previous practice where the quality and governance team grades each incident. From 3 April 2023, staff reporting an incident have been required to input the level of harm they judge the incident being reported has caused. Reviewers then make a secondary assessment to determine the actual impact. The implementation has not resulted in any queries from staff which is in part attributed to extensive documentary guidance made available to staff along with ongoing training. The Quality and Governance Team continue to monitor the harm levels used and will routinely validate entries to ensure consistency. It is essential to note, that while every preparatory effort has been made to ensure the transition is smooth, unanticipated consequences remain possible, and we will have the Quality and Governance Team on standby to work through any initial challenges. Although, lessons from early adopter Trusts have indicated a smooth transition.

2. Caring

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-23 Current Performance		Apr-23 Trending Performance	Apr-23 Variance	Mar-23 Current Performance		Mar-23 Trending Performance	Mar-23 Variance
Caring	Community FFT % positive*	E	95.0%	99.3%		P	H	98.6%		P	H
	Mental Health FFT % positive*	E	95.0%	93.6%		?		96.5%		?	
	People Pulse Survey - Advocacy Theme (Recommended for Care & Employment)	E	0	-		?		7.3		?	
	Mixed Sex breaches* (Submission recommenced October 20221)	E	0	0		P		0		P	
	Plaudits	I	-	82				99			

b. Key Performance Exceptions

Nothing of statistical significance.

c. Spotlight On: Patient Feedback Project

The importance of gathering feedback from patients, their families, or carers during every step of their time spent in our care is recognised as vitally important. Patient Feedback calls can help to pick up any negative experiences helping to ensure that they are addressed quickly. This will help to ensure that concerns are addressed quickly thereby potentially preventing these concerns escalating to complaints.

The ability for a person to feedback should not just happen once they are discharged, so with the help of volunteers, a pilot has been undertaken to call patients (with consent) to gain insight into their experience with the service they are currently receiving care from. The first service to trial the Patient Feedback calls was the Home Oxygen Service. When calling patients from the Home Oxygen Service, we also found that loved ones (spouses) and/or carers were also present, thus offering insight into not only the patients but the carers experience in 'real time'. The pilot has recently moved onto the Community Physiotherapy service, with initial positive outcomes, and Primary Care.

Following further piloting and evaluation, the benefits of post-discharge calls will be explored across a wider range of services.

3. Effective

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-23 Current Performance		Apr-23 Trending Performance	Apr-23 Variance	Mar-23 Current Performance		Mar-23 Trending Performance	Mar-23 Variance
Effective	Bed Occupancy - Brambles	I	92.0%	94.7%				96.2%			
	Bed Occupancy - Fanshawe	I	92.0%	97.0%				91.8%			
	Bed Occupancy - Jubilee	I	92.0%	94.4%				126.2%			
	Bed Occupancy - Spinnaker	I	92.0%	95.6%				118.3%			
	Bed Occupancy - Brooker	I	85.0%	60.5%				54.7%			
	Bed Occupancy - Hawthorns	I	85.0%	94.4%				126.1%			
	Bed Occupancy - Maples	I	85.0%	78.7%				90.6%			
	Bed Occupancy - Kite	I	92.0%	67.3%				74.5%			
	Bed Occupancy - Snowdon	I	92.0%	96.4%				100.9%			
	Length of Stay - Brambles	I	24.0	35.1				21.9			
	Length of Stay - Fanshawe	I	24.0	23.3				27.5			
	Length of Stay - Jubilee	I	18.0	29.8				37.5			
	Length of Stay - Spinnaker	I	24.0	16.8				18.5			
	Length of Stay - Brooker	I	78.5	27.7				54.2			
	Length of Stay - Hawthorns	I	34.9	17.3				14.2			
	Length of Stay - Maples	I	48.6	63.8				11.6			
	Length of Stay - Kite	-	-	0.0				121.0			
	Length of Stay - Snowdon	-	-	51.7				41.5			
	Non-Criteria to Reside (NCtR) [patient count]	-	-	35				34			
	% clients in settled accommodation	E	59.0%	61.1%				61.9%			

Bed Occupancy and Length of Stay – Brambles, Fanshawe, Jubilee, Spinnaker

Non-Criteria to Reside (NCTR) *(previously known as Delayed Transfers of Care)*

Solent's community wards continue to have a high special cause variation for bed occupancy, reflecting the rates being consistently above the 92% internal target. The high occupancy rates across these wards reflect the flex our community wards admission criteria are giving to maximise system flow and proactively bring

patients from the acute trusts into the community. These patients often have more complex needs whilst they are on the ward or require more complex support upon discharge, causing both an increased average length of stay, and larger number of patients that do not meet Solent's Criteria to Reside.

The length of stay on the Brambles Ward is frequently greater than on Fanshawe ward because of the increased rehabilitation offering on Brambles, whereby patients are being admitted to the ward with higher acuity and at an earlier stage in their rehab journey. Brambles are also offering mutual aid to Hampshire partners on a regular basis, and on occasion these patients have taken longer to discharge whilst packages of care/rehab equipment is arranged.

Bed Occupancy and Length of Stay – Hawthorns, Maples

Occupancy rates within our adult acute (Hawthorns) and PICU (Maples) mental health wards have flagged a special cause variation due to the continued high levels of occupancy, significantly above the Royal College of Psychiatrists recommended level (85%). The occupancy rate on Maples has dropped in April, due to high staff sickness levels and an increased acuity of patients. Due to the medical staffing shortages due to sickness and vacancies, the service has temporarily altered its skill-mix and rosters, which is causing small delays in discharge times and prolonging length of stay. All staffing levels have remained within the legal safe staffing limits throughout. Collectively these reflect the continued pressure on our mental health wards, where demand exceeds capacity. Performance is expected to continue to be challenged over the next few months while the new model stabilises.

b. Key Performance Exceptions

Urgent Community Response (UCR) – Data Quality Improvement

It has previoulsy been reported that there were a number of data quality issues with the reported compliance of activity on the 2-hour Urgent Community Reponse pathway. After a concerted effort by the teams in both cities, the backlog of unvalidated information has now been completed and processes implemented to ensure timely review of information moving forwards.

There continues to be a discrepancy between the nationally published UCR figures to the locally reported figures. Solent have fed back their findings on the discrepancies to NHS Digital but have had little engagement to achieve a resolution. It has therefore been agreed locally to use our internal performance report as the single source of the truth on UCR performance both internally and with system partners/ICB.

Urgent Community Response (UCR) – 2-Hour Performance

Compliance rates in Portsmouth have exceeded the 70% target for the past 3 months and appear to be reaching a more stable position. Capacity within the Portsmouth teams continues be impacted by the acuity of patients on the Virtual Ward, capping the volume of referrals able to be received into UCR. There has also been a notably higher proportion of referrals from the SCAS urgent care desk in the past month.

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	YTD
2 Hour Referrals	502	422	476	442	409	402	350	423	335	265	292	262	4580
Compliant	320	229	324	359	307	297	246	222	215	186	229	201	3135
Compliance %	64%	54%	68%	81%	75%	74%	70%	52%	64%	70%	78%	77%	68%

Figure 3: Portsmouth UCR 2-hour compliance, previous 12 months

Compliance in Southampton has also stabilised yet is still below target due to capacity issues within the Community Nursing teams. This is reflected by the reduction in the total number of 2-hour referrals seen in Southampton, as referrals through the UCR team have remained at a consistent volume throughout the year. There has recently been signs of positive recruitment into the community offer and the forthcoming relocation of our community services into Oakley Road should add resilience to our offer, however in the short-term we expect performance to continue at this level.

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	YTD
2 Hour Referrals	366	319	348	291	272	287	319	331	379	352	419	379	4062
Compliant	318	255	268	207	207	232	213	219	241	217	242	239	2858
Compliance %	87%	80%	77%	71%	76%	81%	67%	66%	64%	62%	58%	63%	70%

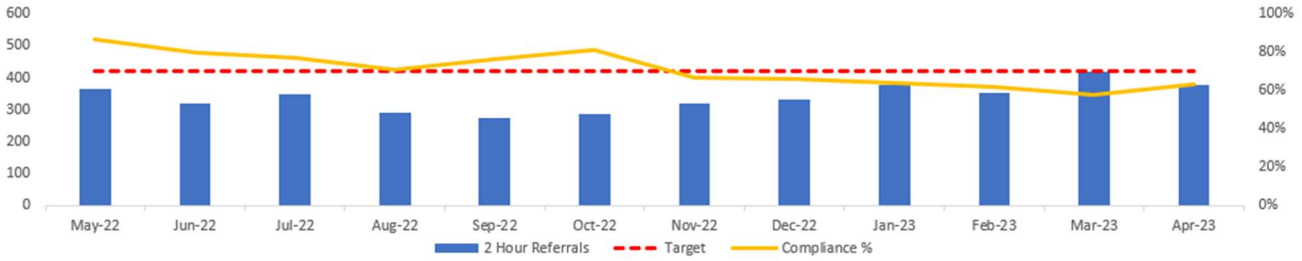


Figure 4: Southampton UCR 2-hour compliance, previous 12 months

Elective Recovery Framework (ERF)

From 1 April 2023, our elective care services have been included within the Elective Recovery Framework, which aims to increase productivity in elective services, reducing the number of patients waiting, and the length of time patients wait, for an initial assessment/treatment.

Work has been ongoing with the ICB and NHS England to ensure the baselines on which performance is measured accurately reflect the services we provide. We are awaiting final confirmation of the targets, and at present have one outstanding query with them relating to our Physiotherapy and Trauma and Orthopaedics baseline. For the purposes of this report, we have assumed all adjustments will be accepted.

	Activity actual	Activity Plan	Activity variance	Income actual	Income Plan	Income variance
Cardiology	102	129	-27	£18,564	£23,478	-£4,914
CPMS Child Protection/LAC	94	59	35	£17,766	£11,151	£6,615
CPMS General Paediatrics	6	6	0	£1,416	£1,416	£0
CPMS Neuro-disability	64	67	-3	£12,096	£12,663	-£567
Diabetes	0	11	-11	£0	£1,507	-£1,507
Pain Management	49	74	-25	£10,780	£16,280	-£5,500
Physiotherapy	1180	1346	-166	£223,020	£254,394	-£31,374
T&O	780	599	181	£134,160	£103,028	£31,132
	2275	**2291**	**-16**	**£417,802**	**£423,917**	**-£6,115**

Figure 5: Initial month 1 ERF performance, pending validation and confirmation of targets

If the adjustments are not expected, the position will look very different, with a deficit position at month 1 of around £102k. This will obviously prove very challenging for service to achieve and would require significant action to be taken if achievement of the target was prioritised.

From a delivery perspective, there are a number of ongoing pieces of work relating to assuring the accuracy of the data and helping services to understand and plan their capacity to maximise the potential to deliver the required volume of first contacts. As an example, we know there were eligible first contacts within the Diabetes service in April (reported as 0 in figure 5 below), however, due to incomplete data in some mandatory fields these have been excluded from the submission. This information will be retrospectively corrected and resubmitted in Month 2.

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

Corporate Business Review Meetings have been reset following the introduction of a new chair, our Chief Finance Officer. The meetings which took place to cover the March/April period were used to set out the framework for the meetings moving forwards. Corporate teams were given an opportunity to raise any areas of escalation, of which there was one common theme raised throughout.

The requirements for the Due Diligence and Full Business Case for Project Fusion were highlighted by each team as being an area of concern. Most teams reported that capacity to deliver the above was a challenge as the full extent of the information required is becoming more evident. Specific risks relating to Project Fusion continue to be raised through the individual steering groups; however, it was deemed worth noting through the Performance Governance route, specifically in relation to the impact on business-as-usual delivery and identifying what will not be able to be delivered, and the associated risks to this, in place of the work on Project Fusion. Corporate teams also reported concern about the lack of experience within their teams to contribute to such a large programme of work and acknowledged that whilst every effort is being made to deliver the requirements, it is a learning curve for everyone.

4. Responsive

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-23 Current Performance		Apr-23 Trending Performance	Apr-23 Variance	Mar-23 Current Performance		Mar-23 Trending Performance	Mar-23 Variance
Responsive	Patients waiting > 18 weeks	-	-	4627		P		4613			H
	Accepted Referrals	-	-	23570		P	L	29035			
	Formal complaints per 1000 WTE	-	-	2.3		P		4.9			
	Number of complaints	I	15	7	●	?		15	●	?	
	Number of complaint breaches	-	-	7		?	H	4			
	RTT incomplete pathways*	E	92.0%	81.3%	●	P		80.2%	●	?	
	Maximum 6-week wait for diagnostic procedures	E	99.0%	100.0%	●	P	H	100.0%	●	?	
	Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0	●	?		29	●	?	
	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50.0%	67.0%	●	P		75.0%	●	?	
	Talking Therapies - Proportion of people completing treatment moving to recovery	E	50.0%	48.5%	●	?	L	53.4%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 6 weeks	E	75.0%	89.0%	●	P	L	91.0%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 18 weeks	E	95.0%	98.0%	●	P	L	100.0%	●	?	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score*	E	90.0%	88.8%	●	?		89.7%	●	?	

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

b. Key Performance Exceptions

Patients waiting > 18 weeks

Waiting lists, for patients waiting for a first contact, continue to have special cause variation reflecting the increasing trend, and the continued pressure on our services. Whilst the number of patients waiting more than 18 weeks continues to rise, the proportion of long waiters that are over 52 weeks is now at the lowest for more than two years (12 .2%).

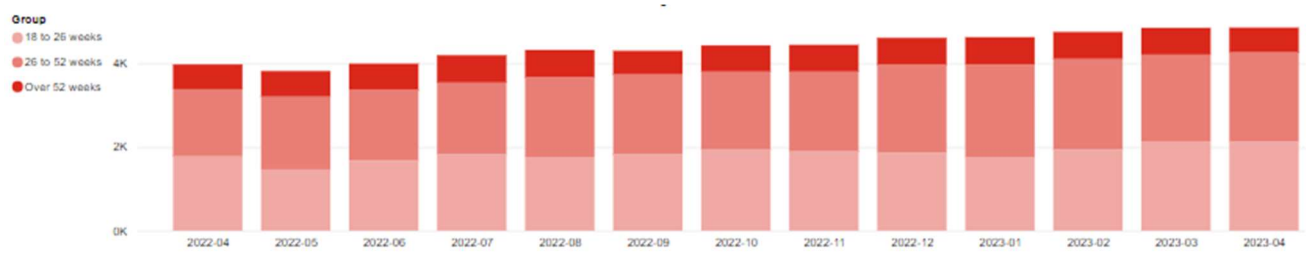


Figure 6: Monthly snapshot of the number of clocks running (>18 weeks) – Trust-wide (excluding Dental Services)

Referrals to Solent services have been, on average, 10% higher during the past 12 months, compared to the previous 12 months, making it challenging for services to gain traction on the growing waiting lists. Restricted investment into services will see waiting lists continue to grow, and will trigger the Executive Team to consider a number of initiatives, including restricting referral criteria into services to focus resource where there is the most impact.

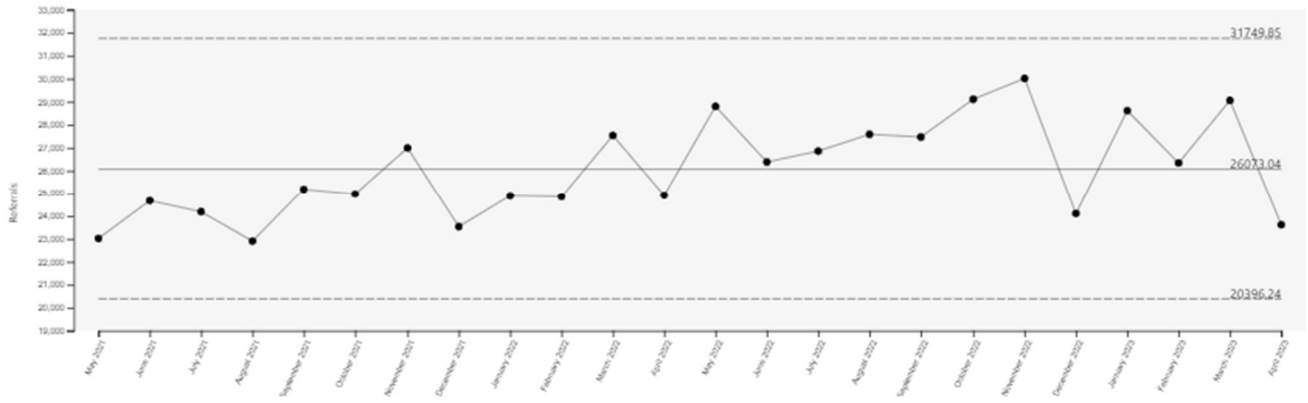


Figure 7: Monthly referrals into Solent services – Trust-wide (excluding Dental Services)

RTT Incomplete Pathways

Patients waiting for an RTT eligible service continue to breach the 92% target to be seen within 18 weeks. Those patients on an incomplete pathway (still waiting to be seen) more than 18 weeks from referral continue to be below the lower control limit. As previously reported, most of the RTT pathway breaches are from our Community Paediatrics Medical service (CPMS) which continues to be the largest area of concern, despite recent recruitment into the service. There has been an increase in the number of referrals for Children Looked After and Adoption Medicals, which paired with staffing issues due to maternity, long-term sickness, and vacancies within the nursing team, have impacted the service's ability to regain control over the waiting list.

Noting the long-standing challenges faced by the service, a deep-dive is to be undertaken at QIR and a transformation project is in the early stages of development within the HIOW ICB. Performance is not expected to improve over the next six months whilst these projects are underway.

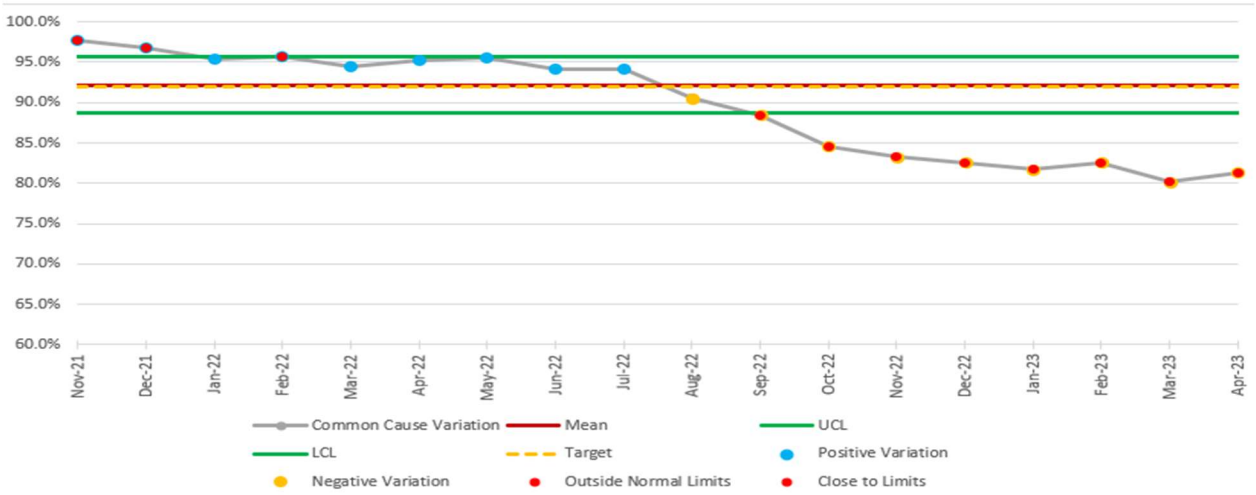


Figure 8: RTT Incomplete Pathways within 18-weeks

6-week wait for Diagnostic Procedures

This metric has flagged a special cause variation for improved performance following achievement of the target for 6 consecutive months. Performance against our usual scope of diagnostics has stabilised considerably in recent months with no concerns being raised. It is worth noting that due to the addition of some new cardiology diagnostic activity, this performance against this indicator is likely to decline in future reports.

The contract for diagnostic echocardiography scans has historically been directly commissioned by the ICB to private provider, Inhealth, however this contract has now ceased. Patients are now being referred to Solent's Cardiology GPSI service, resulting in an increased waiting list for echocardiograms. Solent's echocardiogram activity has previously been excluded from the national diagnostics reporting (DM01) as it is used for surveillance of our existing commissioned patients. The new demand is for diagnostic purposes; therefore, processes are being implemented within service to enable reporting of this activity through appropriate channels in time for May reporting.

It was initially understood that an Echocardiography Technician from Southern Health's Community Diagnostic Centre (CDC) would support the delivery of this new demand, however this has not come to fruition and further conversations with system partners are taking place to resolve resourcing issues. Until this is resolved, performance against the national 6-week waiting time target for diagnostics will likely be breached.

Talking Therapies – Proportion of People Moving Towards Recovery and Waiting Times metrics

Performance against the target for the proportion of people moving towards recovery has flagged a special cause trend as performance has been below the mean for the past 6 months.

The waiting times metrics for IAPT have also flagged a special cause trend as performance has been below the mean for the past 6 months on both the 6- and 18-week access targets, despite performance

consistently meeting the target. Service are aware that demand is currently exceeding capacity and are investigating ways to manage this.

Data Quality Maturity Index (DQMI for the Mental Health Services Dataset (MHSDS)

As previously reported, a data working group has been established to fully understand the issues with each measure contributing towards the DQMI score, with an intention to improve performance in time for quarter 2 reporting.

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

Trust Wide

ICT Incidents

Organisationally there has been increased incidents and concerns raised relating to ICT stability and access over the past few months, linked to the migration of network infrastructure from the legacy ICT provider to the new provider. During March and April 2023, 11.3% of incidents raised were relating to the cause group 'ICT & Digital Info/Systems', compared to 6.7% throughout 2022/23. Escalations were raised across all service lines relating to the impact these issues have had on the ability to provide patient care, a few examples of which are detailed below.

Adults Southampton have seen 40 incidents raised during March, predominantly linked to telephony issues and access to the EPMA system on the inpatient wards. Business continuity plans have been enacted on several occasions, which has impacted the quality of clinical delivery and staff morale. The issues with access to EPMA directly resulted in a medication error (no harm) during the week the networks were migrated.

Adults Portsmouth staff are experiencing difficulties accessing the Solent network when working from Portsmouth Hospitals University Trust (PHUT) sites. This has delayed discharges from the hospital due to lack of access to complete the necessary patient care plans and discharge documentation.

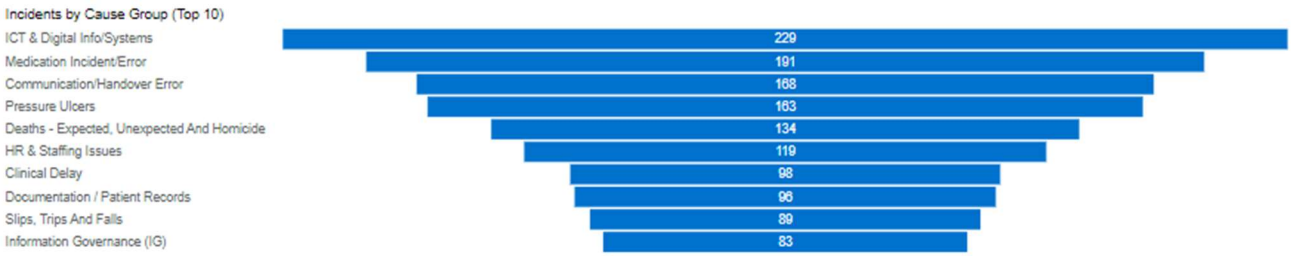


Figure 9: Top 10 Incident Cause Groups, March-April 2023

Musculoskeletal, Pain and Podiatry (MPP) Services

Pelvic Health Service

The Pelvic Health Service has seen an increase in referrals which has been driven by NICE guidance and the subsequent change in practice of Portsmouth Hospitals University Trust (PHU), this has led to increased waiting times which currently sit at 11 months. The service has been historically underfunded with only 1 WTE to provide the clinical capacity for the Pelvic Health service inclusive of Gynaecological and Obstetric referrals. There is no provision for colorectal and gastroenterology services, or for men with pelvic health issues.

The Solent Pelvic Health Service has engaged with both PHU and local commissioners to change the resource in the provision of Specialist Pelvic Health physiotherapy and those that have been engaged in the conversations all agree that any funding changes need to come from PHU, as this is acute activity and funded within tariff. A further meeting is scheduled with PHU to discuss future funding and possible options should an agreement not be reached. Options range from revising the referral criteria to reduce new referrals into the service until the backlog of patients is addressed to closing the service completely.

