Agenda

Solent NHS Trust In Public Board Meeting

Date: Monday 4 December 2023
Timings: 09:30 – 13:05
Meeting details: Lecture Theatre 2, 4th Floor, Block A, St Mary's Hospital, Milton Road, Portsmouth, PO3 6AD

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**	Acting Chief People Officer	To receive
4	10:35	10mins	**Reflection on Patient and Staff Stories**	Chief of Nursing and AHPs	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 Visits –** *verbal update* • **Freedom to Speak Up -** *verbal update*	Chief of Nursing and AHPs	Verbal update
10-minute break					
Items to receive					

7	11:10	10mins	**Chief Executive's Report**	CEO	To receive
8	11:20	10mins	**6 monthly progress update on Business Planning**	Chief of Transformation	To receive
9	11:30	10mins	**Information Governance Update**	CFO	To receive
11	11:40	10mins	**Re-forecast of Solent Financial Plan**	CFO	To receive
12	11:50	10mins	**Board Assurance Framework**	CEO	To receive
13	12:00	15mins	**NHS Impact Self-Assessment**	Director of Research & Improvement	To receive
Items to approve					
14	12:15	30mins	**Integrated Performance Report** *Including:* • *Safe* • *Caring* • *Effective* • *Responsive* • *People* • *Finance* • *Research and Improvement* • *System Oversight Framework*	Executive Leads	To receive
Governance					
Reporting Committees and Governance matters					
15	12:45	15mins	**People Committee –** *Exception report from meeting held 23 November 2023*	Committee Chair & Acting CPO	To receive
16			**Mental Health Act Scrutiny Committee-** *Exception report from meeting held 16 November 2023*	Committee chair	To receive
17			**Audit & Risk Committee –** *Exception report from meeting held 10 November 2023*	Committee chair	To receive
18			**Quality Assurance Committee-** *Exception report from meeting held 23 November 2023* • *Safe Staffing Quarter 2 Report*	Committee chair	To receive

19			**Non-Confidential update from Finance & Infrastructure Committee–** *non confidential escalation report from meeting held 27 November 2023*	Committee chair	Verbal update
20			**Charitable Funds Committee –** *Exception report from meeting held 9 November 2023*	Committee chair	To receive
21			**Remuneration and Nominations Committee –** *Exception report from meeting held 9 November 2023*	Committee chair	To receive
Any other business					
22	13:00	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	13:05	---	**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:

- *5 February 2024*

Item 5.1

Minutes

Solent NHS Trust In Public Board Meeting

Date: Monday 2 October 2023
Timings: 09:30
Meeting details: Meeting Room 1 – First Floor, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Chair: **Mike Watts,** Acting Trust Chair (MW)	
Members: **Andrew Strevens,** CEO (AS) **Angela Anderson,** Chief of Nursing and Allied Health Professionals (AA) **Nikki Burnett**, Chief Finance Officer (NB) **Debbie James**, Chief Strategy & Transformation Officer (DJ) **Dan Baylis**, Deputy CEO & Chief Medical Officer (DB) **Alasdair Snell,** Chief Operating Officer (ASn) **Sorrelle Ford**, Acting Chief People Officer (SF) **Gaurav Kumar**, Non-Executive Director (GK) **Vanessa Avlonitis,** Non-Executive Director (VA) **Stephanie Elsy,** Non-Executive Director (SE) **David Kelham,** Non-Executive Director (DK)	**Attendees** **Sam Stirling**, Corporate Affairs Administrator **Aderemi Aderibigbe**, Associate Director Quality, Safety, Governance & Risk (AAd) **Anna Rowen**, Associate Director Diversity & Inclusion (AR) **Apologies** **Dominic Ford**, Governance Programme Lead (DF)
Patient Story (item 2) **Johanna,** Patient's Mother	**Staff Story (item 3)** **Anastasia Mulenga-Lungu**, Head of Community Engagement (AML) **Rujeko Mada**, Associate Practice Educator (RM) **Ophelia Watson**, Head of Experience of Care (OW)

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. Apologies were received as noted above.
1.2	The meeting was confirmed as quorate. The declarations of interest form was circulated and there were no updates to note.
2	**Patient Story**
2.1	AA welcomed Johanna to the In Public Board meeting. Patient background was shared and experiences of care following referral to the Community Physiotherapy service was provided. Break down in communications and delay between the acute hospital and community services were highlighted. Considerations of most appropriate treatment pathways were confirmed and the Board were informed that care had since been positive and engaging.
2.2	AA thanked for sharing experiences and commented on gaps in pathways, particularly for specialty areas such as Oncology. AA highlighted work required in relation to transition services for children and ensuring accessibility for service users.
2.3	AS queried impact of the service and it was confirmed that the Physiotherapy team provided strong level of care and made a significant difference to the patients mobility. AS emphasised the importance of working through communication challenges to ensure clear pathways.

2.3	DB reflected on the lessons highlighted and proactive management of pathways and waiting lists. Pressure on services and management of demand was noted. DB commented on the importance of working across the Integrated Care System (ICS) to review transitions of care between acute and community services as a priority. DB reflected on the fundamental continuous improvement work required, considering financial, workforce and demand pressures, to recognise and react appropriately.
2.4	DK shared frustrations and challenges in relation to pathways/handover processes. AS commented on delivery of services as a result of the previous way of commissioning and major organisational changes made to consider pathways. Challenges were shared and the importance of pathway-based commissioning was emphasised.
2.5	MW reflected on the importance of ensuring learning and no further issues across services/pathways. VA queried usefulness of sharing the story with the acute organisation to ensure cross-learning and highlight issues. AA commented on work undertaken as a result of this case to influence and effect change and agreed usefulness of widely sharing. AA confirmed ongoing work across the ICS to improve transition elements of care.
2.6	The Board thanked Johanna for joining the meeting. *Johanna left the meeting.*
3	**Staff Story**
3.1	SF introduced members of staff to the meeting to share their experiences, in honour of Black History Month. • AML shared a role-playing exercise based on experiences of providing care. Positive values and policies in place were shared, however AML commented on the importance of further work regarding how these were delivered and translated into actions for front-line services. • The role of senior leaders working together to drive change was emphasised. • RM explained her role within the Trust and negative personal experiences were shared. Differences in treatment due to race were explained. RM also highlighted difficulties speaking up and impact on mental health. • OW shared positive experience of working within Solent and queried why this was not the normal experience of many black members of staff. Important role of management/ leadership and the importance of speaking out was emphasised.
3.2	AML informed of the following actions requiring Board commitment, in order to drive work forward and improve experiences. • Strong monitoring and reporting through use of data (complaints and concerns) to identify areas of challenge • Process for racially linked complaints and process to work on 'hot spot' areas • Expansion of Freedom to Speak Up elements to ensure links to diversity and inclusion work • Review of mentoring, banding and recruitment to consider potential areas of bias • Consideration of work to ensure full manager/leadership support
3.3	MW thanked AML, RO & OW for bravely sharing their stories. AML thanked the Board for their willingness to support this area and take action.
3.4	AS thanked for candour and reflected on areas of learning and improvements in terms of triangulating data.
3.5	AML emphasised the importance of sharing stories and building staff confidence to raise issues and know that they will be addressed. The Board thanked AML, RM & OW for sharing their stories. *AML, RM & OW left the meeting.*

4	**Reflection on Patient and Staff Stories**
4.1	It was agreed to hold further reflections in Confidential Board, due to item/timeslot provided on the agenda.
5	**Previous minutes, matters arising and action tracker**
5.1	The minutes of the last meeting were agreed as an accurate record, subject to amendment. There were no matters arising to share.
5.2	The following actions were confirmed as complete: AC005063 and AC005064 It was agreed to capture request for a roving Board model as a formal action from the previous minutes.
6	**Safety and Quality – contemporary matters**
6.1	<u>Freedom to Speak Up</u> It was confirmed that there were no issues to escalate. The Board were informed that the current Freedom to Speak Up Guardian (Beth Carter) had been successful in securing a national secondment. Ongoing considerations of replacement/selection process was confirmed, in consideration of Fusion and strengthening relationships and the single support offer.
6.2	<u>Board to Floor Visits</u> There were no updates/escalations in relation to Board to Floor Visits. MW and VA briefed the Board on recent visits undertaken. Positive areas and actions identified were shared.
6.3	DB informed of joint consultant and junior doctor strike action taking place. It was noted that active management was being held and there were no issues to escalate at this time.
7	**Reinforced Autoclaved Aerated Concrete (RAAC) Update**
7.1	NB provided an update and confirmed areas identified at St Marys Hospital using RAAC. The Board were informed of precautionary measures in place and full structural engineering report completed. NB provided assurance that all plans, including evacuation plans, had been reviewed and no further actions identified following discussion with NHSE. Constant monitoring was noted.
7.2	MW requested assurance that there were no other Solent sites identified with RAAC. NB assured of visual inspections, regulatory checks and assessments, with confirmation from all landlords. **The Board received assurance from the report.**
8	**Solent's Learning from the Lucy Letby Case**
8.1	AA presented the update and shared the importance of responding to findings from this case and ensuring appropriate mechanisms were in place to ensure an agile response. Continued response from the Trust and consideration of implications, particularly from a patient safety perspective were noted. Extensive review at the Quality Assurance Committee was confirmed. **The Board received assurance from the update.**
9	**CEO report**
9.1	AS presented key highlights from the report.