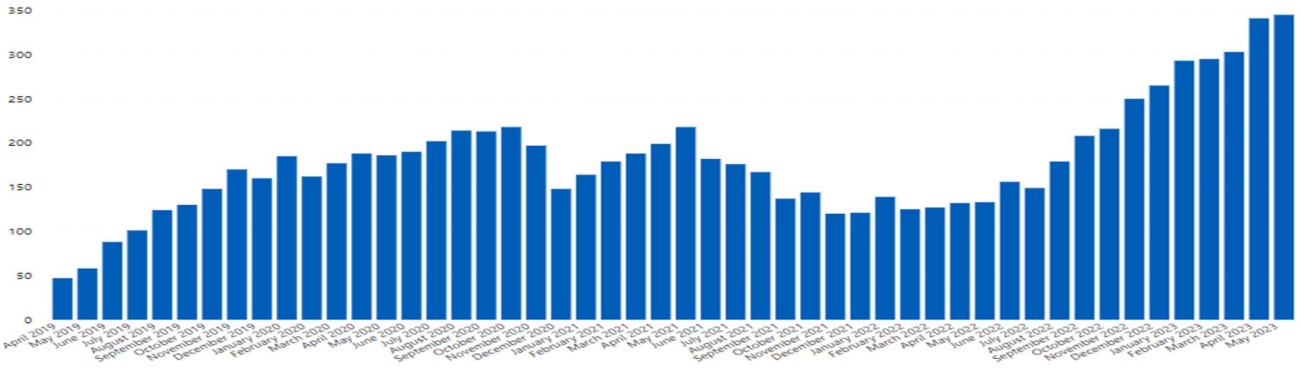


Figure 10: Pelvic Health Waiting List, 2019/20 to date

Podiatry

There are currently 2,395 patients on the waiting list at April 2023, which is a 15% increase from February 2023. It is expected that this waiting list will grow over the next two quarters as a result of hard to fill vacancies and high acuity prioritisation of clinics.

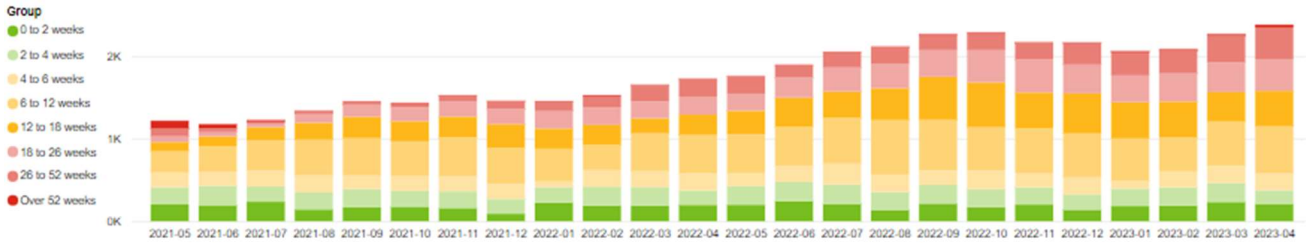


Figure 11: Monthly snapshot of the number of clocks running – Podiatry Service

There are significant workforce constraints within the service at present (vacancies, maternity leave and long-term sickness) and skillset unable to meet service clinical demands both in numbers and risks. Service have been instructed to recruit to vacancies and have gone at risk to recruit additional posts as historically the service has high staff turnover, although there are national shortages of Podiatrists so it is recognised that this will be challenging. Over recruiting both to senior and band 5 posts will help to ensure that vacancies do not further impact on performance and ensure that candidates are secured when they are available.

A Task and Finish Group has also been set up looking at demand and capacity modelling alongside waiting list management, triage, reducing number of patients receiving domiciliary care to increase productivity, multi-agency management of wound care pilots, discharge policies and managing risks and diversifying the workforce, including apprenticeships.

Primary Care

Quality and Outcomes Framework (QOF) Standards

There has been a significant improvement in the achievement of QOF standards within our GP Practices in 2022/23, where 91% of available points were achieved, compared to 73% in 2021/22. This was the best performance in the Primary Care Network (PCN) in which our GP Surgeries sit and reflects the improvement in public health outcomes for the registered population. This also brings a financial benefit to the service, earning them an additional £210k.

GP Workforce

The GP workforce within our surgeries is currently fragile, with significant vacancies for substantive GPs. The workforce is struggling to meet demand, and a significant amount of locums are being utilised to backfill. Other staff groups within the workforce are feeling pressured due to the lack of consistency, although do not have the same levels of turnover. Different strategies to manage resourcing are being considered and ways to attract, and retain, GPs into a non-partner model practice are being considered, along with plans to address cultural process issues within the surgeries.

5. People

a.

Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-23 Current Performance		Apr-23 Trending Performance	Apr-23 Variance	Mar-23 Current Performance		Mar-23 Trending Performance	Mar-23 Variance
People	Sickness (annual)*	I	4.5%	5.5%				5.6%			
	Sickness (in month)	I	4.5%	5.2%				5.5%			
	Turnover (annual)*	I	14.0%	14.1%				13.9%			
	Turnover (in month)	I	1.2%	1.0%				1.2%			
	New starters (FTE)	-	-	41				63.9			
	Proportion of Temporary Staff (in month)	E	6.0%	4.1%				5.2%			

b. Key Performance Exceptions

Sickness

There has been a reduction in sickness absence both in the annual (5.5%) and in-month (5.2%). This is in line with normal seasonal trends as we move out of the winter period into warmer weather. It is expected that sickness will fall again slightly over the summer, down to circa 5%. Whilst there has been an overall reduction, the volume of long-term absence cases that are being managed has risen. The Health & Wellbeing Plan is a continued driver internally to support with this. Focusing on the management of long-term conditions and reasonable adjustments to support colleagues back into the workplace. Reasonable

adjustments are being considered with our staff networks, supporting us with the coproduction of better policies and used language in this area from their lived experience. Mental Health continues to be a concerning trend and we are continuing to invest and work alongside partners to provide services, signposting and supporting those in need. An example of this is the EDNA service, which supports our colleagues who are Neuro Diverse.

Vacancy Levels

Our vacancy level continues to fall following a successful hiring month in January and the closing of open vacancies through the planning cycle. The Recruitment & Attraction Team have planned events in June and July with all services attending to spotlight Solent as a local employer of choice. There have been key successful hires in hard to fill roles, notably on the Isle of Wight. The Trust's staff turnover figure remains consistent at 14.1%, only just exceeding the 14% target. Following investigations into the reasons for leaving in the quarterly exit interview surveys carried out, we have identified a trend in the top ranked primary reasons for leaving which are, Personal, Personal Development, and Working environment. Feedback from the NHS Staff Survey will be considered in terms of further focused work in areas such as personal development, with a revised appraisal dashboard to be rolled out. The Trust will be encouraging the uptake of the NHS Quarterly Pulse Survey to provide regular temperature checks on how the workforce are coping with change, workload, and overall satisfaction in the workplace.

Industrial Action

The Trust has seen continued pressure from Industrial Action. The BMA led further action from Junior Doctors between the 11th to 15th April, which saw up to 21 of our medics participate. Notification from the BMA of further balloting of the Consultant workforce will take place from the 15th May. The RCN organised further action for Nurses from Sunday 30th April to 1st May, 15 Solent Nurses participated in this. Following the acceptance by the NHS Staff Council on 2nd May of the pay offer by the Government for Agenda for Change staff in England, further industrial action relating to this is unlikely but not ruled out. Collaborative working across the ICS continues in the operational planning for these actions.

c. Spotlight On: Agency Usage

There is continued pressure to reduce temporary staffing usage, particularly after a trend of high usage from November through to March. Focused activity on rostering optimisation and financial controls have started to turn the tide on the usage of agency staffing, showing a significant reduction in April. A review of off-framework bookings is underway, with a collaborative system approach to controlling market prices, particularly within the locum specialities. There is a heavy focus on agency usage both organisationally and across the ICS, with the ICB strongly focused on this area. Weekly reporting of usage of bank and agency to the ICB will be required by all providers. A Headroom & Utilisation BI dashboard is being developed to relate staffing availability, budget, and variance together for services to better understand their establishment control.

6. Finance

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-23 Current Performance		Apr-23 Trending Performance	Apr-23 Variance	Mar-23 Current Performance		Mar-23 Trending Performance	Mar-23 Variance
Finance	Year to date surplus/(deficit) Actual v budget	-	-	-1.7%			L	0%			
	Agency spend % pay	I	3.5%	3.1%		?		2.2%		?	
	Cash balance	-	-	£23.4			L	£26.3			
	Aged debt (over 90 days)	-	-	192			H	191			
	Use of Resources Score	-	-	0				2			

b. Spotlight On: Month 1 Results

The plan for 23/24 is a £2.2m deficit, with an expectation that we end the year with a breakeven run rate.

The Trust is reporting an in-month adjusted deficit of £580k, £300k adverse to plan. The main driver of this variance is the unidentified element of savings included within the plan, which have been phased equally across the year.

Cost Improvement Plans (CIP)

The trust has an efficiency programme of £23.2m, of which £19m is made up of identified schemes owned by service leads. Most of the schemes are phased to gain impact from M4/M6 onward. The residual £4.2m of unidentified schemes phased is phased equally across the year with work ongoing to finalise schemes to deliver the full requirement.

Capital

The capital plan for 2023/24 is £21.9m, consisting of £4.1m internally funded, £13.1m Public Dividend Capital (nationally) funded, and £4.7m Integrated Care System funded.

Month 1 capital spend was £0.2m, £0.9m under plan. An underspend in the early part of the year is not unusual due to delays in the national planning timetable impacting the governance process, with spend catching up later in the year.

Cash

The cash balance was £23.4m as at 30 April 2023, £3.0m lower than March. The reduction in cash was primarily due to payment for Microsoft Licences of £2.0m and capital expenditure of £1.2m.

Aged Debt

The Trust's total debt was £3m at the end of April, a decrease of £2.2m on March, due to some high value invoices paid in month. 91+ days overdue debt at the end of April was £0.4m, slightly worse than March, due to an invoice becoming over 90 days with no known disputes. SBS continue their normal procedures to chase, along with finance assistance.

Aged Creditors

The Trust aims to pay its creditors on receipt of undisputed, valid invoices within 30 days or payment terms, whichever is later. Performance against this metric is monitored nationally by NHS England against a target of 95% achievement.

For April 2023 the Trust paid 89% of volume of invoices within target and 93% of value, so whilst not achieving target on either it is an improvement on prior months. A plan is being executed to increase compliance of the 95% target.

7. Research & Improvement

a. Performance Summary

During 2022/23, 1508 participants were recruited into 51 studies. This is an increase of 20% on the previous year which highlights recovery of research post-pandemic. Once again, Solent maintains its position as the most research active Care Trust in the National Institute for Health Research annual league tables.

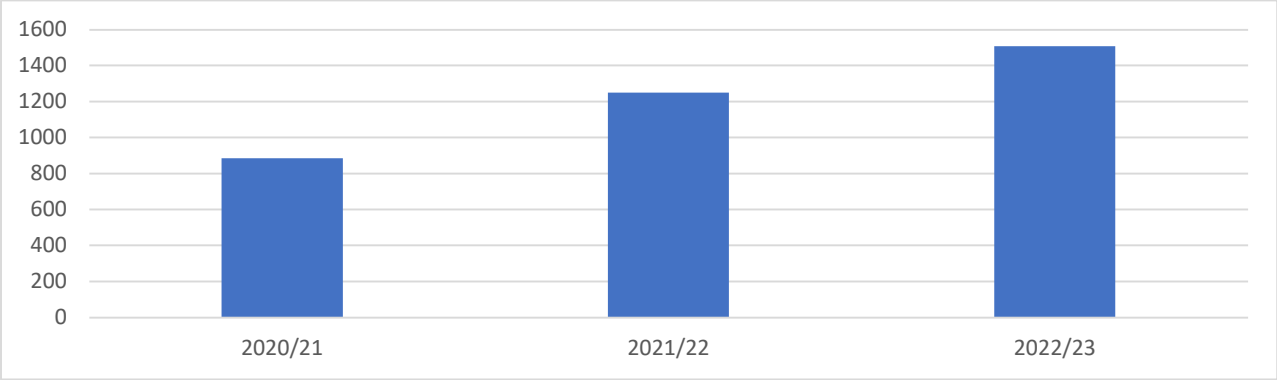


Figure 12: Research Participant Recruitment year on year

We have recruitment across all our service lines, with Children's and Family being our most research active. This is due to a large childhood immunisation study.

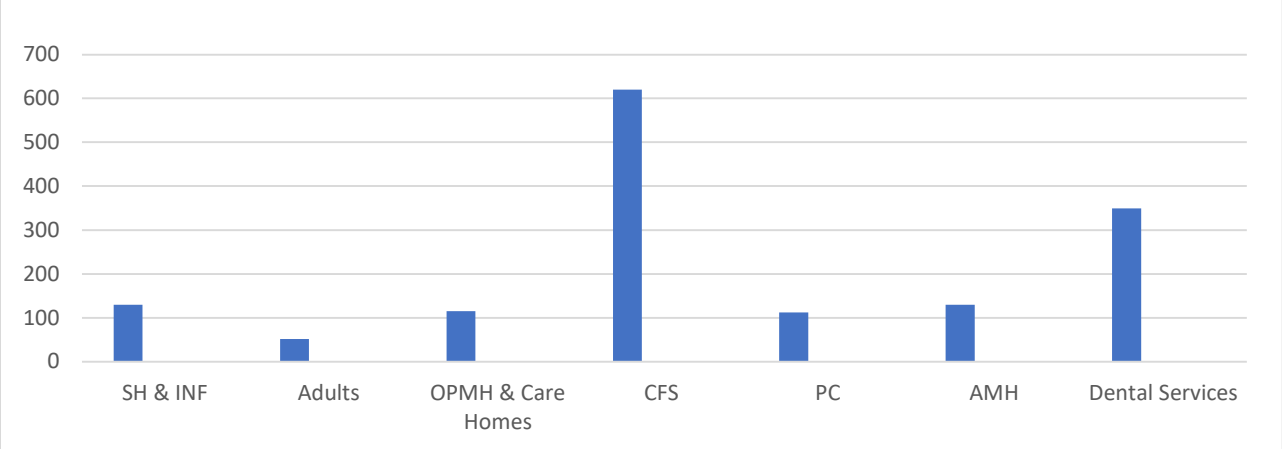


Figure 13: Research Recruitment by service line, 2022/23

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		**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		**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		**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		**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 2023/24 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 Hampshire and Isle of Wight Integrated Care System (HIOW ICS) that Solent is part of, has been moved into System Oversight Level 4, highlighting the addional support being received from NHS England with regards to managing the financial deficit of the ICS through a Recovery Support Programme.

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	Apr-23 Current Performance		Apr-23 Trending Performance	Apr-23 Variance	Mar-23 Current Performance		Mar-23 Trending Performance	Mar-23 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	0		?		0		?	
	S042a: E. coli blood stream infections	E	0	0		?		0		?	
	S081a: IAPT access (total numbers accessing services)	E	366	426		P		501		P	
	S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (3 months rolling)	E	0	39		F	H	239		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%	81.1%		F		103.0%		F	
	S105a. Proportion of patients discharged to usual place of residence	-	-	63.0%				65.5%			
	S107a. Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	E	70.0%	69.0%		F	L	66.0%		F	L
	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	2		?	H	0		?	L
	S013a: Diagnostic activity levels - Imaging	E	545	584		?	H	535		?	H
	S013b: Diagnostic activity levels - Physiological measurement	E	77	72		?		82		?	
Preventing Ill Health	S117a: Proportion of patients who have had a first consultation in a post-covid service more than 15 weeks after referral	-	-	6.3%			L	4.0%			L
Looking after our people	S071a: Proportion of staff in senior leadership roles who are from a BME background	I	12.0%	8.0%		F		6.7%		F	
	S071b: Proportion of staff in senior leadership roles who are women	I	62.0%	71.6%		P		73.0%		P	
	S071c: Proportion of staff in senior leadership roles who are disabled	I	3.2%	4.5%		P	H	4.5%		P	H
	S067a: Leaver rate	I	14.0%	14.1%		?	H	13.9%		?	H
	S068a: Sickness absence (working days lost to sickness)	I	5.0%	5.2%		F		5.5%		F	H
Finance and Use of Resources	S118a: Financial Stability	E	-	Data not currently available							
	S119a: Financial Efficiency	E	-	0.0%				2.2%			
	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 have been covered within this months, or previous iterations of the Trust Board Integrated Performance 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. With the introduction of the Elective Recovery Framework at Solent in 23/24, we should start to see a reduction in the proportion of follow up contacts, as first contacts increase.

Key

In-month Performance Indicator

- Metric is achieving the target
- Metric is not achieving the target

Trending Performance Indicator

Target has been consistently achieved, for more than 6 months

There is a variable and inconsistent performance against the target

Target has been consistently failed, for more than 6 months

Variance Indicator

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

Special Cause Variation, for 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.

Board and Committee Summary Report

Title of Paper	**NHS Provider Licence – Self Certification 2023/24**				
Date of paper	**5 April 2023**				
Presentation to	**Trust Board**				
Item No.	**9.2**				
Author(s)	**Sandra Glaister, Head of Corporate Assurance**				
Executive Sponsor	**Rachel Goldsworthy, Chief of Staff**				
Executive Summary	**The Trust is required to comply with all relevant conditions of the Provider Licence issued by NHSE on 1 April 2023. This paper provides a self-assessment of compliance with the relevant conditions of the licence and a declaration of compliance signed by the Chair and the Chief Executive Officer (CEO).**				
Action Required	**For decision?**		**For assurance?**	**Y**	
Summary of Recommendations	**The Board is asked to:** • **Receive assurance that the Trust complies with the relevant conditions of the Provider Licence.**				
Statement on impact on inequalities	**Positive impact (inc. details below)**		**Negative Impact (inc. details below)**		**No impact (neutral)** **X**
Positive / negative inequalities	**This paper provides assurance that existing arrangements within the Trust comply with the relevant conditions of the Provider Licence. As no changes will be instigated by this paper the impact is neutral.**				
Previously considered at	**The Remuneration and Nominations Committee reviewed the self-assessment at the meeting of 24 March 2023.**				

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services		8. Looking after our people		12.Digital transformation	
2. Alongside Communities		9.Belonging to the NHS		13. A greener NHS	
3. Outcomes that matter		10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	**Significant**		**Sufficient**		**Limited**		**None**	
Assurance Level	**Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance and, whether any additional reporting/ oversight is required the Board**							
Executive Sponsor Signature	 Rachel Goldsworthy, Chief of Staff							

NHS Provider Licence – Self Certification 2023/24

The NHS provider licence was first introduced in 2013, the licence forms part of the oversight arrangements for NHS providers, serves as the legal mechanism for regulatory intervention, and underpins mandated support for challenged providers. NHSE published a revised version of the licence on 1 April 2023 to reflect current statutory and policy requirements and support providers to work effectively as part of integrated care systems.

Prior to publication of the new licence, only FT's were required to declare compliance with all Licence conditions. All trusts are now required to comply with the conditions of the licence; the first annual declaration for the new licence forms part of this report. Appendix 1 shows the full licence and assurance that the Trust complies with each relevant condition.

As recommended by NHSE, we previously reported compliance 'in shadow' with a limited number of licence conditions in every Board Performance Report; annually the CEO and Chair signed a self-declaration of compliance that was retained internally.

As agreed at the Remuneration and Nominations Committee on 24 March, compliance with the new licence will now only be included with the Board Performance Report every six months; It will be included next in the December 2023 Report to the In Public Board. We will continue to make an annual declaration as follows;

Annual Declaration

The following is the annual declaration of the Trust's compliance with the Provider Licence, signed by the Chair and CEO on behalf of the Board, it will be published on our website.

Signed by :

XX, **Chair**

Date: xx **2023**

Signed by :

XX, **CEO**

Date: xx **2023**

Licence number: 400051

Item 9.3

Solent NHS Trust – Compliance with NHS Trust Provider Licence

1. Integrated care	
IC1 – Provision of integrated care	**Response**
1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i) is integrated with the provision of such services by others, and ii) is integrated with the provision of health-related services or social care services by others and iii) enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph 2.	The Trust's Clinical Framework describes how, as key partners in the Hampshire and Isle of Wight (HIOW) Integrated Care System (ICS), we provide clinical leadership to co-create comprehensive, effective pathways of care across HIOW. The Trust has adopted the 'one NHS team' approach and embrace the new NHS Duty to Collaborate; jointly owning ICS ambitions to provide effective, appropriate, resilient services across HIOW.
2. The objectives are: a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, b. reducing inequalities between persons with respect to their ability to access those services, and c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.	The Trust's Clinical Framework prioritises outcomes that matter to patients and describes objectives to reduce inequalities in access to care and Improve the way the Trust delivers care; ensuring that services focus on the priorities which really matter to people and achieving outcomes that count.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.	The Trust takes a proactive approach to guidance issued by NHSE and the Board is provided with updates of the actions and decisions taken by services following receipt of the guidance.
4. Nothing in this licence condition requires the licensee to share information with other providers of health care services for the purposes of the NHS if disclosure of the information would [materially] prejudice its commercial or charitable interests.	The Trust has noted that it does not need to share information with other providers that would materially prejudice its commercial interests.
IC2: Personalised Care and Patient Choice	
1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.	Personalised Care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9; the intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This is a core theme of the Trust's Clinical Framework, specifically Priority 4: 'We will adopt a life-course approach which removes barriers and personalises care'.

IC2: Personalised Care and Patient Choice Ctd	
2.Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.	Detail of services are available on the Trust's public website to support patients with comparing and choosing providers. Patients have access to the Patient Information Policy and leaflets describing services are available in alternative formats. The Trust has adopted the 'one NHS team' approach and embrace the new NHS Duty to Collaborate; jointly owning ICS ambitions to provide effective, appropriate, resilient services across HIOW.
3.Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.	Detail of services are available on the Trust's public website to support patients with comparing and choosing providers. Patients have access to the Patient Information Policy and leaflets describing services are available in alternative formats such as large print, Braille, alternative languages and audio. Performance Reports including quality data are available via the Trust's annual Quality Account to support patients with their choice of provider.
4.Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	The Patient Information Policy and leaflets describing services are available in alternative formats to ensure information about services is clear and accessible. Performance Reports including quality data are available at the Trust's In Public Board and via the Trust's Annual Report and Quality Account to support patients with their choice of provider.
5.Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.	Information about services is available to patients in a variety of accessible formats to support patients with making informed choices. Performance reports provided at In Public Board meetings and the Annual Report and Quality Account provide data information to support patients with comparing and choosing providers to deliver their care.
6.In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	The Trust's Conflicts of Interest Policy, based on NHSE guidance, supports staff with understanding the underlying principles that determine inducements to refer patients or commission services are not permissible.
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	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.

2. Trusts Working in Systems	
WS1: Cooperation	
1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	This applies to the Trust at present and when it becomes part of a foundation Trust.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.	Annual Report 2021/22 What We Do page 11 describes the Trust working with NHS bodies and local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner; i) as necessary and appropriate for the purposes of developing and delivering system plan(s). ii) as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year iii) as necessary and appropriate for the purposes of delivering agreed people and workforce plans. b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i) as necessary and appropriate for the purposes of delivering NHS services. ii) as necessary and appropriate for the purposes of improving NHS services.	3.a i) & iii) & 3.b i) & ii)The Trust is committed to improving collaboration between employers across the ICS to increase overall workforce supply and enable health and care staff to work across the Hampshire and Isle of Wight system. Trust Strategy 2021-25 p59 3.a ii) The Trust will work in collaboration with its system partners to achieve financial balance.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a. the Secretary of State for Health and Social Care; or b. NHS England. For the purpose of this condition, cooperation is considered synonymous to collaboration.	The Trust reviews all guidance published by NHSE and the Board is informed of the progress of the implementation of required actions.
WS2: The Triple Aim	
1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	This applies to the Trust at present and when it becomes part of a foundation Trust.

WS2: The Triple Aim Ctd	
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.	The Trust is committed to achieving the Triple Aim and this is built into the Trust Strategy 2021-25.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.	The Trust reviews all guidance published by NHSE and the Board is informed of the progress of the implementation of required actions.
4. In this condition, "the triple aim" refers to the aim of achieving: a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) c. more sustainable and efficient use of resources by NHS bodies, and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.	a & b) The Trusts Mission includes the commitment to provide Great Care, to be collaborative and inclusive and work alongside communities to improve health, reduce health inequalities and improve experience of care. Trust Strategy 2021-25.P27. c) The Trust will demonstrate Great Value for Money and ensure efficient, sustainable use of resources, in line with the NHS Triple Aim, by focusing on four key enablers: digital transformation, a greener NHS, supportive environments and effective partnerships. Trust Strategy 2021-25.P60
WS3: Digital Transformation	
1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	The Trust has noted that it is required to meet this condition.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	H &SC Act 2012 S250 (1) sets out the power of NHSE to prepare and publish information standards. • The Trust will comply with guidance on these standards issued by NHSE where they are relevant to requirement of the WS1 cooperation condition (developing and delivering system plans/delivering NHS services/Improving NHS services. • In respect of WS1, the Trust's Digital Strategy sets out the ambition for Solent's digital activities (to) increasingly align and blend with the wider health and social care information. In respect of WS2 Triple Aim conditions (health & well-being/reducing inequalities/sustainable resources), the digital strategy is aligned to the NHSE Long Term plan that includes the elements of the Triple Aim in the 5 goals for digital transformation.
3.The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	

3. General Conditions	
G1: Provision of information	
1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.	Section 96 sets out the parameters for NHSE to set or modify licence conditions. The Trust notes the requirement to provide information to NHSE in respect of this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.	The Trust notes the requirement to provide information to NHSE in respect of this condition.
3. The Licensee shall take all reasonable steps to ensure that information is: a. in the case of information or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested.	The Trust will provide accurate and complete information and will ensure all documents provided are true copies of those requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	The Trust notes it is not expected to provide information to NHSE in excess of that it would provide in civil proceedings.
G2: Publication of information	
1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.	The Trust notes the requirement to publish information about health care services following instruction from NHSE.
2. For the purposes of this condition "publish" includes making available to the public, to any section of the public or to individuals.	The Trust produces the Annual Report in accordance with NHSE and Group Accounting Manual guidance, available to the public. The Trust also fulfils Freedom of Information requests received from the public.
G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)	
1. The Licensee must ensure that a person may not become or continue as a **Governor** of the Licensee if that person is: a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);	This condition does not currently apply to Solent as it is not a Foundation Trust.

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director) Ctd	
c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.	
2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.	The Trust issues employment contracts to Directors that states their employment with the Trust is conditional upon satisfactory outcomes of pre-employment checks. The checks and processes required by Regulation 5 are incorporated into the Trust's Fit and Proper Persons Test (FPPT) SOP. The process is followed on appointment of a Director appropriate six monthly checks are undertaken and Directors submit annual self-declarations of their continued compliance with the requirements of the FPPT .
3. For the purposes of paragraph 2, a person is not fit and proper if that person is: a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or b. an organisation which is a body corporate, or a body corporate with a parent body corporate: i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a); ii. in relation to which a **voluntary arrangement** is proposed, or has effect, under section 1 of the Insolvency Act 1986; iii. which has a receiver (including an **administrative receiver** within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; v. which passes any resolution for winding up; vi. which becomes subject to an order of a **Court for winding up**; or vii. **the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.**	a. The Trust issues employment contracts to Directors that states their employment with the Trust is conditional upon satisfactory outcomes of pre-employment checks. The checks and processes required by Regulation 5 are incorporated into the Trust's Fit and Proper Persons Test (FPPT) SOP. The process is followed on appointment of a Director appropriate six monthly checks are undertaken and Directors submit annual self-declarations of their continued compliance with the requirements of the FPPT . b. does not apply to the Trust.

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director) Ctd	
4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.	The Trust follows CQC Regulation 5 in respect of the FPP requirements and retains evidence on file to support this.
G4: NHS England guidance	
1. Without prejudice to any obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.	Section 96(2) sets out the limits on NHSE to set or modify the conditions of the licence. The Trust will have regard to any guidance issued by NHSE in respect of the Provider Licence.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.	The Trust will inform NHSE of the reason for deviation from: • Conditions set by NHSE in respect of the Provider Licence or modifications to the licence issued as guidance. • Any other conditions of the licence
G5: Systems for compliance with licence conditions and related obligations	
1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: a. the Conditions of this Licence, b. any requirements imposed on it under the NHS Acts, and c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	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.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and b. regular review of whether those processes and systems have been implemented and of their effectiveness.	a. The Annual Governance Statement describes the implementation of systems to identify and control risks. b. The effectiveness of processes is reviewed at least annually by responsible officers and reported in the Annual Governance Statement.
G6: Registration with the Care Quality	
1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.	The Trust is registered with the Care Quality Commission. The CQC website lists the services the Trust can legally provide and lists the Trust's Chief Nurse is listed as the responsible officer for them. (CQC website – Solent NHS Trust – Registration Details).

G6: Registration with the Care Quality Commission Ctd	
2. The Licensee shall notify NHSE promptly of: (a) any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or (b) the cancellation by the Care Quality Commission for any reason of its registration by that Commission.	The Trust will immediately inform NHSE of any changes to its CQC registration.
3. A notification given by the Licensee for the purposes of paragraph 2 shall: (a) be made within 7 days of: i. the making of an application in the case of paragraph (a), or ii. becoming aware of the cancellation in the case of paragraph (b), and b. contain an explanation of the reasons (in so far as they are known to the Licensee) for: i. the making of an application in the case of paragraph (a), or ii. the cancellation in the case of paragraph (b).	The Trust will notify NHSE within 7 days of any application it makes to cancel CQC registration or any cancellation made by CQC.
G7: Patient eligibility and selection criteria	
1. The Licensee shall: (a) set transparent eligibility and selection criteria, (b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and (c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.	(a) Referral criteria is set out for each service and is available on the Solent public website Home – Our Services – Service listings. (b) The criteria is applied transparently to people choosing to receive Healthcare from the Trust. (c) Referral criteria is available on the Solent public website Home – Our Services – Service listings.
2. "Eligibility and selection criteria" means criteria for determining: (a) whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and (b) if the person is selected, the manner in which the services are provided to the person.	The referral criteria available on the Trust public website sets out (a) What would constitute eligibility for the service (i.e. registered with a local GP). (b) How the service will be delivered (i.e. telephone support/clinic settings).
G8: Application of section 5 (Continuity of Service)	
1. The Conditions in Section 6 shall apply: a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service, b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2.	The Trust will provide services in accordance with NHS standard contract. Contractual performance and risk will be and reported via Commercial Group with escalation to Finance and Commercial and Finance infrastructure in accordance with Standard financial instructions and the Trust governance structure and controls.

G8: Application of section 5 (Continuity of Service) Ctd	
c. where the circumstances set out in paragraph [6] apply (expiry of contract without renewal or extension) d. where the circumstances set out in paragraph [7] apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service) e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.	For services set out in Section 6.1c and 6.1d services will identified and managed through our robust contractual risk assessment process with escalation as referred above. For noting; presenting risk for non-contracted activity and/or implied arrangements will be reported through Contract management system with escalation to service PRM and Commercial Group with mitigations considered as part of standard contract review process and controls.
2. A service is designated as a Commissioner Requested Service if: a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or d. the Commissioner, not earlier than the expiry of the [28th] day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.	The Trust has noted this condition. All notices to the Trust are managed in accordance with contract management controls with governance in accordance with Trust SFI.
3. A notice in accordance with this paragraph is a notice: a. in writing, b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.	The Trust has noted this condition. All notices will be reviewed on its own merits in accordance with NHS contractual obligations and respond to commissioner in accordance with general conditions of NHS contract with governance Commercial Group, F&C and F&I.
4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.	The Trust has noted this condition.
5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.	The Trust has noted this condition. This will be identified through Contract review process and formal escalation to ICB / NHSE in accordance with NHS standard contract particulars and general conditions.

G8: Application of section 5 (Continuity of Service) Ctd	
	Note; Potential risk to Trust of implied contract/ NCA which will be reported through risk assessment process. For highlighting NHS contracts for ICB have a number of service lines under one terms so being clear which service extension / renewal relates otherwise will be deemed NHS contract as whole.
6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either: a. an instruction of the sort referred to in paragraph 7, or b. a notice in writing to the Licensee stating that it has decided not to issue such an instruction.	The Trust has noted this condition. This will be identified through Contract review process and formal escalation to ICB / NHSE in accordance with NHS standard contract particulars and general conditions. Note – Potential risk to Trust of implied contract/ NCA which will be reported through risk assessment process. For highlighting NHS contracts for ICB have a number of service lines under one terms so being clear which service extension / renewal relates otherwise will be deemed NHS contract as whole.
7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.	The Trust has noted this condition. All notices will be reviewed on its own merits in accordance with NHS contractual obligations and respond to commissioner in accordance with general conditions of NHS contract with governance/approval via Commercial Group, F&C and F&I.
8. A service shall cease to be a Commissioner Requested Service if: a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired	The Trust has noted this condition. All notices, which includes cessation of provision will be reviewed in accordance with NHS contractual obligations and respond to commissioner in accordance with general conditions of NHS contract with governance/approval via Commercial Group, F&C and F&I.

G8: Application of section 5 (Continuity of Service) Ctd	
9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.	The Trust has noted this condition. In accordance NHS standard contract relating to contract query, requests should be reasonable and relevant. The Trust adheres to FOI regulations with governance processes in place to approve the content of responses before they are provided.
10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.	The Trust has noted this condition. This requirement is met by GC13 of national contract with clear process and controls through approval of contract variation order and/or notice
11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.	The Trust has noted this condition.
12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.	The Trust has noted this condition.
13. In this Condition "NHS contract" has the meaning given to that term in Section 9 of the 2006 Act.	The Trust has noted this condition.
4 – Trust Conditions	
NHS1: Information to update the register	
1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	These conditions do not currently apply to Solent as it is not a Foundation Trust.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents: (a) the current version of Licensee's constitution; (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and (c) the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.	

NHS1: Information to update the register Ctd	
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.	
4. The obligation in paragraph 3 shall not apply to: (a) any document provided pursuant to paragraph 2; (b) any document originating from NHS England; or (c) any document required by law to be provided to NHS England by another person.	
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short, written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	
NHS2: Governance arrangements	
1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSE.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	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.

NHS2: Governance arrangements Ctd	
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time; and b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have systems and processes in place to meet any guidance issued by NHS England on digital maturity d. comply with the following paragraphs of this Condition.	a. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSE. b. The Trust's Annual Report describes the Trust's compliance with guidance on tackling climate change and delivering net zero emissions. c. The Trust's Digital Strategy describes how the Trust meets requirements on digital maturity. There is a dedicated governance reporting structure for digital services to enact guidance issued by NHSE in respect of digital maturity.
4. The Licensee shall establish and implement: 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.	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.
5. The Licensee shall establish and effectively implement 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, NHS England 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);	• We regularly review our governance processes including our Board Code of Conduct and associated protocols. The Trust ended the financial year 2021/22 with a small surplus. • The Trust has submitted a break-even plan for 2022/23. • Internal control processes have been established and are embedded across the organisation as outlined within the Annual Governance Statement. In early 2022/23 the Board agreed actions to enhance the internal controls regarding pre-employment checks and recruitment processes. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls.

NHS2: Governance arrangements Ctd	
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.	
6. The systems and/or processes referred to in paragraph 5 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's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	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.
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	• Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. Details of the composition of the Board can be found within the public website.

5. NHS Controlled Providers Conditions	
CP1: Governance arrangements for NHS-controlled providers	
1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.	NHS-controlled providers are providers who are: Not NHS trusts or NHS foundation trusts, they are controlled by or more NHS Trust and are required to hold a provider licence. This condition does not apply to Solent.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time; and b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have systems and processes in place to meet any guidance issued by NHS England on digital maturity d. comply with the following paragraphs of this Condition.	
4. The Licensee shall establish and implement: 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 and to the NHS body by which it is controlled (as defined below).	
5. The Licensee shall establish and effectively implement systems and/or processes: a. 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, NHS England 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;	NHS-controlled providers are providers who are: Not NHS trusts or NHS foundation trusts, they are controlled by or more NHS Trust and are required to hold a provider licence. This condition does not apply to Solent.

5. NHS Controlled Providers Conditions	
CP1: Governance arrangements for NHS-controlled providers Ctd	
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.	NHS-controlled providers are providers who are: Not NHS trusts or NHS foundation trusts, they are controlled by or more NHS Trust and are required to hold a provider licence. This condition does not apply to Solent.
6. The systems and/or processes referred to in paragraph 5 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's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	

6 – Continuity of Services	
1: Continuing provision of Commissioner Requested services	
1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.	The Trust has noted conditions 1 – 5. The Trust will use its governance structures for contract formation and will use contract review mechanisms should changes to contracts become necessary.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G9(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.	
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except: (a) with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or (b) at any time when this condition applies by virtue of Condition G9(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or (c) if required to do so by, or in accordance with the terms of its authorisation by, anybody having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.	
4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within [28] days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.	
5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in:	

1: Continuing provision of Commissioner Requested services Ctd	
a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.	
CoS 2: Restriction of the disposal of assets	
1.The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register").	The Trust has an asset register that is maintained by the Finance Department.
2.The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	The asset register is populated with items with a value in excess of £5k and a useful life of more than one year. Trust owned land and sites are also recorded on the register including St James Hospital, St Mary's Hospital and the Western Community Hospital.
3.The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	The asset register is maintained by the Finance Department. Depreciation over the useful life of the asset is charged to income and expenditure. Capital schemes are recognised on the asset register as soon as they begin. The Capital Accounting Group meets on a monthly basis to review capital schemes, any capital schemes between the value of £5k and £50k may be approved by the Group. Schemes over that value over are presented to the Finance and Infrastructure Committee, if approved they are added to the Finance and Infrastructure Committee for review and if accepted they are added to the Asset Register. A formal business case must be submitted to NSHE for assets over 10m
4.The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.	NHSE has not given written notice to the Trust in respect of the Trust's ability to carry on as a going concern. Paragraphs 5 to 8 do not apply to the Trust.
5.The Licensee shall not dispose of, or relinquish control over, any relevant asset except: (a) with the consent in writing of NHS England, and (b) in accordance with the paragraphs 6 to 8 of this Condition.	
6.The Licensee shall furnish NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	

<table>
<tr><th>CoS 2: Restriction of the disposal of assets Ctd</th><th></th></tr>
<tr><td>7.Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.</td><td rowspan="2"></td></tr>
<tr><td>8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where: a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to: i. transactions of a specified description; or ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.</td></tr>
<tr><td>9. In this Condition:
<table>
<tr><td>“disposal”</td><td>means any of the following:
(a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or
(b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or
(c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or
(d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered,
and references to “dispose” are to be read accordingly;</td></tr>
<tr><td>“relevant asset”</td><td>means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee’s ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;</td></tr>
<tr><td>“relinquishment of control”</td><td>includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and “relinquish” and related expressions are to be read accordingly.</td></tr>
</table></td><td>The Trust has noted the meaning of the terms used in this condition.</td></tr>
</table>

CoS 2: Restriction of the disposal of assets Ctd	
10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding: a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.	The Trust will have regard to guidance issued by NHSE in respect of the management and recording of assets.
CoS 3: Standards of corporate governance, financial management and quality governance	
1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services provided by the Licensee, and b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.	The Trust has governance structures in place for the management and oversight of quality and finance via groups and subcommittees of the Trust Board. The arrangements would be regarded as suitable for; a. provider of commission requested services. b. provide reasonable assurance of going concern c. provide reasonable safeguards against quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.	The Trust applies systems and standards to maintain high standards of corporate governance, financial management and quality a. in response issued by NHSE b. to use risk ratings published by NHSE and c. to maintain the risk rating regarded as acceptable by NHSE.
CoS 4: Undertaking from the ultimate controller organisation	
1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and	The Trust does not have an ultimate controller. Paragraphs 1 to 5 do not apply to the Trust.

CoS 4: Undertaking from the ultimate controller organisation Ctd	
b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.	
2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	
3. The Licensee shall: a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it; b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c. comply with any request which may be made by NHS England to enforce any such undertaking.	
4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: 33 | Provider licence consultation notice: Part B – NHS Provider Licence – for consultation a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.	
5. A person is not an ultimate controller if they are: a. a health service body, within the meaning of section 9 of the 2006 Act; b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust; c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or d. a trustee of the Licensee and the Licensee is a charity.	
CoS5 – Risk pool levy	
1.The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.	The Trust makes payments under the Risk Pool Schemes for Trusts (RPST); Liabilities to Third Parties (LTTP) and Property Expenses Scheme (PES) by the date they are required to be paid.

CoS 5 – Risk pool levy Ctd	
2.In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	The Trust has noted the requirement to pay sums payable by way of levy or any interest payable within 28 days of a demand in writing from NHSE.
CoS 6: Cooperation in the event of financial or quality stress	
1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: **a. the ability of the Licensee to continue to provide commissioner requested services due to [quality stress], or b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to [quality stress]** c. the ability of the Licensee to carry on as a going concern	The Trust has noted the obligation to give written notice to NHSE in the event of concerns around quality stress or going concern.
2. When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.	This paragraph does not apply to the Trust as there are currently no concerns around quality stress or going concern.
CoS 7: Availability of resources	
1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	The Trust has noted it should act in a manner to ensure it has the required resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	The Trust has noted it should not by its actions create a material risk to the availability of the require resources required resources.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or	a. The Trust submitted the following to NHSE at the same time as the Annual Report in 2022. 1. A Statement of Directors Responsibilities in respect of the accounts, confirming the directors belief they present a fair and balanced view. 2. Trust Accounts Consolidation Schedule (showing the separate accounts in the Trust) signed by the Chief Executive Officer. 3. Certificate on summarisation schedules signed by the Director of Finance and the CEO. 4. Statement of the Chief Executive's responsibilities as the accountable officer of the Trust. 5. A letter to NHSE from the CEO confirming there were no events after the reporting period.

CoS 7: Availability of resources Ctd	
limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources". c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".	6. The above documents confirm the opinions of the Directors and CEO that the accounts form a fair and balanced view of the Trust's financial status. 7. The Trust will comply with any further requirements or changes to the format of submissions to confirm the availability of required resources.
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	The Statement of Directors Responsibilities in respect of the accounts, that takes into account the main factors considered when issuing the certificate
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	The Statement of Directors Responsibilities was signed by the Chief Finance Officer and the Chief Executive Officer 20.06.22 and provided to NHSE.
6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3	The Trust has noted it must inform NHSE if the expectation regarding required resources changes.
7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	A Statement of Directors Responsibilities in respect of the accounts, Statement of the Chief Executive's responsibilities as the accountable officer of the Trust are published in the Trust's Annual Accounts.
8. In this Condition: "distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; "Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts; "Required Resources" means such: a. management resources including clinical leadership, b. appropriate and accurate information pertinent to the governance of quality c. financial resources and financial facilities, d. personnel, e. physical and other assets including rights, licences and consents relating to their use, and f. subcontracts , and g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.	The Trust has noted the meanings of the terms in this condition.

<table>
<tr><th colspan="2">7. Costing Conditions Ctd</th></tr>
<tr><th colspan="2">C1: Submission of costing information</th></tr>
<tr><td>1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall: (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition</td><td>Finance managers manage service line finance to ensure the service lines process all costs around Financial crime compliance</td></tr>
<tr><td>2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England’s Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.</td><td>The Trust collects information as required by National Costing Submission Guidance and is working towards a PLICS submission at year end. Activity Information is provided in the PLICS data software and is aligned to the Trust’s financial information to form the submission.</td></tr>
<tr><td>3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors: (a) obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and (b) provides that information to NHS England in a timely manner.</td><td>Diagnostics and sexual health are subcontracted. The data supplied is processed by the Production Team within the Performance Team. The information is monthly activity and cost breakdown that is held by the Finance and Performance teams.</td></tr>
<tr><td>4. Records required to be maintained by this Condition shall be kept for not less than six years.</td><td>Records are kept for 6 years; the Information Governance Team ensures we comply with NHSE standards for record retention.</td></tr>
<tr><td>5. In this Condition:<table><tr><td>“the Approved Guidance”</td><td>means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England.</td></tr><tr><td>“other relevant information”</td><td>means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.</td></tr></table></td><td>The Trust has noted the meaning of the terms used in this condition.</td></tr>
</table>

C2: Provision of costing and costing related information	
1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.	The information is submission is provided via the annual PLICS submission. 2022/23 is the first year for the submission of patient level costing rather than aggregated information. This is in accordance with approved costing guidance.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a. in the case of information (data) or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested;	a) All submissions are reviewed by the Finance team for accuracy prior to submission. There are data quality reports available from PLICS via a data quality tool provided by IQVIA. The tool matches cost with activity to provide an itemised cost and reports of anomalies are fed back to the Finance team for investigation. B) only prime documents are submitted upon request.
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	The Trust notes that it is not expected to provide information to NHSE exceeding that which it would not provide in civil proceedings.
C3: Assuring the accuracy of pricing and costing information	
1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.	The Trust accesses a data quality tool provided by IQVIA that reviews data and highlights potential anomalies in accuracy of the PLICS data to allow correction prior to submission to NHSE to ensure data meets the requirements of the Approved Costing Guidance.
2. This may include but is not limited to a. Regular assessments by the providers internal and/or external auditor b. specific work by NHS England or NHS England nominated representative on costing related issues and c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information. d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.	Data management processes are currently being audited by PwC. a. The Trusts internal and external auditor undertake risk assessments of the Trust and prepare annual work programmes based on this. b. The Trust will work with NHSE representatives on request. c. The Trust has access to a data quality tool provided n IQVIA. d. Documentation relating to the work of internal and external audit is retained. Assurance in respect of the financial accounts provided by the Trusts external auditors, Ernst and Young, is available in the Annual Report and Accounts.
Section 8 – Pricing Conditions	
P1: Compliance with the NHS payment scheme	
1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with, section 116 of the 2012 Act, wherever applicable.	The Trust complies with the rules and applies the methods of the NHS Payment Scheme.

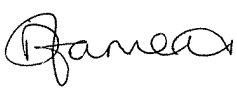
Board and Committee Summary Report

Title of Paper	Annual Review of Strategic Objectives				
Date of paper	27 May 2023				
Presentation to	Trust Board				
Item No.	10.1				
Author(s)	Debbie James, Chief Strategy and Transformation Officer				
Executive Sponsor	Debbie James, Chief Strategy and Transformation Officer				
Executive Summary	In 2021, the Solent Strategy was refreshed and we established a new strategic framework, which includes 15 strategic priorities describing the principles and commitments we have adopted to help achieve our organisational vision. In addition to our annual business objectives, we set out delivery commitments for 2022/23 against each of the 15 strategic priorities, which describe the work we are doing to support their achievement. This report describes the objectives and delivery commitments we progressed, and achieved, in line with our strategic priorities, during 2022/23. A comprehensive report describing progress against our commitments will be provided at the August Board.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The Board is asked to note the update provided.				
Statement on impact on inequalities	Positive impact (inc. details below)	X	Negative Impact (inc. details below)		No impact (neutral)
Positive / negative inequalities	The report summarises progress against the Trust's strategic objectives, which incorporate actions to deliver improvements which impact positively on unwarranted variation and health inequalities.				
Previously considered at	Executive Oversight Group Meeting				

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services	X	8. Looking after our people	X	12.Digital transformation	X
2. Alongside Communities	X	9.Belonging to the NHS	X	13. A greener NHS	X
3. Outcomes that matter	X	10. New ways of working	X	14. Supportive Environments	X
4. Life-course approach	X	11. Growing for the future	X	15. Partnership and added value	X
5. One health and care team	X				
6. Research and innovation	X				
7. Clinical and professional leadership	X				

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

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

Item 10.2

Strategic Priorities Update – 2022/23 Final Report

NHS Solent NHS Trust

Purpose of this report

In 2021, the Solent Strategy was refreshed and we established a new strategic framework, which includes 15 strategic priorities describing the principles and commitments we have adopted to help achieve our organisational vision. In addition to our annual business objectives, we set out delivery commitments for 2022/23 against each of the 15 strategic priorities, which describe the work we are doing to support their achievement.

This report describes the objectives and delivery commitments we progressed, and achieved, in line with our strategic priorities, during 2022/23.

Our Strategic Priorities are:

Great Care	1	We provide safe, effective services which help people keep mentally and physically well, get better when they are ill and stay as well as they can to the end of their lives
	2	Our communities are at the heart of what we do and we will work alongside our communities to improve the way we deliver care
	3	We will focus on outcomes that matter, co-created with the people who know our services best
	4	We will adopt a life-course approach which removes barriers and personalises care
	5	We will work collaboratively, at the appropriate scale, as one health and care team
	6	We will drive and embrace research and innovation to deliver excellent, evidence-based care
	7	We will ensure strong clinical and professional leadership is at the heart of delivery and decision making across our area
Great Place to Work	8	Looking after our people – we will look after the health and wellbeing of our people and prioritise work-life balance
	9	Belonging in the NHS – we will create an inclusive, compassionate culture which addresses inequalities
	10	New ways of working - we are committed to embedding new ways of working and delivering care
	11	Growing for the future – we will develop a workforce which is sustainable for the future
Great Value for Money	12	Digital and data transformation - We will improve the experience of staff and service users by implementing digital solutions which optimise existing practice, innovate new practice and enable effective decision making through excellent data and business intelligence
	13	Green NHS - we will be smarter in how we use resources when delivering high quality healthcare, so that we are environmentally, economically and socially sustainable
	14	Supportive environments - we will ensure our built environments provide best value whilst enabling and supporting changes in healthcare delivery and responding to the needs of the population
	15	Partnerships and added value - we will work in partnership to identify opportunities to work effectively at the appropriate scale to address unwarranted variation, deliver social value, improve NHS and community sustainability and ensure effective use of resources

Strategic Priorities Update – 2022/23 Final Report

2022/23 Business objectives

In 2022-23, service lines and corporate functions identified a range of transformation and improvement business objectives to support delivery of the Trust's 2021-25 organisational strategy. Of the 97 objectives initiated:

- 45 related to strategic priorities linked to our mission to provide Great Care
- 19 aligned with strategic priorities linked to our mission to be a Great Place to Work
- 33 objectives focussed on strategic priorities linked to our mission to provide Great Value for Money

End of Year Position

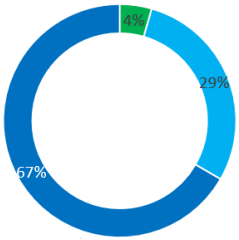
The below table identifies the final position of the business objectives at the end of April 23.

Business Objective in Progress	4	4%
Completed	49	51%
Closed	44	45%
Total	97	100%

The Business objectives completion rate for 2022-23 was 51% of total objectives agreed, with 45% closed in-year and the remaining schemes continuing to be worked on into 2023-24.

A summary illustrating completion against Strategic Priorities is provided below:

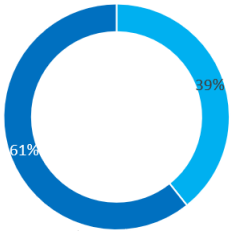
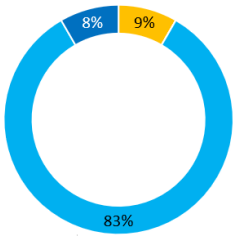
Business objectives 22-23 achievement summary

RAG			Strategic Priority	Total	R	A	G	Cl	Co
	Great Care	1	We provide safe, effective services which help people keep mentally and physically well, get better when they are ill and stay as well as they can to the end of their lives	1	0	0	0	0	1
		2	Our communities are at the heart of what we do and we will work alongside our communities to improve the way we deliver care	14	0	0	0	6	8
		3	We will focus on outcomes that matter, co-created with the people who know our services best	1	0	0	0	1	0
		4	We will adopt a life-course approach which removes barriers and personalises care	3	0	0	1	2	0
		5	We will work collaboratively, at the appropriate scale, as one health and care team	4	0	0	1	1	2
		6	We will drive and embrace research and innovation to deliver excellent, evidence-based care	19	0	0	0	1	18
		7	We will ensure strong clinical and professional leadership is at the heart of delivery and decision making across our area	3	0	0	0	2	1
				45	0	0	2	13	30

Strategic Priorities Update – 2022/23 Final Report

NHS Solent NHS Trust

Business objectives 22-23 achievement summary

RAG			Strategic Priority	Total	R	A	G	Cl	Co
	Great Place to Work	8	Looking after our people – we will look after the health and wellbeing of our people and prioritise work-life balance	5	0	0	0	4	1
		9	Belonging in the NHS – we will create an inclusive, compassionate culture which addresses inequalities	3	0	0	0	1	2
		10	New ways of working - we are committed to embedding new ways of working and delivering care	8	0	0	0	3	5
		11	Growing for the future – we will develop a workforce which is sustainable for the future	12	0	0	0	3	9
				28	0	0	0	11	17
	Great Value for Money	12	Digital and data transformation - We will improve the experience of staff and service users by implementing digital solutions which optimise existing practice, innovate new practice and enable effective decision making through excellent data and business intelligence	12	0	2	0	10	0
		13	Green NHS - we will be smarter in how we use resources when delivering high quality healthcare, so that we are environmentally, economically and socially sustainable	1	0	0	0	1	0
		14	Supportive environments - we will ensure our built environments provide best value whilst enabling and supporting changes in healthcare delivery and responding to the needs of the population	3	0	0	0	2	1
		15	Partnerships and added value - we will work in partnership to identify opportunities to work effectively at the appropriate scale to address unwarranted variation, deliver social value, improve NHS and community sustainability and ensure effective use of resources	8	0	0	0	7	1
				24	0	2	0	20	2
Cl = Closed			Objectives have closed for 22-23 as elements will form part of 23-24 projects, are no longer a priority or may be now governed under Project Fusion						
CO = Completed			Objectives have met all milestones and have delivered intended change	97	0	2	2	44	49

During the 2022-23 planning process, the benefits that would be delivered through achievement of service line and corporate objectives were also mapped, as follows:

Performance improvement	Improving clinical and corporate services through improved processes or digital improvements	22
Patient Outcomes	Directly aiding and improving patient care	13
Solent financial sustainability and value for money	Improving how funds are spent or improving the outputs a service can deliver within the financial envelope available	9
Improved workforce sustainability	Improving staff retention and conditions	4
Improved Workforce Capacity	Contributing to helping the workforce deliver care by improving efficiencies	1

Strategic Priorities Update – 2022/23 Final Report

Over 27% of completed objectives directly aided and improved patient care, resulting in expected improvements to patient outcomes. An example of this was the redesign of in-patient bed provision in Portsmouth to fully embed discharge to assess and home first models of care:

Discharge to Assess – Southsea Unit – Improved Patient care

This programme saw the redesign of in-patient bed provision in Portsmouth which supports the national directive to fully embed a 'Discharge to Assess' and 'Home First' enabling patients to safely leave hospital as soon as they are medically fit, so assessments of their long-term care needs happen outside of the acute environment once they have the met their full rehabilitation potential.

The model involved decommissioning 12 beds at Jubilee house a service provided by Solent NHS and combining with Portsmouth City Council (PCC) rehabilitation unit Southsea unit at Harry Sotnick House functioning as a discharge to assess unit with a 40-bed capacity.

The blended model incorporated staff from the PCC Southsea unit and Jubilee house into single operating team employed by Solent NHS. The initiative of bringing both health and social care teams together into a fully integrated workforce enabled the implementation of a flexible and efficient D2A bed pathway utilising skill sets and improving patient flow and bed utilisation.

This model supports patient safety, experience and the wider system benefits associated with D2A models. The mode went 'Live' in October 2022 on time following a successful workforce transfer. Whilst it is early days to see the benefits reported through metrics; the model has already seen tangible improvements in both patient experience enabling people to remain well and independent for as long as possible by maximising their recovery, managing their long-term conditions, and returning to their usual place of residence.

Over 45% of completed objectives achieved performance improvement benefits. These include schemes to improve work practices, processes and tools. An example of which includes electronic prescribing and medicines administration:

Electronic Prescribing and medicines administration (EPMA) – Performance improvements.

This year saw the development of the EPMA programme with the onboarding of a dedicated team trained in the use of the EPMA system ensuring that medication orders are accurately recorded and administered, reducing the risk of adverse drug events. Ensuring patient safety is at the heart of what the EPMA team do. The digital system enables critical information to be provided in a timely way, the automated processes are more efficient whilst reducing the risk of error. The Team continues to work closely with our software provider to develop new and streamline older processes, reducing the time and effort required to administer medications.

The use of EMA systems is already having a positive impact on the efficiency of the Trust, freeing up clinician time and saving money. For 23/24, the team are focusing their efforts on creating duplicatable reports to provide data analysis to inform processes improvements which ultimately improve patient outcomes. This along with supporting scientific research and building new drug profiles put us in a strong position to support the wider system and project fusion.

Strategic Priorities Update – 2022/23 Final Report

Forty-four objectives were closed in 2022-23, for a variety of reasons:

- Some (31) objectives were partly or wholly redefined for delivery in 2023-24, often because the case for change and scope of the work that needed to be completed has evolved.
- Some (3) objectives were closed because, as the year progressed, it became obvious that they were not longer a priority, or no longer relevant to the direction of the service. This may, for example be due to operational changes, new commissioner priorities or a the evolving ICB direction.
- It was agreed that 5 objectives would no longer be monitored as business objectives as they had become part of the service's operational remit and would therefore be taken forward as business as usual (BAU) work.
- Some (5) objectives were closed because they now form part of the Project Fusion workstream.

The following objectives will not form part of the next planning year but will continue to be worked on, as they are multiyear projects:

Service	Business Objective
Finance	• PLICS System Implementation
Medicines Management	• Expansion of EPMA into SHFT ahead of new Trust formation • Long Covid MDT Support
Dental	• We will develop 'Dementia - Friendly' clinics across Hampshire and IOW

Title of Paper	Information Governance & Data Security Compliance Report 2022/23				
Date of paper	15th May 2023				
Presentation to	Trust Board				
Item No.	11				
Author(s)	Sadie Bell, Head of Information Governance & Digital Security / Data Protection Officer				
Executive Sponsor	Rachel Goldsworthy, Chief of Staff / SIRO				
Executive Summary	The aim of this paper is to update the Trust Board on the Trust's current compliance with Information Governance & Digital Security Practices / Mandatory Requirements. To present the Trust's year end position for 2022/24 and to share the learning and areas for improvement including the priorities for the next financial year				
Action Required	For decision?	(Y/N)	For assurance?	(Y/N)	
Summary of Recommendations	The Board are asked to receive the report and in doing so: • Not assurance of the Trust's current and expected compliance levels / status • Note the risks identified and priority areas of focus going forward for 2023/24				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) x
Positive / negative inequalities	n/a				
Previously considered at	Review by the Trust's SIRO				

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services	x	8. Looking after our people		12.Digital transformation	x
2. Alongside Communities		9.Belonging to the NHS		13. A greener NHS	
3. Outcomes that matter	x	10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

Information Governance & Data Security Compliance Report 2022/23

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 concerning;

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

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. The Trust submitted its baseline submission on the 28th February 2023, as partially met. The final submission is 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; the Head of IG & Digital Security would like to offer the board an assurance statement that the Trust is expected to achieve full compliance on all mandatory requirements by the end of June 2023. All internally lead requirements outstanding are in the final stages of competition and our ICT contractors are currently collating all remaining evidence and assurance.

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	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 is being monitored through the newly re-established Information & Cyber Security Group (Part A – Contractors Assurance), with a large number of requirements already meeting compliance.	A joint project involving the Trust's Digital Security Team, the Information Governance Team and the Trust's Medical Devices Lead, is underway, to conduct the necessary Security and Data Protection Impact Assessments. In addition, the Trust's Head of IG and Digital Security is working with our new ICT contractors, to assess these requirements through the Trust's newly installed Network Access Control (NAC) tool, which allows the Trust to assess, monitor and control what devices connect to our network, to ensure that only approved devices can.

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

Compliance Status	**No. Requirements**
Compliant	57
Compliant (non-mandatory)	1
Compliant, but require some additional work, in order to strengthen compliance	4
Compliant, but require an annual review	7
Partially complaint	9
To address with new contractors	42
Non-compliant (newly mandatory or changes to requirement compliance)	2
Non-mandatory	9

3. Summary of Information Governance's Legal Requirements Compliance (Freedom of Information and Subject Access Requests) Annual Compliance 2022/23 * as of 15th May 2023

Concerning	**Summary**
SARS	• There was a 6.8% decrease in the number of requests received, when comparing 2021/22 to 2022/23 • Overall compliance in 2022/23 to date: 96.4%, which is above the mandatory compliance rate of 95%. Each quarter met the mandatory compliance rate. • Currently 29 requests (Q4) have not been released, however are also currently not due to be released (legal deadline); therefore, figures are subject to change.
FOIs	• There was a 12.7% increase in the number of requests received, when comparing 2021/22 to 2022/23 • Overall compliance in 2022/23 to date: 95.2%, which is above the mandatory compliance rate of 95% and higher than last years compliance rate of 92%. Each quarter, with the exception of Q3 met the mandatory compliance rate. Towards the end of Q3 the IG Team experienced some staff shortages that impacted upon compliance rates, but this has now been addressed and further cross cover introduced. • Sessions have been held with services, who receive frequent FOI's, to assess how we can proactively address FOIs, with a number of the actions from this session now in place, reducing the impact of FOI's on the Trust.
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 A.

4. Information Governance/Security Incidents 2022/23 Deep Dive

4.1 ***IG Incident Summary 2022/23***

Concerning	Summary 2022/23
No. Incidents reported	• 814 Information Governance Incidents were reported • 381 (46.2% 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. • 433 incidents, within Solent NHS Trust's control were reported within 2022/23.

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 in wrong record / record error (152)
	  ○ PID sent to wrong person / address (148)

Human Error vs Process	• 69.7% of the IG incidents reported were in connection with Human Error • 27.3% of the IG incidents reported were in connection with Processes (Failure to follow, Lack of and Unaware of) • 2.8% of the IG incidents reported were in connection with ICT / System Errors • 0.5% of IG incidents reported were in connection with lack of training
Important to note	• The Trust has reported one incident from 2022/23 (March 2023) to the ICO; after a review of the evidence, it has been identified that an individual has inappropriately accessed the medical records of a single individual (patient). The patient has been informed and the Trust is awaiting the outcome of the ICO review.

Type of Incident	No of Incidents Report April 22 – March 23
PID in Wrong Record / Record Error	152
PID Sent to Wrong Person / Address	148
PID Saved / Stored Insecurely	40
Inappropriate Access / Disclosure	28
PID Found in Public Place	28
Non-Encrypted Email Used for PID	22
Other IG	11
Lost / Missing PID	4
Cyber Security	0 *this type of incident is reported as "No IG Breach"
Lost Smart Card / ID Badge	0 *this type of incident is reported as "No IG Breach"

Actions from 2022/23 deep dive:

Communication Reminders	*Revision, Monitoring & Learning*	*Service Engagement*
• 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"	• 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. • Undertake a monthly assessment of reported IG incidents,	• IG Team to undertake further service engagement, to assess how improvements / changes to practices can assist in reducing the number of incidents relating to PID in wrong record and PID sent to wrong person / address.

• 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 • IG Team to re-issue "carrying PID" service engagement communication. • Continue with IG Rapid Learning Communications	undertaking service engagement on the most common themed incident, working with services to assess new practices • Revision of IG Training (alongside bespoke IG Training), to include and address the most common types of reported IG incidents that impact Solent NHS Trust and the learning that has been identified as a result of these incidents.	• 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)

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

5. Information Management & 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.

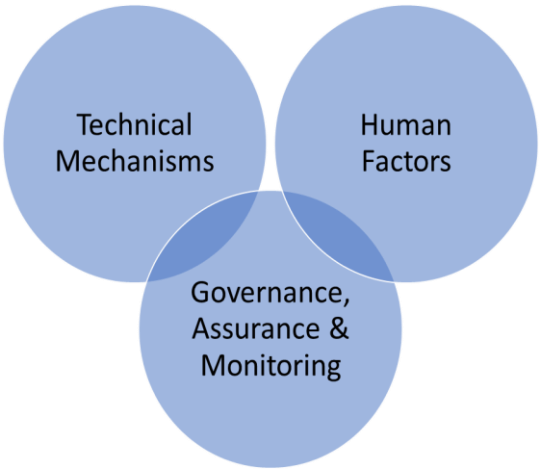
5.2 As part of this journey the Trust has established an Information Management & Cyber Security Strategy, which is a sub-strategy of the Trust's Digital Strategy. This strategy has outlined several key deliverables and achievements.

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

Cyber Security Model



The Trust's Information Management & Cyber Security Strategy has been placed on hold, whilst the Trust appoints to some key vacancies within both the Information Governance & Digital Security Teams. These posts are currently at varying stages of appointment, with the expectation of full appointment by July 2023. In the interim a number of key tasks have commenced.

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*** • 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***	• 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***

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 May 2023 SIRO Risk Register (Cyber security, IG, ICT and Information Management))

1. **Patching & Cyber Security (Score 20 – Active Risk):** The Trust has a number of risks associated with the Trust's network and software patching, which is actively being addressed by the Trust's new ICT suppliers. 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. Our new ICT suppliers are currently in the process of updating all outdated patching and have implemented a robust patching process going forward. The Trust / ICT supplier have also implemented several new monitoring tools, to assess vulnerabilities and impacts. 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.

2. **Risk 2174: Message Exchange for Social Care and Health (MESH) - National Opt-Out currently not working. (Score 16 – Active Risk):** There is a risk that as a result of the Trust's MESH connection currently not working (due to issues with previous ICT contractor – new ICT contractors are working to resolve this, but timelines are currently to be determined), that the Trust is failing to meet its legal obligations with regards to the mandated National-Opt Out. The consequences are that the Trust could face fines, due to be non-compliant. The Trust is also in breach of Data Subject rights, which could result in complaints and loss of trust in the data to only use data under legal justification. It is important to note that the Trust's Data Warehouse Team have put in a large number of mitigations in place to safeguard patient data and ensure the Trust does not breach its legal obligations.

3. **Overseas Workers (Score 12 – Active Risk):** There is a risk that by allowing staff to work overseas and access the network from abroad, could leave the Trust vulnerable to cyber-attacks. The consequence of this is that the Trust could endure a cyber-attack, resulting in loss of data, unable to access systems and therefore undertake BAU, reputational damage and fines. The IG Team and ICT Services are in the final stages of implementing an assessment, approval and monitoring policy and process, to securely facilitate overseas working.

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 strengthen the Trust's cyber security position and mitigate gaps in practice.
- Implementation of the Information Management & Cyber Security Strategy

Appendix A: Information Request Compliance Breakdown * as of 15th May 2023

Subject Access Requests – Quarterly Breakdown

	2021/22				2022/23			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
No. requests received	312	291	321	333	287	315	252	317
No. requests responded to within 21 days (best practice)	282	270	286	245	221	245	208	240
No. requests responded to within mandated timescale (one calendar month)	29	20	27	64	51	62	33	41
No. breaches within (legal deadline)	1	1	8	24	15	8	11	7
% Compliance – Legal Requirement (approx. 30 days)	99.7%	99.7%	97.5%	92.8%	94.8%	97.5%	95.6%	97.6%
Not Due	-	-	-	-	-	-	-	29

	2021/22	**2022/23**
No. requests received	1257	1171
No. requests responded to within 21 days (best practice)	1083	914
No. requests responded to within mandated timescale (one calendar month)	140	187
No. breaches within (legal deadline)	34	41
% Compliance – Legal Requirement (approx. 30 days)	97.3%	96.4%
Not Due	-	29

Freedom of Information Requests – Quarterly Breakdown

	2021/22				2022/23			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
No. Requests	98	103	94	91	83	118	107	127
No. Responded within 20 working days	94	95	87	79	82	112	97	123
No. Breaches	4	8	**7**	12	1	6	10	3
% Compliance – Legal Requirement (21 days)	95.9%	92.2%	92.5%	86.8%	98.8%	94.9%	90.7%	97.6%
No. Not Due	-	-	-	-	-	-	-	1

	2021/22	**2022/23**
No. Requests	386	435
No. Responded within 20 working days	355	414
No. Breaches	31	20
% Compliance – Legal Requirement (21 days)	92.0%	95.2%
No. Not Due	-	1

Summary of Initial Findings

Introduction / Purpose:
The Head of Information Governance & Digital Security / Data Protection Officer has undertaken a deep dive into the Information Governance (IG) Incidents reported in the financial year 2022/23. 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 2022/23, a total of 814 Information Governance Incidents were reported. However, out of them 381 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 46.2% of the reported incidents.

With regards to the remaining 433 incidents (53.2% 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 – March 23
PID in Wrong Record / Record Error	152
PID Sent to Wrong Person / Address	148
PID Saved / Stored Insecurely	40
Inappropriate Access / Disclosure	28
PID Found in Public Place	28
Non-Encrypted Email Used for PID	22
Other IG	11
Lost / Missing PID	4
Cyber Security	0 *this type of incident is reported as "No IG Breach"
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 76.2% of the reported IG incidents and should be the focus of further investigation. Please refer to "next steps" within the report, for further actions.

Human Error vs Process

- 69.7% of the IG incidents reported were in connection with Human Error
- 27.3% of the IG incidents reported were in connection with Processes (Failure to follow, Lack of and Unaware of)
- 2.8% of the IG incidents reported were in connection with ICT / System Errors
- 0.5% of IG incidents reported were in connection with lack of training

These findings indicated that the root cause of most incidents are not to do with the processes in place currently within the Trust, but the human elements of working practices. 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 34.5%.

IG Incidents vs No Breach / Out of Our Control

An assessment of the number of IG incidents reported (433) vs the number of incidents reported that either resulted in No IG Breach or were Out of Our Control e.g. caused by a third party (381), show an approx. 50%/50% split. This demonstrates;

- A good reporting culture, as we are reporting just as many near misses / out of our control incidents as we are actual breaches. This allows for greater awareness and assessment of incidents, to prevent actual IG Breaches
- Is a testimony to changes in working practices to reduce the impact / IG breach and incident may have on data e.g. removing large amounts of PID from documents / communications, mean if an incident is to occur, it would not necessarily result in an IG Breach.

Common Themes / Findings:

Appendix i outlines the type of IG Incidents reported, alongside the root causes theme.

1) **PID in Wrong Record / Record Error:** This type of incident is most 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:** The three most common root causes for this type of incident were;
   - 53% of incidents relating to the selecting of the wrong email address when sending emails (mainly internally)
   - Sending information to the incorrect GP Practice
   - Sending information to patients, but including information of other patients; although the number of these incidents have reduced since last year, following on from the Trust's service engagement around bulk printing.

   All of the above require further service engagement, to assess how improvements / changes to practices can assist in reducing the number of incidents.

3) **PID Saved/stored Insecurely:** It is important to note that this type of incident is associated with PID internally, therefore other mechanisms are in place to reduce the impact of these type of incidents and all staff are bound by confidentiality. That said, it is still an area that needs to be addressed. All incidents related to the information being left on desks, in locked offices, unlocked filing cabinets, etc… but without extra levels of security e.g. locked draw / cabinet – communication around "when is safe not safe" to be cascaded to all staff

4) **Inappropriate Access / Disclosures:** All incidents of this type, with the acceptation of one, were identified as unintentional staff breaches. A number of root causes have been identified when reviewing these types of incidents;

   a. ICT accounts – ICT contractors inadvertently gave access to staff members 1 account to staff member 2
   b. Accidental disclosures – where processes were not followed, although the best intentions were behind the actions. Processes and staff awareness of these processes have been reflected on with each incidents. Awareness is to be cascaded Trust-wide
   c. Unaware that access was not appropriate – a number of cases indicate that staff have accessed their own records, when undertaking systems training, in order to learn the system. Staff were unaware of that this was not appropriate. This type of incident is addressed in IG Training

5) **PID Public Place:** This type of incident had two common root causes
   - Transporting PID in the community,
   - Or as a result of PID being left in publicly accessible areas within Trust buildings (found by staff not the public), which is being addressed through "when is safe not safe" communication campaign, identified under "PID Saved/Stored Insecurely"

6) **Non-encrypted Email Used for PID:** This type of incident is connected to human error, but also the factor of the Trust operating two email systems, one non-encrypted and one encrypted. It is unlikely that this type of incident will be reduced / removed, until the Trust implements one email system (encrypted for all email traffic). This therefore should be considered an accepted risk; however guidance and instructions will continue to be shared with staff, reminding them of what email systems are for PID. In addition to this clarification on our working partners secure email systems will also continue to be cascaded and shared with staff, as they also start to move towards a one email system.

7) **Lost / Missing PID:** With the exception of one incident that related to PID being handed into reception by a patient, the remaining three incidents relate to the carrying of patient daily contact sheets containing PID. The IG Team undertook some service engagement around the need of carrying PID and worked with services to implement new processes/practices, towards the end of 2021/22, which has led to a decrease in these types of incidents. Re-issuing guidance produced as a result of this service engagement is recommended.

8) **Cyber Security:** None of the reported incidents have resulted in any IG Breaches. The reporting demonstrates good practice within the Trust. The IG Team will continue to cascade learning to staff, as well as continue with Cyber Security Annual Training, which forms part of the mandatory IG Training.

High Risk Incidents / Serious Incidents: Only one IG High Risk Incident has been reported in 2021/22 and no Serious Incidents have been reported.

Next Steps:

- 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
- IG Team to re-issue "carrying PID" service engagement communication.
- Revision of IG Training (alongside bespoke IG Training), to include and address the most common types of reported IG incidents that impact Solent NHS Trust and the learning that has been identified as a result of these incidents.
- 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
- IG Team to undertake further service engagement, to assess how improvements / changes to practices can assist in reducing the number of incidents relating to PID in wrong record and PID sent to wrong person / address.
- 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)

Appendix i –Incident Analysis and Root Cause

	Human Error	ICT - System Issue	Lack of Training	Process - Failure to Follow	Process - Lack of	Process - Unaware of	Total (excluding No IG Breach and OOC)	No IG Breach	Out of Our Control (OOC)
PID in wrong record/ records error	141	2	-	8	-	3	**152**	17	25
PID sent to wrong person/ address	118	7	1	19	-	4	**148**	28	56
PID saved/ stored insecurely	11	-	-	27	-	2	**40**	51	6
Inappropriate Access / Disclosure	2	2	-	18	2	4	**28**	10	9
PID found in public place	7	-	-	20	-	1	**28**	2	2
Non encrypted email used for PID	18	-	**1**	1	-	2	**22**	1	10
Other	4	1	-	2	-	4	**11**	7	10
Lost/ Missing PID	1	-	-	3	-	-	**4**	3	1
Cyber security	-	-	-	-	-	-	**-**	85	-
Lost Smart Card / ID Badge	-	-	-	-	-	-	**-**	58	-
Total	**302**	**12**	**2**	**98**	**2**	**18**	**434**	**262**	**119**

Board and Committee Summary Report

Item 12.1

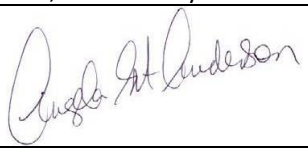
NHS Solent NHS Trust

Title of Paper	Quarterly Safe Staffing Report Quarter 4 January - March 2023 (2022 / 2023)			
Date of paper	April 2023			
Presentation to	In Public Board			
Item No.	12.1			
Executive Sponsor	Angela Anderson, Chief of Nursing & Allied Health Professionals			
Executive Summary	This report provides Trust Board with an overview of the Nursing & AHP safe staffing status for the quarter 4 period January – March 2023. 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.			
Action Required	For decision?		For assurance?	Y
Summary of Recommendations	The In Public Board is asked to: • Following review of workforce metrics, quality indicators and service line commentaries the staffing levels across the nursing & AHP workforce in Solent NHS Trust were maintained at minimum safe staffing levels during this period and where there were concerns mitigations were put in place including use of temporary staffing. • Feedback from the Q2 report requested a breakdown of temporary staff usage by registered and non-registered. This has not yet been achieved but will be included in future reports as we continue to develop the workforce intelligence data set with the Workforce Team. • Note the progress against implementation of the MHOST acuity and dependency tool in our mental health wards and the planned implementation of the Community Nursing Safer Staffing tool in adults Portsmouth and adults Southampton. • Note that following the business planning process, a review of inpatient clinical establishments has been requested by the Chief of Nursing & AHPs and will inform future establishment setting.			
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Previously considered at	Quality Improvement and Risk Group & **Quality Assurance Committee**			

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services		8. Looking after our people		12.Digital transformation	
2. Alongside Communities		9.Belonging to the NHS		13. A greener NHS	
3. Outcomes that matter		10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

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

Executive Summary

This report provides Trust Board with an overview of the Nursing & AHP safe staffing status for the quarter 4 period January – March 2023. 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 Board 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 4 continued to be challenging for all services. Safe staffing and patient safety were managed effectively by reviewing patient acuity and dependency, caseload, and flexible working. The impact of the outbreaks was monitored consistently and mitigations in place to manage effectively.

Surge capacity was utilised throughout the quarter in Jubilee (10 beds), Spinnaker (5 beds) and Fanshawe (2) in response to system pressures. The additional 10 beds in Jubilee have moved from surge capacity to being fully commissioned from the 1st April 2023. The surge beds in Fanshaw and Spinnaker closed within February and March.

It is noted that there have been some challenges obtaining data for the purposes of the report and to enable comparison with Q4. The changes required to the establishment for Jubilee following their move and increase in bed base in October does not appear to have been completed, this has therefore created anomalies in the reporting of CHPPD and in relation to vacancy factor. This also applies to unavailability data within Community Nursing for this quarter and therefore will create anomalies in the overarching data set.

There has been a slight reduction in the overall sickness absence rate as a percentage of total unavailability in Q4 (37%) from 42% in Q3, looking individually at units Jubilee seeing a reduction from 67% to 61%, Lower Brambles from 54% to 49% and Snowdon from 58% to 49%, however these areas continue to report the highest absence levels due to sickness.

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 service line commentaries the staffing levels across the nursing & AHP workforce in Solent NHS Trust were maintained at minimum safe staffing levels during this period and where there were concerns mitigations were put in place including use of temporary staffing.

1. Background

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

1.2 This report provides inpatient data published and includes Care Hours Per Patient Day (CHPPD) data. The significance of this data and its inclusion will be developed over the future 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 and services 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. Some services have daily huddles where concerns can be escalated via the service line and organisational assurance framework as deemed necessary.

As the situation continues to stabilise, with minimal restrictions, the safe staffing meetings have reverted to a business-as-usual format. This has presented an opportunity to review the agenda and to bring together teams across the trust who deliver similar services; for example, a joint meeting across both cities will be held for the adult inpatient teams, community nursing teams and long-term conditions community services. This presents opportunities to share best practice, compare staffing allocations and develop a shared approach to elements of patient safety and care. In addition, specialists from the E Roster Team, Clinical Workforce Development and Business Partners will be invited to give their overview of the available data.

There were little to no national restrictions from an infection prevention perspective regarding Covid during Q4, however internal restrictions continued to be in place within clinical environments as deemed appropriate and necessary. It is noted there were 7 SARS-CoV-2 outbreaks including staff clusters across inpatient and community services, a significant reduction from Q3 (18). The IPT continued to support the implementation of enhanced IPC practices, including a blanket approach across the Trust of wearing masks to minimise the risk of onward transmission. The national guidance was updated at the end of Q4, and changes will be implemented from Q1 2023/24

The concerns raised in Q2 and Q3, relating to patient and staff safety and wellbeing within the MH Acute Admissions Ward continued throughout part of Q4. 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 non-registered workforce throughout 2021 / 22 and 2022 /23. The review and rapid improvement programme continued within Q4 and the ongoing challenges with recruiting into Band 6 roles has led to the units optimising the visibility of the Band 7 leads.

Following introduction of Autoallocate within Health roster in Adults Southampton Community Nursing in 2021/22, and in Adults Portsmouth in Q3 they have continued to embed this within this quarter starting to realise the benefits from the improved daily allocation support (matching skill set requirements and geographic “clustering” of caseloads).

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 Q4. This includes unavailability matrix.

3.2 The data in table 1 below shows a consistent picture across the year and shows that our substantive staff account for circa 90% of the total staffing. Bank and Agency usage has remained between 10-12% respectively. Whilst much of this use of temporary staffing is required so cover sickness/absence the data also indicates that we have required more than our planned levels of staffing and this is reflective of the acuity and dependency of patients as well as some in quarter changes to ward configurations, particularly in Q3 & Q4.

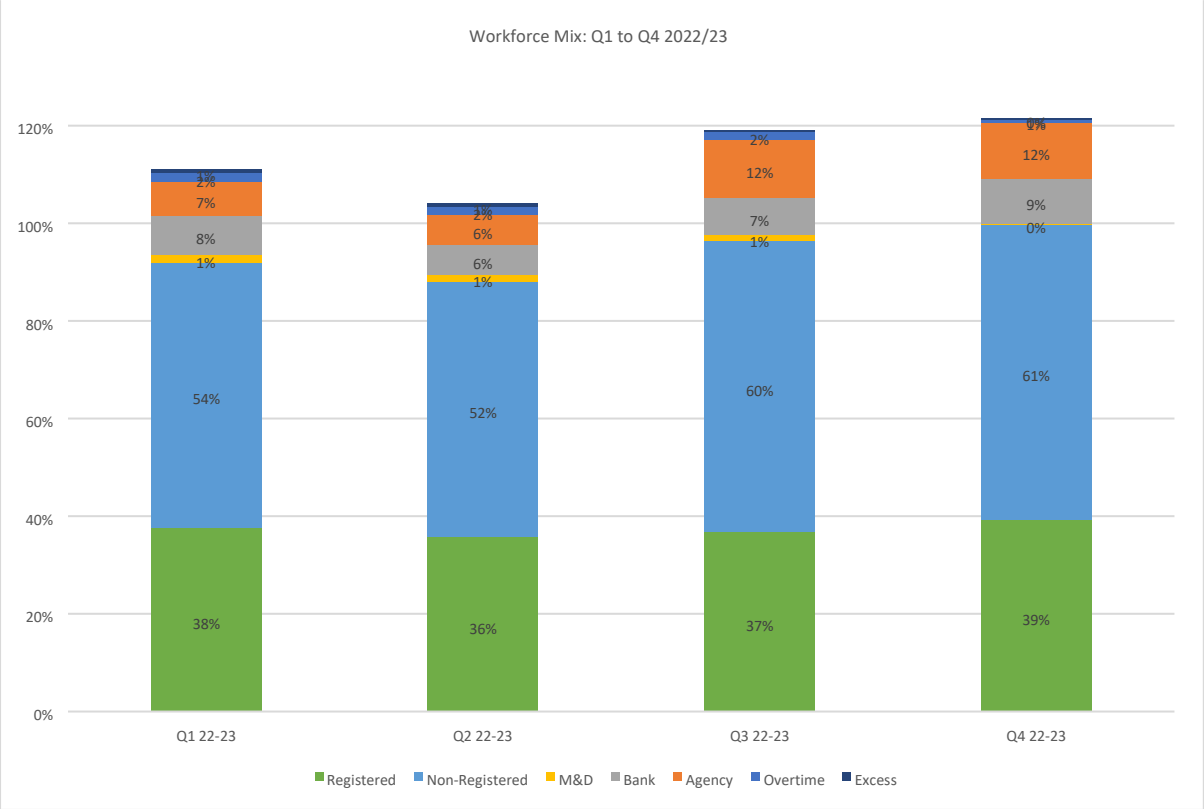


Table 1 Workforce by % Q1 – Q4 2022 / 23

3.3 Table 2 show the skill mix by inpatient area and an overarching position for adult's community services

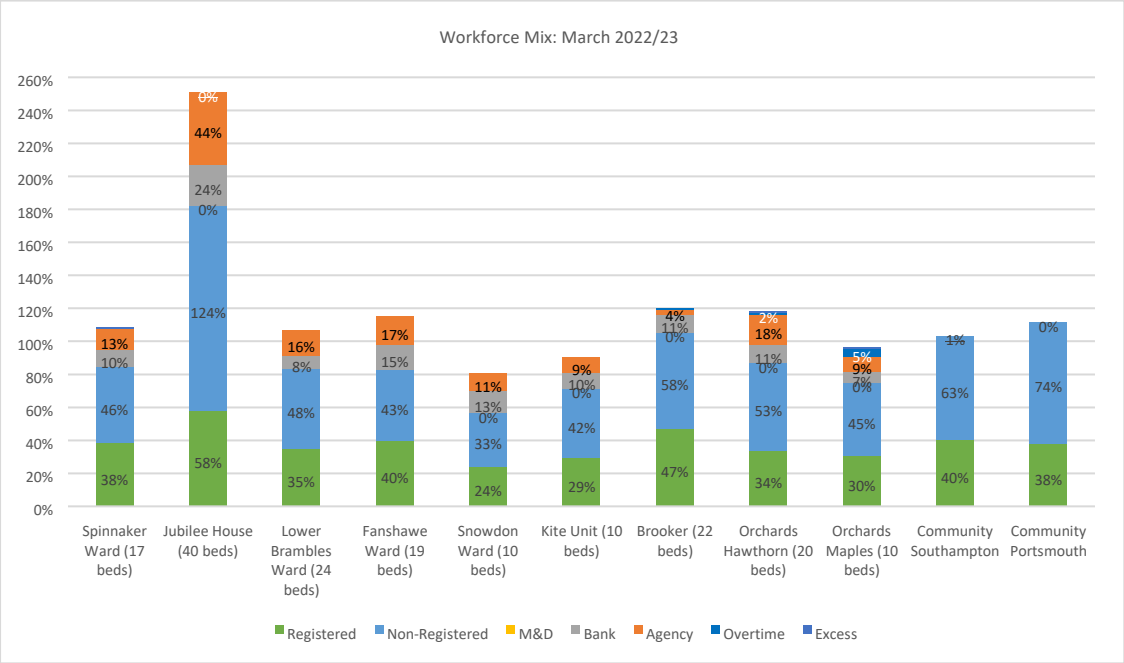


Table 2 Workforce mix by % March 2022 / 23

3.4 It is noted that we have seen increases in temporary staffing across all inpatient areas, however, Jubilee Unit appears to be an outlier in table 2 above. This is because their establishment has not yet been amended to reflect the increase in bed capacity from October 2022. In addition, the unit has been using a high level of temporary staffing, with a predominance of agency staff as opposed to Solent NHS Trust bank staff whilst recruitment to substantive positions is underway following formal

commissioning of 10 beds taking it to a 40 bedded unit. In Q4 overall Jubilee unit has seen a reduction in agency usage from 53% (Q3) to 44%, with an increase in bank staffing use from 8% (Q3) to 24%.

With the confirmation of funding for the additional beds the staffing establishment is under review. The proposed model will be presented via the QIA process for agreement.

3.4.1 Across the organisation there continues to be a reliance on temporary staff at 12%. However, it must be noted the data for the use of temporary staffing within the community services is not available at the time of writing the report.

3.4.2 Within Mental Health Inpatients, Hawthorn ward continues to be an outlier in relation to its use of temporary staffing, particularly agency. This increase is attributable in the main to the response required to address the clinical concerns within the ward environment and the increase in bed capacity following the temporary reconfiguration to two clinical areas in Q3, reverting to a single ward during March 2023.

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 Having reviewed the data additional work is required to ensure CHPPD for each clinical environment is accurate. Therefore, until this is completed the data relating to CHPPD will not be included within this report until we are assured of its validity.

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%. Within the 22% allocation there are specific trust targets for annual leave, study leave and sickness.

5.2 The data in table 5 below shows unavailability by theme across Q1 to Q4 and will support comparison against key performance indicators as listed within the eRoster Policy (2020), Appendix A. There is no significant variation to note across the year.

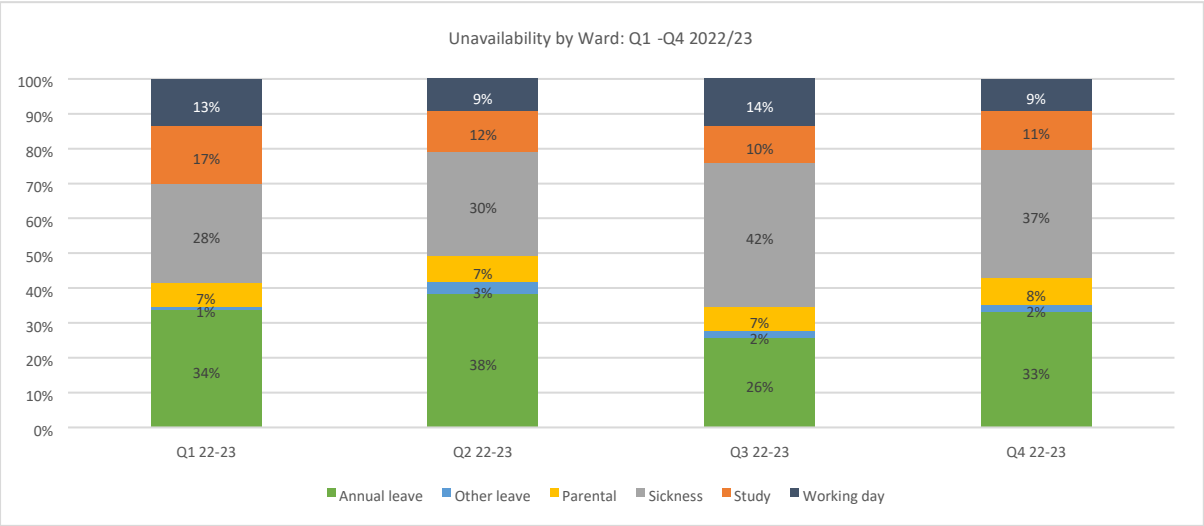


Table 5 Unavailability comparison Q1 – Q4 2022 /23

6.0 Recruitment and Vacancies

6.1 Recruitment and retention remain a challenge across several service areas with turnover currently at 14.1% and specifically nursing turnover at 12.9%. Some services have undertaken recruitment events and we await confirmation of impact in relation to conversation rates. Budgets and establishments have been set for 2023/24 and recruitment to business-critical clinical posts has continued.

6.2 Recruiting senior experienced nurses at band 6 level remains difficult and we are creating developmental roles which support staff to progress through leadership and management within a competency-based framework.

6.3 International Recruitment (IR) continued throughout the reporting period with health care professionals onboarded into RMN, RN and OT roles. Continuing the successful completion of the 22 /23 target for international recruitment for community nursing (24), and the trust has now met its target for mental health nurses (20). NHSE have confirmed there is further funding support for international recruitment in 2023 / 24 and within Q4 it was agreed that Solent NHS Trust would commit to recruit a further 30 international nurses across all disciplines. In accordance with the submission criteria, nurses will have to arrive by 30th November 2023.

6.4 There has been discussions with the Mental Health and Adults service lines Leadership Teams to see how the Mental Health & Community IENs transition programmes can be adapted to provide an enhanced robust clinical induction for any nurse who is new to a mental health or community role. The transferability of the learning from the IEN programme is a positive step to support this transition and acquisition of skills which will aim to support attraction and retention.

7.0 Acuity & Dependency

7.1 Safer Nursing Care tools provide an evidenced based assessment that enables nurses to determine patient acuity and dependency, incorporating a staffing multiplier to ensure nursing establishments reflect patient needs. Solent NHS Trust now holds the licenses to undertake the safer care nursing tools across mental health, adult inpatients, and community nursing.

7.2 MHOST

The mental health inpatient wards completed their first MHOST acuity and dependency data collection in January. However, during this time there were changes to the ward configuration. Therefore, it is

recommended that 2 subsequent data collection cycles are completed now that the ward has returned to normal operational activity. This will take place during Q1 23/24.

The Head of Nursing (Professional Leadership) is working collaboratively with SHFT with regards to the process and analysis of the audit results and introducing a framework post data collection with the mental health teams.

7.3 Safer Care Nursing Tool (SCNT)
An implementation plan is in place to support the adult inpatient wards to complete the SCNT, however we are still awaiting the update of the tool at a national level, as a result the decision has been made to pause implementation until this has occurred with an anticipated time scale of Q1 / Q2 of 23/24.

7.4 The Community Nurse Safe Staffing Tool (CNSST)
Training has been completed for those nursing leaders who will be supporting implementation and cascade training, pending agreement of an ICS system go live date in collaboration with SHFT and IOW Community Trusts. Unfortunately support from the SE Region task and finish group ended in Q4, and a local collaborative approach has been adopted with community providers. It is anticipated the first CNSST data collection will take place in June 2023.

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.

To identify the incidents relating to safe staffing is initially to filter:

1. The Cause Group is **HR or Staffing Issues** And /or
2. The Cause 2 is **Staffing Levels - Affecting Patients** or **Staffing Levels – Affecting Staff** And/or
3. A Contributory Factor is **Staffing – Levels**

8.2.1 Table 9 below shows the incident reporting trend across the organisation relating to staffing issues. There is no significant variance noted and most incidents are reported as near miss or low harm.

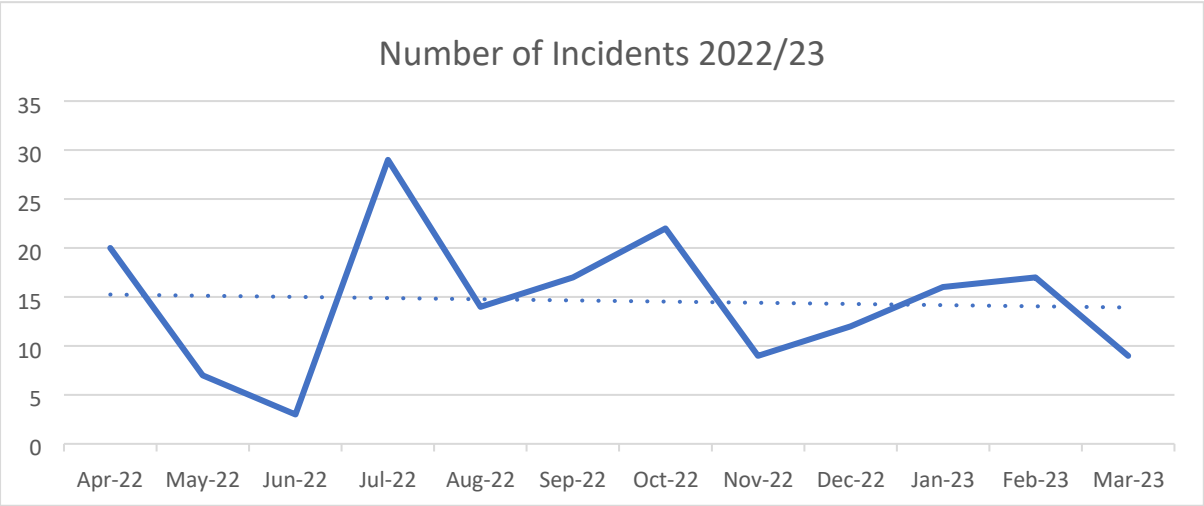


Table 9 Number of incidents for Q4 citing staffing affecting care & staff within community services.

8.2.2 In Q3 it was reported that both PRRT and the MH Crisis team had seen an increase in incident reporting relating to safe staffing. Reviewing the data below Q4 PRRT continue to eb the highest reporter but looking at the trend in table 11 this does not appear statistically significant.

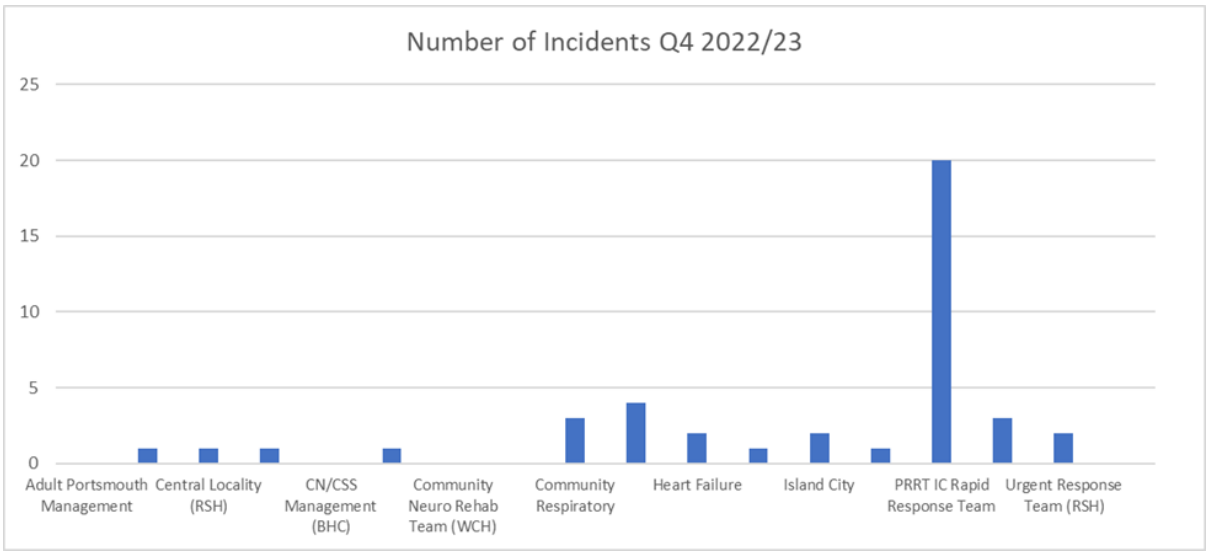


Table 10 2022 /23 incidents relating to safe staffing

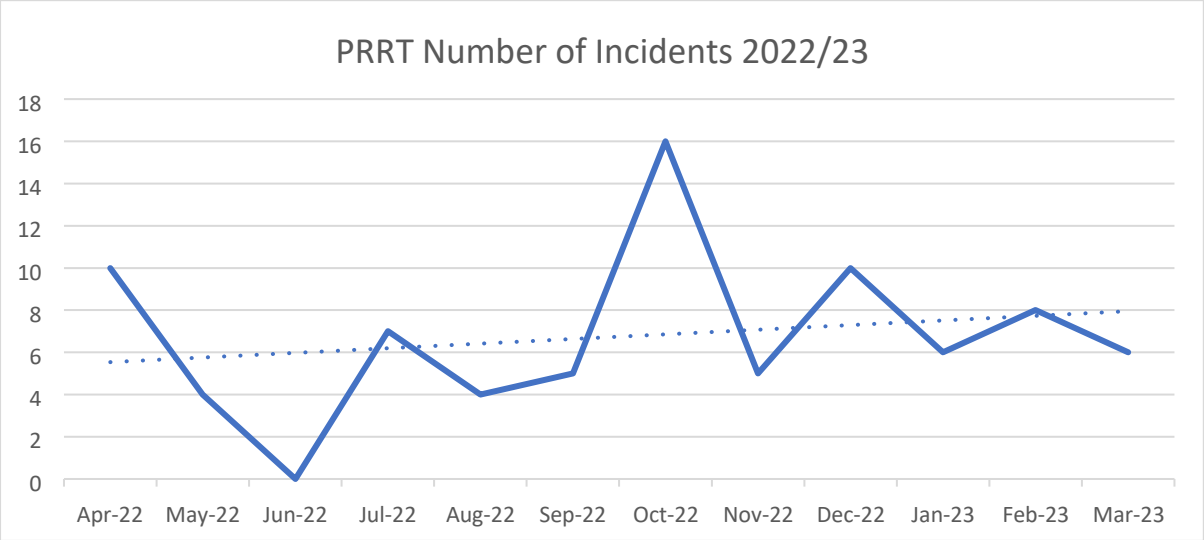


Table 11 trend for PRRT Safe Staffing incidents 2022 /23

8.3 The review of incidents in the Crisis team is similar to PRRT but with significant variance month on month. This is a position we will monitor through the safe staffing meetings in Q1 23/24.

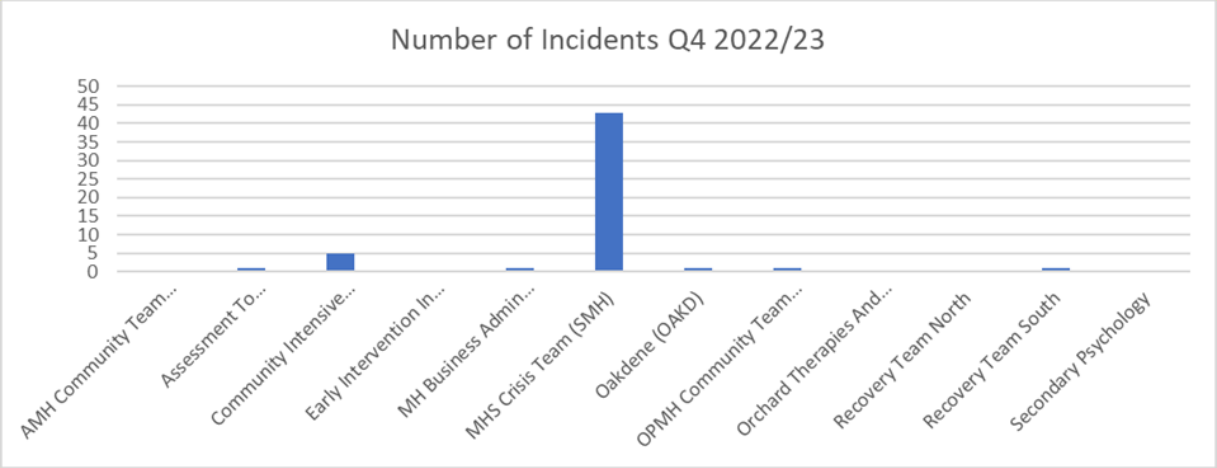


Table 12 Number of incidents for Q4 citing staffing affecting care & staff within MH community services

Table 13 below shows the distribution.

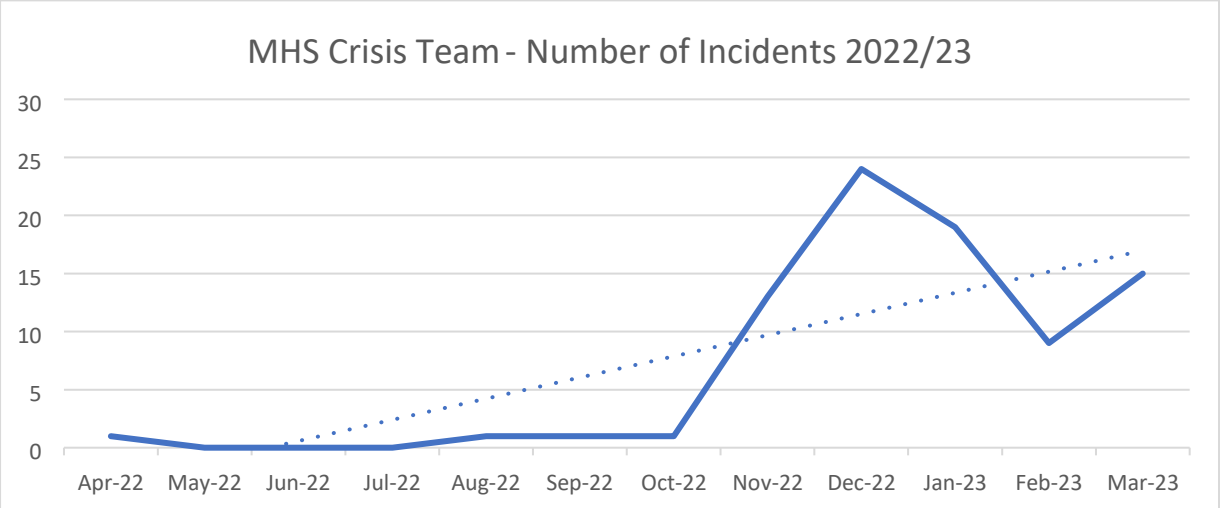


Table 13 2022 -23 Trend of incidents with MHS Crisis Team

8.2.3 Within the adult inpatient wards including mental health, there has been an increase in the number of incidents reported.

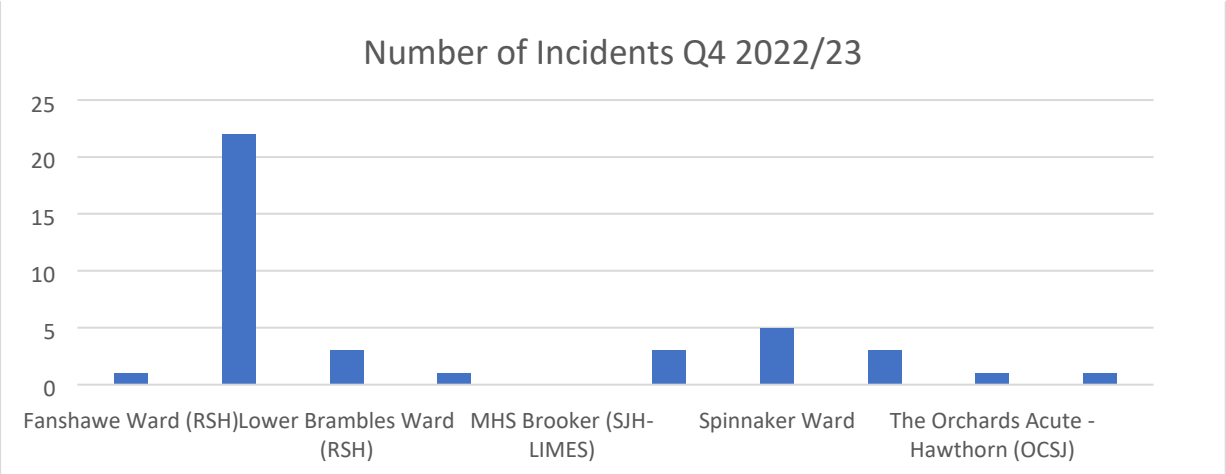


Table 14 Number of incidents for Q4 citing staffing affecting care & staff within Inpatient Services

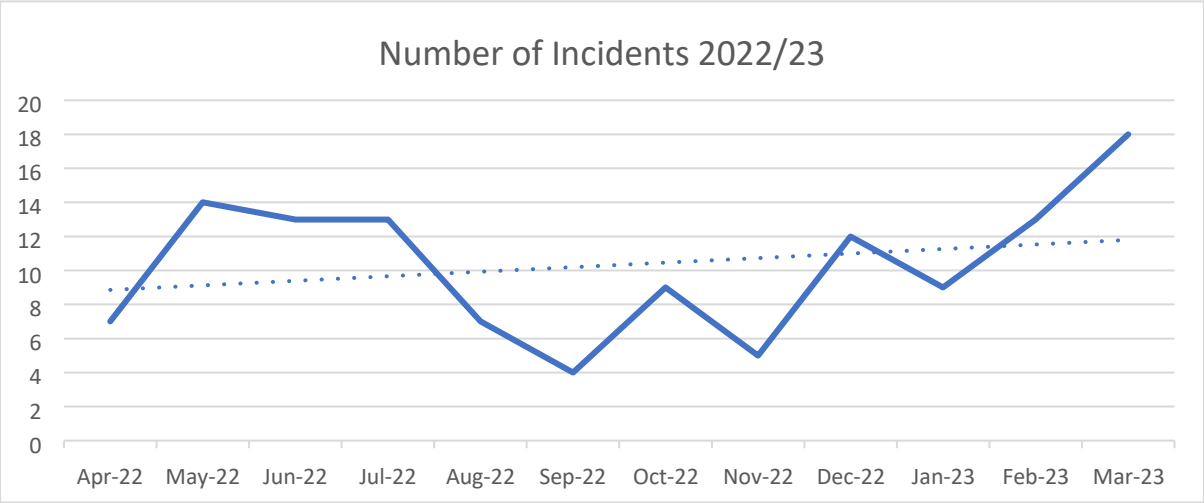


Table 15 2022 /23 Trend of safe staffing incidents for inpatient areas.

Of the 40 incidents reported, Jubilee reported 22 incidents across the quarter, the unit is actively working on an improvement plan. We also note an increasing trend over Q4 and will seek to understand the reasons and consider any actions required.

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 our Solent NHS Trust inpatient wards were compliant. The next audit is due in Q1 23/24

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 Within Q4, following analysis of the service concerns received in the reporting period there appears to be no service concerns directly relating to safe staffing levels. However, it is noted there were many concerns raised regarding inability to secure an appointment or delays in being seen, but not necessarily due to safe staffing levels.

9.3 The data relating to Q4, the trust received 54 complaints: 40 formal complaints, 5 Professional Feedbacks and 9 MP enquiries.

The details of each complaint were further reviewed and found that potentially 3 complaints may link to safe staffing.

C	Child & Family	The complaint letter details patient being alone during the night due to staff not being available. It is unclear whether this relates to staffing or a commissioning issue.
C	Adults Southampton	Verbal complaint report details staff not attending when they said they would (reason as to why not given though)
C	Child & Family	Letter of complaint details they feel the service is very understaffed

Table 16 Complaints linked to safe staffing

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

10.1 In order to triangulate safe staffing, we have identified 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.

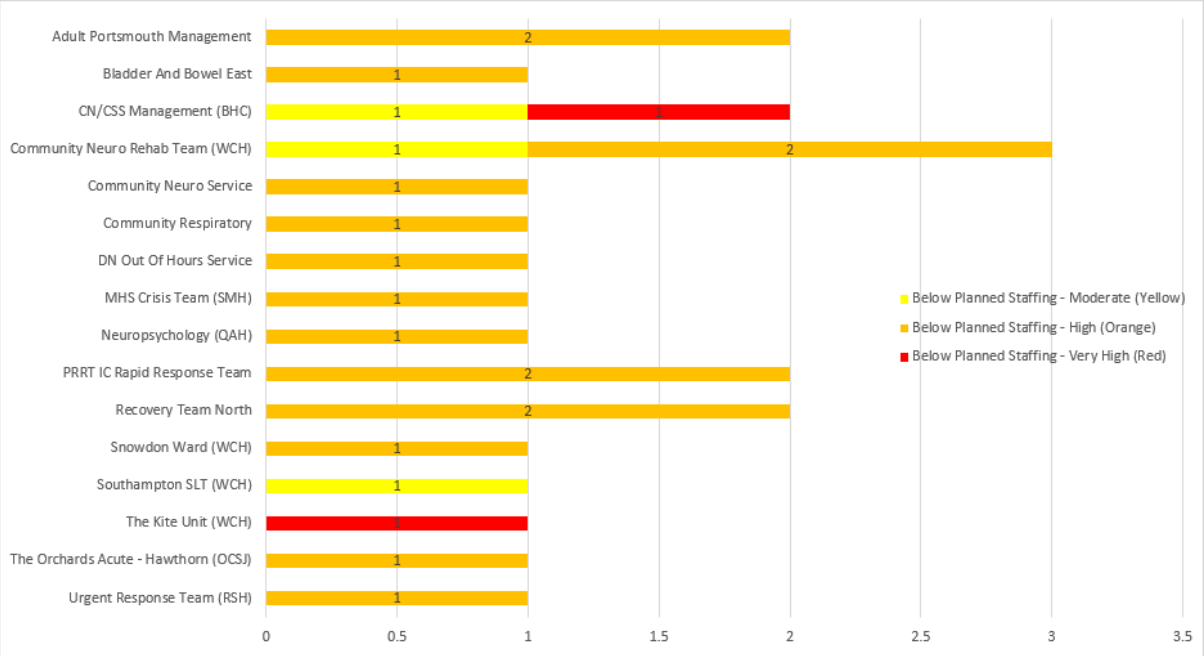


Table 17 Risks citing staffing levels within Q3 impacting upon patient care / service delivery

10.2 The overarching risk themes in relation 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 within the planned levels.

There are two risks noted to be very high

Very High Risks	
ADS - Community Nursing	Community nursing below planned staffing risk. Daily capacity reviews at morning meetings and RAG rating caseloads and staffing. Vacancy rate 29%. Review of template. Additional Band 4 recruitment in place. Insulin administration successful and review of screening to reduce assessment where they are not required.
ADS - The Kite Unit (WCH)	Inpatient below planned staffing risk. Ward doctor cover. Currently the ward Doctor cover on KITE is with Locum doctors including the consultant cover. Yet to recruit into substantive posts (adverts are out).

Table 19 Very high risks relating to staffing affecting patient care / service delivery There is one risk where the rating has been reduced from very high to high

Previous Very High Risk reduced in score to High	
ADP - Adults Portsmouth Management	Overarching whole service below planned staffing risk, controls and actions have a focus on staff wellbeing.

Table 20 Previous very high risks reduced in Q4.

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. The concerns being discussed include:

- Recruitment pause & cost pressures.

- Cost of living including driving & fuel.
- Administration support for clinical staff
- Funding of backfill for upskilling staff, study & placement time
- Morale issues affecting retention particularly IT & Facilities.

Commencing in Q1 23/24 staffing related high risks will be presented at CEG with the initial session in May 23/24 looking at overall staffing related risk's themes and review of unscheduled care/UCR risks.

11. Conclusion

In Q4 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 new 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.

Community Nursing services across both cities continue to be challenged and this has been escalated to the Chief of Nursing & AHPs and a specific piece of work is underway to fully understand the position and to make recommendations to address the findings.

Additional bed capacity continued to be in use throughout reporting period particularly within the Portsmouth system and Quality Impact Assessments had been completed, however towards the end of Q4, areas have reverted to their substantive capacity. The additional beds in Jubilee that had been in use since its opening in October 2022, have now been fully commissioned.

Following the business planning process, a review of inpatient clinical establishments has been requested by the Chief of Nursing & AHPs and will inform future establishment setting.

Services have continued to utilise temporary staff to mitigate gaps in the roster and therefore throughout the reporting period safe staffing levels were maintained. **Appendix. A** http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/HR35 eRostering Policy v6.pdf

Title of Paper	**Equality Delivery System (EDS) Action Planning update 23/2**
Date of paper	02/05/23
Presentation to	In-Public Board following presentation to the People Committee
Item No.	13
Author(s)	Anna Rowen, , Elton Dzikiti
Executive Sponsor	Shahana Ramsden - CPO
Executive Summary	**Equality Delivery System (EDS) Action Planning update 23/24** This item is being tabled for the People committee to confirm they are assured that a robust evaluation and reporting process, that engaged relevant stakeholder, was undertaken as a means of completing our statutory duty under the public sector equality duty act to complete the EDS reporting template - Seeking confirmation of assurance and ratification from PC.

Action Required	For decision?	N	For assurance?	Y

Statement on impact on inequalities	Positive impact (inc. details below)	X	Negative Impact (inc. details below)		No impact (neutral)	

Summary of Recommendations	The People Committee is asked to: • confirm they are assured that the EDS reporting has been carried out in a robust and appropriate way • approved the scoring applied • approve the action plan for 2023/24
Positive / negative inequalities	EDS is designed to address and improve inequalities
Previously considered at	People Committee March 23, JCNC and Community Engagement

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services	x	8. Looking after our people	x	12.Digital transformation	
2. Alongside Communities	x	9.Belonging to the NHS	x	13. A greener NHS	
3. Outcomes that matter		10. New ways of working	x	14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	x
5. One health and care team		EDS- 1,2,7,8,9,10 Worked with stakeholders to review evaluate and validate EDS and co create action plan			
6. Research and innovation					
7. Clinical and professional leadership	x				

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

Level of Assurance *(tick one)*	Sigificant		Sufficient		Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature	Sorrelle Ford, on behalf of Shahana Ramsden							

Equality Delivery System (EDS) Action Planning update 23/24

Purpose

This item is being tabled for the People committee to confirm:

- They are assured that there is a robust evaluation and reporting process and that relevant stakeholder engagement took place.
- that Solent NHS Trusts has met its statutory duty under the public sector equality duty act to complete the EDS reporting template.
- That a sufficient and impactful action plans is in place for 2023/24

Situation, Background and Actions to date

1.0 What is the Equality Delivery System 2 (EDS)

The Equality Delivery System (EDS) was officially launched in 2011, and updated in 2013, with the aim of embedding equality within the current and future NHS – for both commissioner and provider organisations. It is an improvement tool for patients, staff, and leaders of the NHS.

In order to maximise the opportunities that EDS can offer, organisations are encouraged to engage in active conversations with people who use services, patients, public, staff, staff networks, community groups and trade unions to review and develop their approach in addressing health inequalities. The tool is split into three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.

Implementation of the Equality Delivery System (EDS) is a requirement of both NHS commissioners and NHS providers. It can support compliance with the Public Sector Equality Duty (PSED) and will increase the profile and consideration being given to equality within organisational and governance processes.

2.0 Scoring system

Each outcome is scored based on the evidence provided. Once each outcome has a score, they are added together to gain domain ratings. Domain scores are then added together to provide the overall score, or the EDS Organisation Rating.

The scoring system allows organisations to identify gaps and areas requiring action

Undeveloped activity – **organisations score 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

3.0 Summary of assessment

(Full assessment and action plan in EDS Reporting Template)

DOMAIN 1 - Commissioned or Provided services

1 A – Patients (service users) have required levels of access to the service

Assessed as Developing (1)

EDS allows organisations to focus on a specific service as a starting point for discussion. For this to be a meaningful exercise, it is important that the learning from the assessment is disseminated to other services. For the purposes of the Domain 1 submission, Solent focused on the CAMHS (Child and Adolescent Mental Health Services), 5 to 18 years.

The assessment confirms that the service made some attempts to provide information in different formats. For example, the move to a digital platform was communicated in Easy Read and assessors noted the use of Makaton in the Horizon building to improve communication. However, the service acknowledged that access to specialist CAMHS services is impacted by increasing numbers of children waiting for either assessment or treatment and children on waiting lists are triaged so that those with the highest needs and the greatest risks will have access to services more quickly than others. Although a statement is included to confirm that 'children with protected characteristics might fall into these categories because of their protected characteristic,' we require further evidence to demonstrate that potential inequalities are being proactively addressed.

The score for this outcome is 1 and is described as a 'developing activity'. To increase the score further, we would expect to see data to confirm waiting times and evidence that access to treatment for people with protected characteristics is equitable.

1B: Individual patients (service users) health needs are met

Assessed as Developing (1)

The Participation Strategy has supported active involvement of people from diverse backgrounds as Young Inspectors. A pilot to improve data quality so that we have better measures in place has commenced and information is provided in accessible formats, including animations.

The score for this outcome is 1 and is described as a 'developing activity'. To increase the score further, we need to provide evidence to demonstrate what the data is telling us and what we have done to address any inequalities identified.

1C: When patients (service users) use the service, they are free from harm

Assessed as Achieving (2)

The Trust has a robust risk reporting system, whereby all staff at all levels can raise clinical and operational risks that relate to care delivery, individual patients, or environments for review by senior managers.

The score for this outcome is 2 and is described as 'achieving activity'. To increase further we would need to see more quantifiable data that shows how patient voice has shaped service design and what impact this has had. Also, more evidence of co-production and effective impact and delivery of the participation strategy.

1D: Patients (service users) report positive experiences of the service

Assessed as Achieving (2)

The Family and Friends Test for CAMHS West (April 2022) confirmed that 92.9% rated the service as 'Good', 2% rated as 'Poor', and 5.8% rated as 'Do not know'.

Friends and Family Test rolling figures for community and mental health services (April 2022 to Sept 2022) show an average of 94% positive feedback. Trust-wide plaudits log (April 2021 to Sept 2022) has 1,611 compliments.

The score for this outcome is 2 and is described as 'achieving activity'. We can improve even further by understanding the experiences of the 7% of patients who did not rate the service as good. When we benchmarked the data against census data, we could see that further improvements were needed in order to improve our reach. Further community engagement conversations are required to understand barriers to access and improve community representation in patient accessing the services.

DOMAIN 2 - Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions

Assessed as Achieving (2)

Solent's Occupational Health and Wellbeing Service offers a comprehensive service where staff can self-refer encouraging them to consider how they feel about their weight, diet, physical activity, smoking status, work-life balance, sleep, and mental health, and whether they would like support in this area. If they do, staff can access 1-1 support either via a wellbeing call with an Occupational Health and Wellbeing (OH&WB) Practitioner or with the Hampshire and Isle of Wight (HIOW) Health and Wellbeing Support Service. Several measures and interventions are described in the Health and Wellbeing plan including use of Health and Wellbeing champions.

The score for this outcome is 2 and is described as a 'achieving activity'. To increase the score further we would expect to see data broken down so that we can assess whether proactive steps are taken to offer support to communities where the risk of prevalence of a particular condition is higher.

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source

Assessed as Developing (1)

The assessment does not address this outcome in sufficient detail.

The score for this outcome is 1 and is described as a 'developing activity'. To increase the score further we would need to cross reference this outcome with staff survey data and employee feedback to demonstrate a significant decrease in bullying and physical violence from any source.

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment, and physical violence from any source

Assessed as Achieving (2)

There is a comprehensive range of offers for staff which can be accessed through self-referral or managers referral. These include the Employee Assistance Programme (EAP for counselling), Resolution Hub, the Ripple Model (for incidents) and access to Freedom to Speak up Guardians and the Trust Chaplain.

The score for this outcome is 2 and is described as 'achieving activity'. To increase the score, we need to see a breakdown of data to assess whether support is delivered in a way that takes cultural differences into account. Gathering of data to demonstrate that access to these support offers is equitable for people from under-represented groups would also improve this score.

2D: Staff recommend the organisation as a place to work and receive treatment

Assessed as Excelling (3)

National comparisons of Staff survey data confirm that Solent NHS Trust is one of the top 3 Mental Health and Community Trusts to be recommended as a place to work, with a score of 72%. The

assessment demonstrates that there is a significant amount of activity to support the Health and Wellbeing of our staff.

The score for this outcome is 3 and is described as 'excelling activity'. The assessment could be further enhanced through the inclusion of data and tables to confirm the scores when benchmarked against peer organisations. Important to break down the survey results to understand differential responses for underrepresented groups.

DOMAIN 3 – Inclusive Leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities

Assessed as Excelling (3)

It is clear that there is a visible commitment to Equalities at Board and Executive level which includes acting as Sponsors of Staff Networks, engagement in reverse mentoring, executive participation in cultural intelligence training and Diversity and Inclusion awareness sessions at board level.

The score for this outcome is 3 and is described as a 'excelling activity'. To maintain this, we need data and information to confirm that the Senior Leadership Team are leading and addressing health and workforce equalities across all service lines.

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed

Excelling (3)

It has been noted that there are other complementary themes already addressing this domain which include development of a Diversity and Inclusion Action Plan 2022/23 to support inclusive recruitment, and opportunities for growth and supporting inclusion and a sense of belonging for all. The plan has clear set of measurable actions and outcomes including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) that are regularly reported to people committee and the board. The 'Alongside Communities' strategy, as endorsed by the board, aims to reduce health inequalities through engaging and empowering the voice of the communities we service.

The score for this outcome is 2 and is described as a 'developing activity'. In order to increase this, we could analyse board and committee papers to assess the extent to which equality and health inequalities related impacts and risks are discussed and would need to demonstrate that actions are in place to identify and address the inequalities identified.

3C: Board members and system leaders (Band 9 and VSM) ensure change to mechanisms are in place to manage performance and monitor progress with staff and patients

Assessed as Achieving (2)

Although we have a statutory duty to produce an Annual Diversity and Inclusion report, we have increased this to bi-annual reporting to ensure tighter assurance on progress. The annual reporting outlines plans and progress with Gender Pay Gap reporting, Workforce Race Equality Standard and Workforce Disability Equality Standard. We have an opportunity to enhance support for LGBTQ+ communities by engaging with national standards such as the Stonewall Equality Index.

Action plans are actively in place to ensure mitigations and improvement are continuing. Regular monitoring and assurance mechanism of qualitative and quantitative data relating to EDI (Equality, Diversity and Inclusion) is in place

The score for this outcome is 2 and is described as 'achieving activity'. In order to increase the score further, we would need evidence that staff and patients have been involved in assessing our compliance.

5.0 Conclusion

Domain	Outcome	Score
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**1**
	1B: Individual patients (service users) health needs are met	**1**
	1C: When patients (service users) use the service, they are free from harm	**2**
	1D: Patients (service users) report positive experiences of the service	**2**
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions	**2**
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	**1**
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment, and physical violence from any source	**2**
	2D: Staff recommend the organisation as a place to work and receive treatment	**3**
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**3**
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**3**
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**2**
Overall Score for Solent NHS Trust	**Achieving Activity**	**22**

Next steps and actions - Set up work stream with colleagues in Solent and Southern to ensure regular and consistent reporting against EDS indicators and delivery of 22/23 actions

See the document NHS Equality Delivery System Reporting Template for detailed reporting evidence and action plan

Item 14

Solent NHS Trust
Trust Board Terms of Reference

Reference to "the Board" shall mean the Trust Board

1 Constitution

1.1 The Board is accountable to the Secretary of State for the effective direction of the affairs of Solent NHS Trust, setting the strategic direction and appetite for risk of the Trust, establishing arrangements for effective governance and management and holding management to account for delivery, with particular emphasis on the safety and quality of the Trust's services and achievement of the required financial performance

1.2 The Board has established the following Committees:

- Audit & Risk Committee
- Remuneration & Nominations Committee
- Mental Health Act Scrutiny Committee
- Quality Assurance Committee
- Finance and Infrastructure Committee
- Charitable Funds Committee
- People Committee
- Strategy & Partnership Committee

2. Purpose

- The purpose of the Trust Board is to govern the organisation effectively and ensure that the Trust is providing safe, high quality, patient-centred care.
- The Board is responsible for ensuring Solent is a value based organisation which provides; Great Care, is a Great Place to Work and provides Great Value for Money, where everyone counts and contributes.
- The Board leads the Trust by undertaking the following key roles:
  - Ensure the management of staff welfare and patient safety
  - Formulating Strategy, defining the organisations purpose and identifying priorities
  - Ensuring accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance
  - Seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
  - Shaping a positive culture for the board and the organisation.

3. Responsibilities

3.1 The general responsibilities of the board are:

- to maintain and improve quality of care;
- to ensure that the trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to foster positive and productive external relationships with partners and stakeholders in the local health economy, in particular with patient/user groups and forums; Local Authorities, Health and Wellbeing Boards, Hampshire & Isle of Wight Integrated Care System partners, Healthwatch and Primary Care Networks.
- to exercise collective responsibility for adding value to the trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the trust board will work in a way that makes the best use of the skills of non-executive and executive directors.

3.2 **Leadership**

The board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the trust is a good employer by the development of a workforce strategy/plan and its appropriate implementation and operation;
- promotes the health and wellbeing of staff
- implementing effective board and committee structures and clear lines of reporting and accountability throughout the organisation.

3.3 **Quality**

The board:

- ensures that the trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- has an intolerance of poor standards, and fosters a culture that puts patients first;
- ensures that it engages with all its stakeholders, including patients and staff on quality issues; and
- ensures that issues are escalated appropriately and dealt with.

3.4 **Strategy**

The board:

- sets and maintains the trust's strategic vision, aims and objectives, being cognisant of the Hampshire and the Isle of Wight Integrated Care System for, ensuring the necessary financial, workforce and physical resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- monitors and reviews management performance to ensure the trust's objectives are met;
- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, and ensures its delivery as a means of taking forward the strategy of the trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the trust.

3.5 Culture, ethics and integrity

The board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of trust business;
- ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- ensures fairness and continuity to improve people practices;
- embeds the Learning Organisation and Quality Improvement ethos into all activities;
- ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time;
- promotes diversity and inclusion

- is responsible for maintaining a Freedom to Speak Up Culture

3.6 Governance and Compliance

The board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations;
- ensures that all licence conditions relating to the trust's governance arrangements are complied with;
- ensures that the trust has comprehensive governance arrangements in place that guarantee that the resources vested in the trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the trust fulfils its accountability requirements;
- ensures that the trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the regulators;
- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of trust business;
- agrees the schedule of matters reserved for decision by the board of directors;
- ensures the proper management of and compliance with the Mental Health Act and other statutory requirements of the trust;
- approves the Annual Report, Quality Account and Annual Accounts
- considers directives, comments and recommendations from its committees and takes the appropriate action
- ensures there are appropriately constituted appointment (including remuneration) and evaluation arrangements for senior positions
- ensures that the statutory duties of the trust are effectively discharged;
- acts as corporate trustee for the trust's charitable funds;
- will conduct an annual appraisal of the Board's effectiveness.

3.7 Risk

The board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the trust's clinical and corporate activities;
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;

3.8 Finance

The board:

- ensures that the trust operates effectively, efficiently, economically;
- oversees the achievement of the Trust's Control Total;
- ensures the continuing financial viability of the organisation;
- ensures the proper management of resources and that financial responsibilities are fulfilled;
- ensures that the trust achieves the targets and requirements of stakeholders within the available resources;
- reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

4 Membership

The Trust Board will comprise the following:

Voting members:

- Independent Chair (Chairperson)
- Five Non-Executive Members
- Chief Executive
- Chief of Nursing & Allied Health Professionals
- Chief Finance Officer
- Chief Medical Officer & Deputy CEO
- Chief People Officer

Non-voting member:

- Chief Operating Officer
- Chief of Staff, Governance and Corporate Affairs
- Chief Strategy and Transformation Officer

- In the case of the number of votes for and against a motion being equal, the Chair of the Board will have a second, casting vote.
- A manager who has been appointed formally to act up for an officer member during a period of incapacity or temporarily to fill an officer member vacancy, shall be entitled to exercise the voting rights of the officer member.
- Members will be expected to attend at least 75% of meetings.
- When an executive director member is unable to attend a meeting, a nominated deputy must be identified. The nominated deputy must be a direct report to the Board member.

5 Attendees

- Lead officers representing other services/departments may attend when required or at the invitation of the Chair.

6 Secretary and Administration

- The Corporate Support Manager and Assistant Company Secretary or their nominee shall act as the secretary of the committee and will arrange to take minutes of the meeting and provide appropriate support to the Chairman and committee members**.**
- The agenda and any working papers shall be circulated to members five working days before the date of the meeting.

7 Quorum

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

8 Frequency

- Meetings will be held every other month or more frequently if required, under the Chairmanship of the Solent NHS Trust Chair.
- The following meetings will be held:
  - In Public Meeting
  - Confidential Meeting
  - Workshops (in private) to support board development and strategic planning

9 Notice of meetings

- Meetings shall be summoned by the secretary at the request of the Chairman.
- Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member and any other person required to attend, no later than 5 working days before the date of the

meeting. Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

10 Minutes of meetings

- The secretary shall minute the proceedings of all meetings, including recording the names of those present and in attendance.
- The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly**.**
- Minutes of meetings shall be circulated promptly to all members once agreed.
- Minutes will be available under the Freedom of Information Act 2000.

11 Authority

The Board may:

- seek any information it requires from any employee of the Trust in order to perform its duties
- obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- call any employee to be questioned at a meeting of the Board as and when required.

12 Reporting

- The Board will develop an Annual Cycle of Business where scheduled items throughout the year will be presented.
- The Board will receive updates (including exception reporting) from its reporting Committees via the relevant Committee Chairs. The Chairs of Committees will also be responsible for ensuring relevant information and decisions are reported and cascaded back through the appropriate communication channels.
- The Board will receive project reports on an ad-hoc basis.
- Member's attendance at meetings will be disclosed in the Trust's Annual Report.

Version	19
Agreed at Trust Board	June 2023

Board and Committee Summary Report

Title of Paper	People Committee Exception Report May 2023 for Board				
Date of paper	18 May 2023				
Presentation to	In Public Board Meeting Monday 5 June 2023				
Item No.	15				
Author(s)	Tina King, Business Manager, People Directorate				
Executive Sponsor	Shahana Ramsden, Chief People Officer				
Executive Summary	The Committee noted the exception reports from, People Forum, JCNC and JLNC. The new improved Workforce Report including a 'live' dashboard for services to use was reviewed. The Annual Report was presented and the Committee were assured that the terms of reference had been complied with, objectives had been met and a further discussion will be had to ensure that Project Fusion is reflected sufficiently in those objectives going forward. There were updates and useful discussions on Talent Development and appraisals (where there is currently an 80% compliance rate), the Health and Wellbeing plan and the planned programme to recruit more H&WB Champions. There was a session on Equality, Diversity, Inclusion and Belonging, where the EDS Reporting Template was agreed, and this will be published on our Trust website. Great examples of joint working initiatives in Project Fusion were shared. The next People Committee will be held in July and agenda will include workforce growth and turnover at service level.				
Action Required	For decision?	Y	For assurance?	Y	
Summary of Recommendations	The Board is asked to note this report.				
Statement on impact on inequalities	Positive impact (inc. details below)	x	Negative Impact (inc. details below)		No impact (neutral)
Positive / negative inequalities					
Previously considered at	*The EDS Reporting Template was also presented to the JCNC in March.*				

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services		8. Looking after our people	x	12.Digital transformation	
2. Alongside Communities		9.Belonging to the NHS	x	13. A greener NHS	
3. Outcomes that matter		10. New ways of working	x	14. Supportive Environments	
4. Life-course approach		11. Growing for the future	x	15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	Significant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, **sufficient**, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							

Executive Sponsor Signature	 Mike Watts, Solent NHS Trust Chair

Board and Committee Summary Report

Title of Paper	Quality Assurance Committee Exception Report				
Date of paper	May 2023				
Presentation to	In Public Board				
Item No.	18.1				
Non-Executive Sponsor	Vanessa Avlonitis, Non-Executive Director (Committee Chair)				
Executive Summary	Paper presented to summarise the business transacted at the Quality Assurance Committee held on Thursday 18 May 2023.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The In Public Board is asked: • To note the report from the Committee				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services		8. Looking after our people		12.Digital transformation	
2. Alongside Communities		9.Belonging to the NHS		13. A greener NHS	
3. Outcomes that matter		10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	Sigificant		Sufficient	X	Limited		None	
Assurance Level	Concerning the overall level of assurance the In Public Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Non-Executive 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 reports presented:
    - **Freedom to Speak Up- 6 monthly Report**- The Committee received an overview of the number of cases raised during quarter three and four. Sustained increase was reported and management and support in line with guidance was noted. Issues in relation to reduced resource was raised and suggested mitigations shared, with further executive level discussion agreed.
    - **Community Engagement Annual Report**- Progress, outputs and outcomes of year 2 of Alongside Communities – the Solent approach to engagement and inclusion was shared. Next steps were explained, including overarching plan review and refresh, and production of the objectives and delivery plan for 23/24.
    - **Research and Improvement Annual Report-** An overview of research and improvement activity supported by the Academy in the past year was presented. Mature learning improvement and innovation culture was highlighted, and integrated, co-produced approach was shared. (Included as item 18.2 of Board papers, for information)
    - **Safe Staffing Quarter 4 Report**- The Committee were briefed on the Nursing & AHP safe staffing status for the quarter 4 period, with assurance of staffing levels provided. Continued pressures were noted, and effective management explained. (Included as item 12.1 & 12.2 of Board papers)
    - **External Safety Reports**- Assurance was provided in relation to oversight of processes and procedures in place, following the September 2022 Panorama television programme. An update of key published reports was also provided.
    - **Payment Guide for Working with Patients and People**- An overview of the guide was presented, with focus on providing a consistent approach to recognising, reimbursing, and paying people for their involvement. The Committee agreed that further understanding was required, specifically in terms of finance and in context of Project Fusion.
    - **Performance & Quality Exception Report-** key escalations were shared, including IT challenges, escalations within the mental health service and staffing within the Looked after Children service.
- The Committee **approved** the following reports presented at this stage, prior to final approval at the June Audit and Risk Committee and Extra Ordinary In Public Board meetings:
    - **Quality Account- Great Care Element**– The final draft was presented, and minor amendments suggested by the Committee.
    - **Annual Governance Statement (AGS)**- The Committee were briefed on the statement, including sections within the draft that remain incomplete, to be update prior to final approval.
- There were no **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)** to report. An update regarding CQC engagement was shared.
- **Ethics and Caldicott Panel Exception Report**- There was no panel held since the last meeting.
- The **Board Assurance Framework (BAF) consideration and oversight of risks Report** was deferred following consideration at May Board Workshop.

The Academy of Research and Improvement

Item 18.2 NHS Solent NHS Trust

Research and Improvement

Annual Report: 2022/2023

About the Academy

We focus on empowering and supporting our staff and patients to make improvements to care.

We have an integrated approach, supporting our teams with Research, Quality Improvement, Clinical Effectiveness and Innovation. All activities have patient and community participation at their core.

Our vision

To lead and facilitate improvement through innovation, learning and evidence based care across our communities.

Contents

A word from Dr Dan Baylis

Chief Medical Officer

Bringing together our incredible team at the Academy with our clinical services and the communities we serve has enabled us to deliver meaningful, values based, research and innovation that makes a direct positive impact to real people.

I am so proud of what has been achieved this year and really excited as we look to embed this approach further with ambitious plans for 2023/24. Enjoy this report and thank you for taking the time to share in our achievements!

Activity in numbers

40
QI training days 274 attendees

92
workshops, attended by 670 people

107
Clinical Audits and Service Evaluations

12
national clinical audits and confidential enquiries

1508
participants in 51 Research studies

36
knowledge specialist evidence searches from clinical and corporate services

5
commissioned external evaluations

50
Quality Improvement projects completed

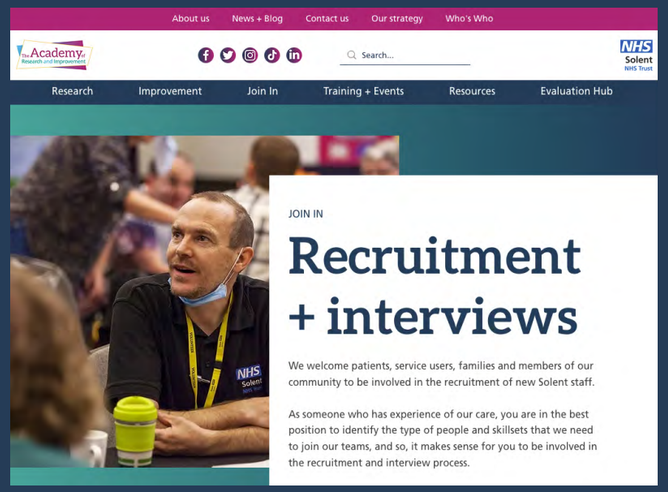
16
Dragons' Den projects funded and active

People Participation

Working in partnership with patients, service users and those in our communities is integral to work that we do and support.

Our Side-by-Side network is a group of 16 people who support us in the Academy, and also work with people across the Trust to facilitate co-designed improvement.

Co-designed resources developed this year:



Interviewing and recruitment

We have developed an online toolkit, which supports patients and people to be part of recruitment and interviews. The toolkit explains why it is important, how people can be involved, and provides guides and checklists. The tools were co-designed with a group of patient representatives, the community organisation ReMinds, members of our Learning Disabilities Service, and Children and Family Services.

"I am fortunate to be involved in both recruitment and the interview process on several panels. As a patient I don't need the knowledge in the specific field of the advertised post, my only interest is how the candidate demonstrates their awareness and experience of patient and people involvement and focuses on the patient need. My participation gives me an opportunity to represent the patient voice."

Ellie
Young person who was part of interview panels

"When I found out that I was going to be interviewed by the service users, this told me this is a good place to work. Meeting the service users is what made me know this is where I wanted to work."

Kevin
Social Worker, Integrated Learning Disability Healthcare Services

"Doing the inductions with staff shows our commitment, gives us a chance to say what we think about how the work should be."

David
Service user

Involvement Payment Guide

People work with us in many ways and our Involvement Payment Guide outlines the process and expectations for reimbursing and paying people. We co-produced the guide with patients, clinical services and community partners.

Involvement resources

We've developed a suite of resources freely available to download and use on our website. These include experience based co-design guides, consent forms and '10 Steps to Working with People and Communities'.

Take a look at the full range of resources >

Training

- Our co-production workshop at the annual conference was run in partnership with Portsmouth Parent Voice, our Integrated Learning Disability Service, Vocational Rehab Service and members of Side-by-Side. Following the success of the conference, and due to high interest in co-production support, we are now developing full co-production training which aims to support staff to build relationships and implement working with patients and people to make improvements together.
- Patient involvement workshops were co-written and delivered, as well as QI training for a MSc Module in Healthy Aging at University of Winchester
- Providing advice, guidance and challenge to teams on our QI training programmes - this includes three patient QI Leaders.

Events and awards

- Our annual conference is co-designed and run with patients and service users. This year this included opening the event, running a workshop on co-production, judging the poster award and chairing sessions.
- Our Trust annual awards also had members of the Side-by-Side network on the judging panel.

"I like to be involved, I think that if I can share my experience, someone else at the end of it will be better off."

Mary Ramsay
Side-by-Side Network Member

"Patients are the most important people in healthcare so their involvement in services and service improvement is paramount."

Julian Martin
Volunteer within the Academy

"Services are constantly fighting fires, but perhaps we as patients, can carry the hose."

Amanda Barfield
Service user

Research

We've successfully rebuilt our research portfolio and activity following the pandemic, and in the last year recruited 1508 participants into 51 studies. This means that in 2022/23, we were the most research active care NHS Trust in England.

Our research activity includes delivering studies, but also training and supporting people to bring research into their roles and working across our communities to make research more accessible.

Dental Nurse, Jeni Malpass, is leading research on oral health promotion, particularly in older adults.

Her work in care homes won the poster prize at the 2022 British Society of Gerodontology Conference.

Researcher Development Programme (RDP)

In 2022 we revamped our clinical academic internship programme to be more inclusive, and introduced the Researcher Development Programme. The programme aims to support people to include research in their work, whether they want to be active researchers, give clinical advice to academic teams or make their service more research aware.

We had eight people on the first cohort, and each training day was supported by a public and patient advocate. The outcomes of the first programme include:

- Publication submitted
- Academic fellowship won
- Masters in Clinical Research started
- Novel research methods utilised in communities - for example, a SLAM poetry event with a community group in Portsmouth

Medical Student, Kaylee Ford (pictured above), won the best undergraduate oral presentation prize at the British Association for Sexual Health and HIV Conference 2022.

Anna Badley is a Community Research Nurse, currently undertaking a PhD with a fellowship from NIHR Wessex ARC on community nursing practice.

This year she also completed a programme of work on nursing-led prevention and management of pneumonia in care homes, with a £100k grant from the Burdett Nursing Trust.

Prof Samuele Cortese is one of our Consultant Psychiatrists in our Child and Adolescent Mental Health Services and a Professor at the University of Southampton.

He is the Mental Health Research lead for Wessex. He is leading programmes of work investigating causes, treatment and care for children with neurodevelopmental disorders, particularly Attention Deficit Hyperactivity Disorder (ADHD).

Dr Lindsey Cherry and Dr Cathy Price were both appointed as Associate Professors at the University of Southampton this year. Cathy is a Consultant in Pain, and Lindsey is a Podiatrist.

Clare Ryan is a Physiotherapist who has an NIHR doctoral fellowship, investigating attendance at Emergency Departments by people with severe back pain. Clare won the best poster prize at the 2022 NIHR Academy Conference.

Research

Community Peer Researchers

We know that research can be difficult to access for many people across our communities, and that there is limited infrastructure for research generation and implementation. We have started to co-design some solutions to that, by engaging a group of community peer researchers. The aim is to build a network of people who can identify, drive and encourage research. This work was part funded by the NIHR Clinical Research Network in Wessex.

Partnering with the Young Foundation's Peer Researcher programme, we advertised for peer researchers and 7 people in Southampton and Portsmouth joined up. With a couple of days training, they then carried out data gathering exercises with their colleagues, clients and other community members on what research meant to them, and what would help them get involved.

This has proved extremely successful, and these seven peer researchers will now support a new cohort – the aim being a broad network across Southampton, Portsmouth and the Isle of Wight and a grant bid for some additional funding to support. An illustrator captured the session and created a design that summarises the outcomes of this initial piece of work. Take a look at the full illustration online >

Studies we've helped to deliver

ARMS

This study has been led by the University of Southampton looking into 'at risk mental states' in patients being treated for mild to moderate common mental health problems in Talking Therapies Portsmouth. Having monitored the prevalence of these symptoms, Cognitive Behaviour therapists from across three trusts including Solent have been trained to offer enhanced CBT to these patients. To date, 23 patients have been offered the advanced treatment.

The PIPA Trial

This study is looking at the use of an online parenting intervention to assess whether the personalised programme reduces the risk of affective disorders in young people aged 11-15 at high risk. We are delivering this in partnership with schools across Portsmouth, Southampton and the Isle of Wight, and 20 young people are currently participating.

Behavioural Interventions to Treat Anxiety in Adults with Autism and Moderate to Severe Intellectual Disabilities

This study explores the feasibility of an intervention pack aimed at people with autism, moderate to severe intellectual disabilities and anxiety. Feedback from LD therapists who have been using the BEAMS-ID intervention:

"I had my last BEAMS session today. The outcomes have been fantastic, below are the ones that were identified today. Our service user:

- **is going to day services happily and is keen to increase her days**
- **shows extreme distress much less often (she now walks away and takes space rather than screaming)**
- **is spontaneously using the strategies e.g. breathing exercises and fidgets**
- **had a very successful trip to Romania (when I first met her she would not leave the house)**
- **is doing more e.g. going to the shops more, going to the cinema**
- **no longer needs reinforcers to go out of the house."**

"Participant got out the car and went on a forest walk!! He did not present as anxious at all, followed his visual timetable, walked for 10 mins (using 10 min timer) and enjoyed chocolate buttons when we got back to the car he kept saying 'happy' 'happy'! So pleased !!"

Research

Care Home Research Partnership

We have a formal partnership to work together on research with over 30 homes in Southampton and Portsmouth. This has allowed residents and staff to take part in studies and to influence how research is conducted.

Pneumo65 - Nurse-led pneumonia prevention

The aim of this study was to understand the diagnosis, treatment, and management of pneumonia for people living with frailty in care home settings. The study involved residents and looked at respiratory illness and pneumonia.

Staff were also interviewed on how they made decisions about the diagnosis and treatment of pneumonia in people living with frailty. Nine care homes took part, with a total of 67 participants, and many residents commented that they felt good about taking part in a study that could benefit people in the future.

"I am doing it for them [the residents]. This pneumonia is not going away, and if we can find something to help then it is worth it."

Care assistant who took part in Pneumo65

"In 2015, we were approached by what is now the Solent Academy to take part in a research project. We've taken part in many studies and research projects over the years, and have been especially involved in social care research studies. I am incredibly proud of our work supporting research, and this pride is shared by our residents, their families, and our team. It helps to motivate us, educate us and refocus our efforts. This is why we value every opportunity to assist in research - it's an excellent way to contribute to something bigger, as well as progress as a business and as carers."

Maria Bungaroo
Manager of Braemar Care Home

Children's Vaccine study - Prevenar

This year, we recruited our 2000th participant to a study called Prevenar. The Prevenar vaccine was introduced into the routine childhood vaccination programme in September 2006. The vaccine protects against serious and potentially fatal pneumococcal infections.

This research study monitors the changes in the bacteria that are currently carried in children's noses to help us to develop and improve the vaccine for the future. The study recruited infants and toddlers from our child andfamily hubs and local community organisations.

It was the first community study that we opened on the Isle of Wight - the picture is of the team when they recruited their first child from the IoW to the study.

SIREN

This study is an Urgent Public Health study which is led by UK Health Security Agency. The SIREN study monitors COVID-19 infections and vaccine effectiveness in healthcare workers. We have been involved in this study since September 2020 and over 100 Solent staff have taken part which involves regular swabs and blood tests.

Three important findings from the Study:

1. Previous infection with COVID-19 offered high protection against reinfection for several months.
2. COVID-19 vaccination was highly effective in reducing infections in the immediate months after vaccination.
3. Protection falls six months after two vaccine doses in those without a previous COVID infection and this informed the decision to roll out the booster programme

"My highlight would be working on the SIREN study. Being involved in such a novel and important study has been really rewarding…knowing that the data we are collecting is helping inform policy for the way we manage COVID and possibly flu in the future, and potentially improve lives because of it."
Rebecca
Clinical Trials Assistant

Evaluation Hub

Community research and evaluation

In 2022, we introduced our Evaluation Hub with a mission to work with health, social and community partners to create community-based evidence that is accessible, responsive, and relevant. Through the hub we deliver three core services:

1 Project support and delivery

- We work with you to design a research or evaluation project.
- We provide full project management support from design, data collection, analysis and dissemination.
- We report on a regular basis to ensure on-going learning and change.
- We support you, your team and those who use your services to jointly use the learning to make improvements.

2 Training, facilitation and consultancy

- We offer training and skills development in pragmatic research and evaluation methods.
- We will facilitate and coach teams who would like to run their own evaluations so that learning is applied.
- We can offer an advisory and consultancy service on the most appropriate methods and approaches for your project.

3 Activism and community focus

- Working with our partners at UCL's Rapid Research Evaluation and Appraisal Lab we are constantly working to develop and test new methods and infrastructure to make it easier to generate evidence that can be used and applied.
- We actively promote and advocate for community-based and community-led research and evaluation.
- We run a peer research co-production academy building capacity and resources within communities.

"We were so pleased to have the opportunity to work with the evaluation team. We were expertly guided from the beginning in identifying the question and sources of data required.

Everyone worked incredibly quickly to capture the moment in time, collecting an incredible amount of data.

We pulled in some of our staff and public volunteers to support with data collection, they were given training sessions, additional support and the opportunity to ask questions at any point. The resulting paper is full of new perspectives and data presented in a clear and concise way with graphs and pictures to entice the reader.

A huge thank you for your skilled delivery, speed and leadership on this project, it has expertly captured a moment in time for nursing."

Evaluation Hub highlights

In the last year, we carried out four commissioned evaluations, and we have another four commissions scheduled to start in 2023/24. Completed projects include:

Accelerator Innovation Fund: Case Studies of Improvements to Elective Care

- Hampshire and Isle of Wight Integrated Care Board, 2022

Read the full report online >

COVID-19: Learning and evaluating during the pandemic

- Solent NHS Trust, 2020

Read the full report online >

Nurses in the community: A rapid appraisal of research, evidence, and innovation in practice

- NHS England, 2022

Read the full report online >

Evaluation of the Afghanistan Resettlement Mental Wellness Programme

- Hampshire and Isle of Wight Integrated Care Board, 2022

Read the full report online >

Quality Improvement (QI)

The Quality Improvement (QI) Programme aims to encourage and enable our staff, patients and carers to work together to make changes to Solent services that improve the experience for those using our healthcare.

It provides the skills to deliver and measure improvement, and does not require participants to have any previous experience of knowledge of QI.

Quality Improvement PROGRAMME

Components of the QI programme

Intro to QI
6 sessions
46 participants

QI Foundation
4 courses
35 participants

"Very clearly presented and easy to follow."

40 Workshops
274 participants

QI Practitioner
1 course
25 participants

Online resources

QI Leader
30 staff
2 patients

Demand and Capacity + QI
10 teams supported

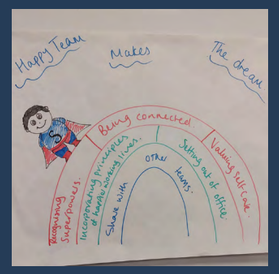
Happier Working Lives
2 courses
81 participants

Bespoke support

QI Cafe

"Thorough intro to tools and good examples and interactivity."

Preceptor programme
4 courses
68 participants



"Thank you so much for all this info and the offer of ongoing support along the way as it's very reassuring."

Applying QI Methodology to the Demand and Capacity challenge

This year, the application of QI methodology to the Demand and Capacity (D&C) challenge has been rolled out. This helps clinical teams understand and manage waiting lists.

What we offer:

- Introductory virtual workshops
- Attendance at team away days
- Whole day sessions for bespoke service support
- In depth support for teams

Services we've supported so far:

- Musculoskeletal (MSK) East and West
- IMAT
- Vasectomy, Sexual Health Services
- Portsmouth Urgent Community Response
- Child and Family Therapies
- Child and Adolescent Mental Health
- Podiatry West
- Children's Paediatric Medical Service West
- Adults Portsmouth Speech and Language Therapy
- Southampton Community Independence Service

The impact we've seen:

- evidence-based workforce planning; understanding of current demand and capacity situation, and capacity requirements for backlog clearance
- accurate understanding of workforce capacity through application of job plans to modelling
- improvement activity seeking to reduce wasted capacity (DNA rates and failure demand)
- identifying patient preferences to match capacity to demand (location/time of day)
- improvement to the efficiency and effectiveness of the triage process
- understanding of the demand for triage and matching of capacity to demand for triage
- streamlined clinical and non-clinical admin processes

A podcast shining a light on this work has been produced in conjunction with the National NHS E/I Demand and Capacity team.

"I can see the vision and value in this work; it is so much more than I expected."

"Pathway mapping has promoted discussion, deeper insight and understanding of the service."

"Collaborating with our Data Analyst to explore and question data has been invaluable."

"You will learn a lot about your own service as you move through the process."

Quality Improvement (QI)

QI projects

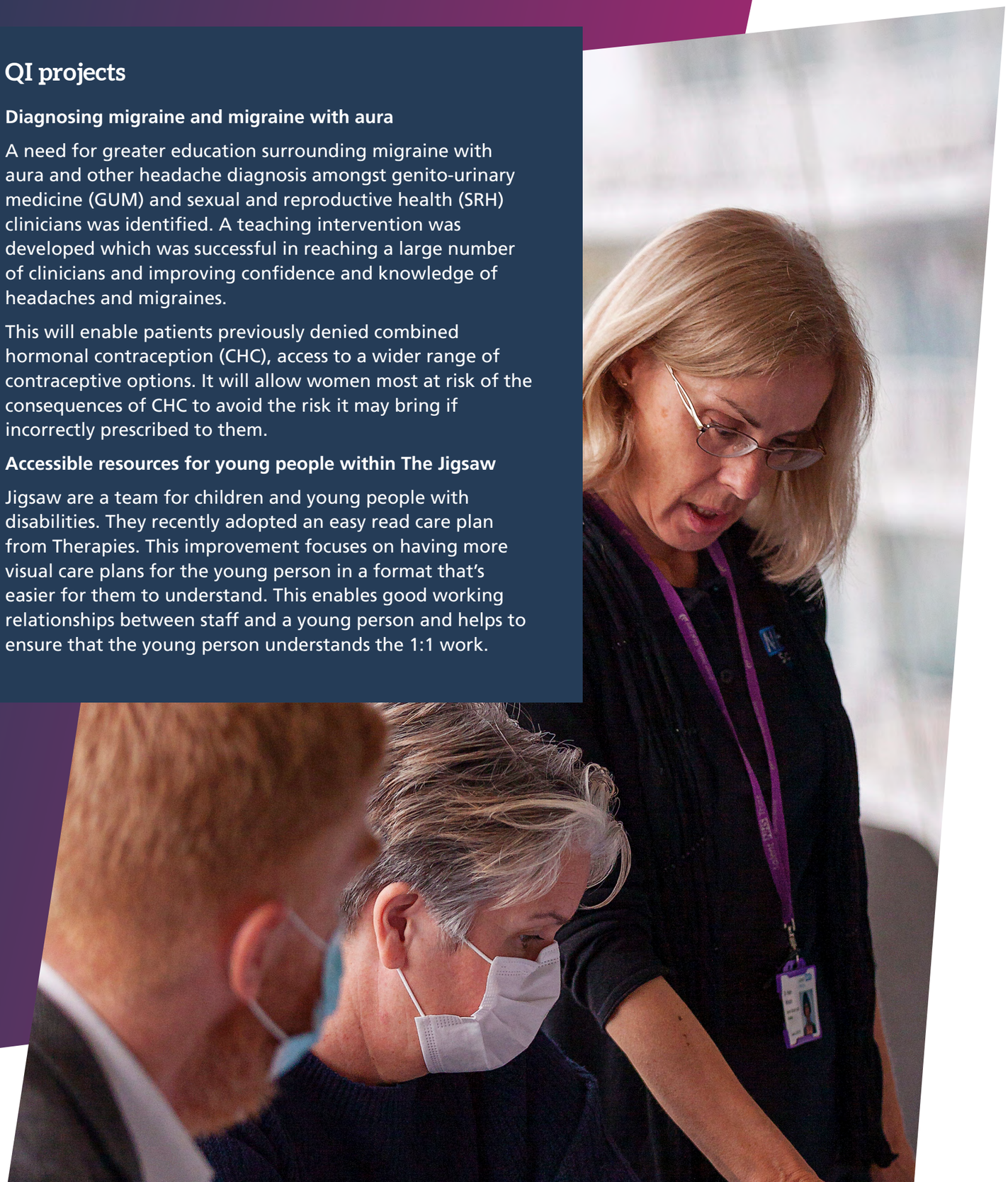
Diagnosing migraine and migraine with aura

A need for greater education surrounding migraine with aura and other headache diagnosis amongst genito-urinary medicine (GUM) and sexual and reproductive health (SRH) clinicians was identified. A teaching intervention was developed which was successful in reaching a large number of clinicians and improving confidence and knowledge of headaches and migraines.

This will enable patients previously denied combined hormonal contraception (CHC), access to a wider range of contraceptive options. It will allow women most at risk of the consequences of CHC to avoid the risk it may bring if incorrectly prescribed to them.

Accessible resources for young people within The Jigsaw

Jigsaw are a team for children and young people with disabilities. They recently adopted an easy read care plan from Therapies. This improvement focuses on having more visual care plans for the young person in a format that's easier for them to understand. This enables good working relationships between staff and a young person and helps to ensure that the young person understands the 1:1 work.



Long COVID monitoring and Clinics for Integrated Learning Disability Service (ILDS) Clients

This improvement initiative looked at supporting ILDS clients who have tested positive for COVID and to offer clients help if they have long COVID. As a result, the named worker meets with the client and completes a long covid monitoring form and follow-ups are scheduled with the client.

Improvements to Domestic Abuse recordings

A new electronic record template was developed for recording conversations on domestic abuse and healthy relationships. This has made it quicker and easier for frontline staff to capture the required date and provides assurances on the support offered to families who are victims of domestic abuse.

Urgent Response Service (URS) - Blood Glucose Level (BGL) Checks

Identifying potential diabetes in patients without a diagnosis, and monitoring BGLs in those with diabetes, helps improve health outcomes. Diabetes leads to many complications, including poor wound healing, renal issues, neuropathy and deterioration in sight. This initiative developed a clear pathway informing staff of the frequency of BGL checks and onward referrals based on initial BGL and Past Medical History.

Combined Patient Information

Different services visiting patients at home (eg, Urgent Response, Community Nursing and Community Independence Services) all had separate folders with useful information for patients and their clinicians kept in the home. This was confusing for the patient and family, and this project consolidated these into one combined record; the folder is now being implemented across Southampton.

The Emotional experience of waiting

The waiting list for Child and Family Therapy Services significantly increased because of therapists being redeployed during the pandemic. To better understand the complexity of the waiting list they gained an insight into family's emotional experience of waiting. Improvements were co-produced with families, which included more frequent contact when waiting, increasing the use of signposting to other services, and supplying resources that could help. On receiving therapy, they enabled appointments to be video recorded and improved the digital and paper resources to support individual needs and interventions.

Quality Improvement (QI)

Preceptee projects

Fungal nail/fungal skin infection patient information leaflet

This preceptee developed a patient information leaflet on the self-management or prevention of fungal nails/ fungal skin infections on the foot. This is a patient friendly leaflet that explains medical jargon and treatment options.

Daily pressure ulcer checklist

To reduce incidents the Lower Brambles Ward created an updated daily pressure ulcer checklist to include pressure points in a more descriptive way and prompting a signal for escalation and actions.

Recognising and managing Autonomic Dysreflexia

With the admission of patients with spinal cord injury and the high risk of developing autonomic dysreflexia, a poster has been developed to help nurses and healthcare workers recognise and manage this, to prevent complications.

'Get It On' (GIO) condom card

Within the clinical sexual health setting there is a small amount of young people being introduced and enrolled onto the GIO C-Card, with the ratio of condoms provided not equal to ongoing condom provision in the Isle of Wight Sexual Health Clinic. The improvement included signposting information created and distributed to those eligible for a GIO C-Card. Updated information and clarification was also provided to clinical staff.

Happier Working Lives (HWL) projects

This year saw the first two cohorts of the Happier Working Lives programme. 15 teams are using QI methodology to create happier, healthier, and more productive working environments. Early changes in practice that had positive impacts on their wider teams include: implementing daily huddles, communication boards, wellbeing boards and generic email for all admin requests.

"It's been a good course, giving lots of useful strategies to keep yourself and others happy. Have felt looked after."

"HWL's is a well organised programme which has enlightened me on how to engage my team and support staff to enjoy work."

One Big Front Door for children's community health: A Health Foundation Funded Project

This is a project that aims to simplify access to our children's services. When families are concerned about their child's development, they currently need multiple referrals to get help from across our services. The team have process mapped the current routes into service and talked to lots of families about their experiences. They are now co-designing a new digital referral pathway with families and community partners. In Spring 2023 there will be a new online and telephone single point of access for all child and families' services and information resources to support needs and waiting well.

QI Leaders

Our QI Leaders are a network of people across our services, supporting their teams and building a QI culture within Solent. They receive a few days training and then join the wider network for regular peer support, coaching and ongoing development of our QI programe.

In 2022 we ran two new cohorts of QI training, for 12 leads. The programme provides participants with an in-depth understanding of QI methodologies and concepts, and provides skills and confidence to lead QI activity. We now have 19 QI leads across the organisation, including some patient QI leads.

Activities and outcomes include:

- Linking different staff and teams to enable collaborative improvement and learning
- Helping teams to turn ideas into quality improvement projects so that they can make sustained and realistic improvements to services
- Working within teams to ensure use of a QI lens with service development, evaluation and review
- Focus on co-production on all improvement
- Increased engagement and partnership working with other colleagues
- Supporting Advanced Clinical Practitioner trainees to include quality improvement in their job plans and work

"I am passionate that staff often know the best way to improve their service, they just need the support and guidance to know how to achieve it - being a QI leader means I can support those conversations and provide guidance to achieve improvement as well as information sharing."
Lou
QI Lead, Portsmouth

"I always leave these days invigorated and re-energised, with ideas about how to drive improvement plans forward in my team."
QI Lead

SOLENT DRAGONS' DEN

Innovation

Solent offers an innovation fund: teams can bid for up to £10,000 for investment in innovation, and support for implementation and review.

In 2022/23 there were 16 Dragons' Den bids, these included:

1. **PReP Provision in Sexual Health Service Spokes.**
   Providing centrifuges to spoke clinics so that those requiring the HIV prophylaxis medication could access it more easily across the county.
2. **Mobile sensory room kit to enable appropriate adaptations to clinical space in CAMHS, Portsmouth.**
   The clinical rooms and waiting room at Falcon House don't give the therapeutic environment needed for some of the young adults. This kit will enable rapid transformation of rooms to make the rooms more conducive to effective consultation and therapy.
3. **Advanced Brachial Toe Index System in the assessment of patients with peripheral arterial disease in Podiatry.**
   Investment in equipment to allow for effective and quick diagnosis of those with arterial disease, reducing risk of amputation.
4. **Engaging with the community to provide group exercise therapy.**
   Working in partnership with a local leisure centre to provide ESCAPE Pain classes to those living with hip and knee osteoarthritis.
5. **Young Person's Involvement Group in Jigsaw.**
   This is a service supporting children and young people with disabilities who have a complex level of need. The service will be setting up an involvement group, allowing their patients to contribute to service design and development.
6. **Digital Diagnostics – measuring cardiac QT interval in people having antipsychotic medication**
   People on antipsychotic medication need regular ECGs to check their heart health - where previously they had to come in for an appointment, this bid is for a small device that will enable the ECG to be done at home, and readings come up on a smart phone app.

Clinical Effectivness

This year we have received 70 Clinical Audit and 37 Service Evaluation reports. 18 of our evaluations have included patients with surveys, focus groups and interviews. We have noted a 60% increase in the number of service evaluations over the last five years which reflects a maturing learning organisation.

Examples of reports

Talking Therapies: Perinatal Provision for Fathers

We have been developing Talking Change's provision for fathers in the perinatal period. We asked a range of individuals who identify as being in a fathering role, some who had had therapy with Talking Change, some who had not, what support with their mental health they would like whilst in the perinatal period (whilst they or their partner is pregnant and/or child is under two years of age). We then used this information to develop our service provision.

An evaluation of emergency contraception from our sexual health service

This evaluation assessed accessibility and quality standards of the emergency contraception service within the community pharmacies across Southampton, Portsmouth and Hampshire.

Solent GP reducing prescribing carbon footprint (asthma inhalers)

Patients were texted to explain their prescription would be changing and time was given to allow them to contact the surgery. After 3 months 726/768 (95%) of patients had been moved onto a lower carbon footprint metered dose Inhaler. Asthma nurses and pharmacists were able to focus on those who are hard to reach and more unsure about this change.

A qualitative analysis of reasons for living and reasons for dying in patients across community mental health services

An analysis was conducted on 62 patients' reasons for living and dying, identified during the Collaborative Assessment and Management of Suicide intervention. This included examples of "one thing that would help you no longer feel suicidal". The main themes for living included activities and personal interests, family and friends, fear, hopeful about the future and the impact of suicide on others. The main themes for dying included control and autonomy, self-blame, lack of purpose in life, loneliness, self-perception, benefit for others, and hopelessness. Themes to reduce suicidality were a stop to negative thoughts and feelings, financial security, future outlook, managing traumatic memories, effective coping skills, relational bonds, support and security, and management of physical pain. These themes will inform the development of therapeutic interventions for suicidality.

A service evaluation of patient experience and patient reported clinical outcomes of a combined physical and psychological programme (CPPP) for low back pain

60 patients were reviewed. Data appears to show that the CPPP is effective in helping improve pain, functional and psychological outcome measures in patients with chronic lower back pain and is achieving high discharge rates from the service of over 80%. Re-referral rates are at 0.02%. Reports from patients highlighted the effectiveness of the group and how the co-delivery from physiotherapists and high-intensity therapists provides a unique holistic approach.

Mental Health Virtual Consultant Supervision.

During 2022 Solent employed three psychiatrists who work entirely virtually. The impact on virtual supervision for junior doctors was considered. It suggested that virtual working improved practicality as sessions were never interrupted and there were no difficulties in finding space. Trainees and supervisors were either very satisfied or satisfied with virtual supervision and pastoral support was able to be provided as usual when compared to face-to-face meetings. Only in a small number of feedback forms, trainee would have preferred meeting face to face due to sensitive information being shared. On occasion there were IT difficulties.

Library and knowledge service

The Academy now has an in house knowledge specialist/ library service. This offers:

- literature searches
- training
- 1:1 support
- workshops

Approximately 35% of support requests that the service receives are for non-clinical topics with many from the most senior colleagues.

Training in health literacy

Poor health literacy (the ability to find and use healthcare information, and make informed decisions about our wellbeing) is associated with poorer health, worse treatment outcomes, and increased health inequality. Portsmouth and Southampton have an average reading age of 7 to 9 years; this means that nearly two thirds of people in either city are likely to struggle with reading and using health information, whether on paper or face-to-face.

Since Autumn 2022, the library service has offered additional workshops on Health Literacy, giving all our colleagues an opportunity to learn practical ways of building on their conversations with patients.

49

1:1 or small group sessions (search discussions, introductions to the library, and searching skills)

24

Workshops (library and other Academy teams)

36

Searches, totalling nearly 200 hours of clinical time saved

756

Solent colleagues are members of the physical library and/or have OpenAthens (online library) accounts

Events and awards

2022 Learning from Excellence Awards

This was the fourth round of the Learning from Excellence awards at Solent. We had 36 nominated winners, of which, 10 were patients and community partners.

Learning from Excellence is a national campaign to learn and build on what goes well in organisations and to provide positive feedback to staff, through peers reporting excellence in healthcare. The reasons for nominations were varied and inspiring, here are just a few of the nominations received:

"He is hard working, friendly and has good knowledge, he goes above and beyond when it comes to patient care."

"She is selfless, hardworking, supportive and encourages newbies in the office. She goes out of her way to make sure everything is okay with everyone. She is excellent!"

"Brooke has supported the quality and transformation work at Solent and has been consistently and reliably supportive for the development of our projects. She has a 'can do' attitude and goes out of her way to support projects. She is a real asset to our team!"

Take a look at the LfE Awards news story >

Events and awards

2022 Annual Conference

Our 11th Academy Conference returned to an in-person event in October 2022. 180 colleagues, patients, carers and community members explored a variety of themes and ideas relating to Solent care and services. Threaded throughout the day was the theme 'Seize the opportunities, for positive changes to healthcare', where we looked at our learning from a variety of projects from the past year, and how we can maximise opportunities to create better patient experiences and care.

The event was co-designed and accredited as a Patients Included Event. We had patients opening the event, chairing panels and running workshops. We also encouraged greener initiatives such as car sharing, limited printed materials, and recycled paper for posters.

Highlights from the day included two excellent keynotes, one by Prof Nav Ayhwalia (pictured) and one on Community Peer Research; a poster cinema and 34 posters, a live Solent Dragons' Den, a Co-production workshop with communities and services sharing experiences; interactive sessions on Demand and Capacity, and Rapid Evaluation Methods.

Safety, Excellence and Improvement Forum

Working alongside the Quality and Safety Team, we hosted a virtual quarterly forum to share learning, ask questions and create conversations about safety, excellence, and improvement activities from across the organisation. We took Novembers forum to Fanshawe Ward and broadcast it from their day room. It was an interactive opportunity for staff to watch and be involved in the forum.

The forum shared learning about the following:

- Seven-day working for rehab staff
- Training for care homes
- Understanding the challenges from Black and Ethnic Minority Communities in using the Talking Change Service
- Safe sleeping advice for health visiting
- Managing emergencies well
- A falling incident in in-patients
- The use of duvets in brain injury rehabilitation
- Staff safety chats
- Data protection versus confidentiality
- Controlled drugs security visits

Heart of Solent Awards

Solent Academy had a number of categories in the Heart of Solent Awards. We were delighted to be an integral part of the Awards with our Side-By-Side members, Roger Stevens and Mary Ramsay, holding places on the judging and award panel.

The Research Award was won by Maria Bungaroo, for her work championing research in care homes. Maria owns and runs two homes in Portsmouth and has worked alongside us in making research accessible for residents and families, successfully delivering a number of large trials.

The People Participation Award was won by Aisha Buckle, the participation lead for our children's services. Aisha works closely with us on involving young people in improvement projects and strengthening their voice.

Carl Adams, our very own Participation Lead, won the Excellence Award for his energy in ensuring personalised care and patient voice at both how we provide care but also in the improvement of services.

Also with us on the day were Louise Wilders and Sarah Baker from the HIVE, Portsmouth and our Yerin Cha and Mel Tipple who were shortlisted for their phenomenal support of the vaccine programme, recruiting and deploying of volunteers.

Our plans for 2023/24

We've got many plans for next year, so look out for us on social media.

Coming up this year...

Creating a joined-up team for delivering community and mental health research and improvement across Hampshire and the Isle of Wight

The formal launch of our Evaluation Hub

Revamping our QI Programme, including increased support for using QI methods in waiting list management

Hosting our first regional 'QI Week' to promote and demystify Quality Improvement

Extending the peer researcher network

The Academy of Research and Improvement

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Board and Committee Cover Sheet

Item No.	20

Presentation to	Solent NHS Trust Board		
Title of Paper	Charitable Funds Committee Exception Report		
Purpose of the Paper	To summarise the key business transacted at the recent Charitable Funds Committee meeting, 19 May 2023		
Author(s)	Belinda Brown, Executive Assistant to Chief Executive	Sponsor	Gaurav Kumar, NED – Committee Chair Debbie James – Executive Sponsor
Date of Paper	25 May 2023	Committees/Groups previously presented	----
Summary of key issues/messages	The committee: - • **Received** the **Quarter 4 (Q4)** Finance Report covering the period 01 January 2023 to 31 March 2023. • was **informed** that the charity received public donations totalling **£654.00** within Q4 and **£666.00** from investment income, and that the charity account balance as of 31 March 2023 was circa **£183,000.00** • was **updated** on spend within Q4, including **£827.00** on staff welfare and **£500.00** for the charity logo • **discussed** the use of designated funds over the next twelve months. • was **informed** that a submission to the NHS Charities Covid 19 Appeal had been approved, subject to receipt of further information on how the grant will be used (resource to grow the charity). The committee was informed that the grant is worth £30,000.00. • was **updated** on the NHS Charities Together stage 3 recovery grant, worth £88,000.00, for which the submission deadline is 30 June 2023. • **Received** an update from members of the Southern Health NHS Foundation Trust's charity, Brighterway, and discussed future ways of working together and the possibility of sharing resource. • Was **supportive** of the request to fund future Health and Wellbeing small requests, within the boundaries of the charity • **Received** an update from Estates • **Approved in principle** to fund improvements to the outside space of Falcon House, utilising the stage 3 recovery grant, if successful. • **Noted** amendments to the Charitable Funds committee Terms of Reference • **Agreed** to fund an NHS poetry competition for local schools, to celebrate the NHS 75th birthday in July 2023 • **Thanked** Rachel Goldsworthy for her support to the charitable funds committee and wished her well in her new role.		

Action Required	For decision?	N	For assurance?	Y

Recommendation	The Board is asked to receive the above summary of business transacted.

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

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