	• Positive feedback from the Trust Annual General Meeting was shared. • AS informed of communications and engagement events taking place in relation to Black History Month. The Board were encouraged to attend events where possible. • Launch of the Staff Survey was reported and SF explained importance of receiving honest feedback and reviewing indicators, including those relating to Diversity and Inclusion and culture. • Positive work of the Staff Networks were explained.
9.2	VA queried how impact and potential harm was being measured in relation to consultant and junior doctor industrial action. ASn explained impact in relation to cancellation of patients and emphasised continued monitoring. MW asked about cumulative impact. ASn highlighted monitoring of areas, such as medically fit for discharge, with associated impacts mitigated and flow maintained. DB reflected on challenges predicting impacts on unscheduled care pathways. It was confirmed that work to quantify harm and impact was being completed at ICS level. SF provided feedback from People Officers across the ICS in relation to staff fatigue and effect on operational colleagues. The Board acknowledged pressures, particularly in the lead up to winter pressures.
9.3	MW commented on staff survey discussions held at the People Committee and SF commented on review of communications. AS confirmed that full Confidential Board discussion would be held in relation to engagement of specific areas. AA noted the importance of ensuring appropriate balance of communications to ensure that staff were not overwhelmed with requests, given existing pressures.
9.4	MW queried further work required in relation to the Board Assurance Framework. Full oversight at each Committee was confirmed, including consideration of the impact of Project Fusion. Contextual overview was noted and further discussions in relation to risk appetite were reported. **The CEO Report was received.**
10	**Same Sex Accommodation Annual Report**
10.1	It was noted that the Trust was compliant and continues to work to the national guidance**.** **The Board approved the Same Sex Accommodation Annual Report.**
11	**Emergency Planning Resilience Response Annual Report**
11.1	The annual report was presented to Board. More focus required in relation to Project Fusion was explained and rapid review to ensure that all Business Continuity Plans were up to date was noted. The Board were informed of interdependencies and the importance of ensuring services were safe and secure on day 1 of the new organisation.
11.2	MW queried early indicators and ASn commented on vast amount of in-depth work taking place, including planning to align policies. It was confirmed that this critical piece would be reviewed by the relevant Project Fusion governance routes.
11.3	AS queried lessons learned and feedback provided following incident reported at the Royal South Hants Hospital. ASn reflected on gaps identified within the incident report and ongoing review to ensure safety. It was confirmed that reporting would be held through the Health and Safety Group.
11.4	AS requested clarity in relation to the number of floors with RAAC. ASn confirmed that this was identified on the 4th and 5th floors of St Marys Hospital (block A).
11.5	AS queried feedback from the peer review of the Trusts current assurance state. **It was agreed that ASn provide an update via post meeting note. Action- ASn.**

	<u>Post meeting note:</u> **The peer review took place at Omega House in Eastleigh. Present were Lee Havey and Taylor Coleman (Solent), Maria Miyazaki and Sarah Yearsley (SHFT) and Phil Hartwell (ICB).** **SHFT and Solent presented evidence and answered any questions Phil had. He was happy with what we had done, he noted that for 2024/25, if we achieved substantial compliance that would be remarkable as there will be so many unknowns and a huge amount of work to do in such a large new trust. Date was the 26th of September (18th was a pre meet with Maria).**
11.6	DK reflected on prioritisation required to ensure Business Continuity Plans were up to date and understanding the data, gaps and additional resource required. ASn explained complexities and importance of ensuring responsive and clear planning prior to day 1 of the new organisation. ASn commented on well-resourced project management required and challenges linked to pressures on staff and services. MW emphasised the importance of Board level oversight and ASn assured of full considerations within the Project Fusion workstreams.
11.7	**The Board received the Emergency Planning Resilience Response Annual Report.**
12	**Winter Resilience & Cold Weather Planning 2023/2023**
12.1	ASn shared key highlights from the report. • It was confirmed that the Deputy COO would be submitting an update in relation to winter principles and associated capacity imminently. • Importance of early insight on pressures, including financial pressures and impact on patients, was explained. It was confirmed that a report would be submitted to executive directors for discussion/challenge. • Communications with the system were shared to ensure that the Trust were open and transparent in terms of support/delivery within financial targets. • Challenging winter expected due to financial constraints and demand on the system was emphasised.
12.2	MW queried reallocation of funds and ASn assured of meeting set up to review financial pressures and potential direct impacts on harm. ASn reported challenges regarding reduction in funding on planned capacity for virtual wards and system consideration of resource taking place. It was confirmed that feedback from the financial recovery meeting would be provided at Confidential Board. DB reflected on whole system financial constraints and the importance of work at ICS and local delivery system level. AA agreed and commented on importance of ensuring correct skills and competencies in place to deliver.
12.3	SE queried progress and DB explained degree of impact, with next steps requiring evaluation as part of a system wide approach. ASn commented on usefulness of the Patients Benefits Case for improvement areas and shared current challenges. Importance of a Board level monitoring brief was noted and further discussions regarding capacity and funding to deliver highlighted. The Board were assured of current commissioned requirements, however ASn emphasised challenges providing system support. AS requested further discussion in Confidential Board and suggested potential review at a future Board Workshop. **The Winter Resilience & Cold Weather Planning 2023/2023 was received.**
13	**NHS Impact Baseline for Improvement and Self-Assessment**

13.1	The Board were briefed on new framework from NHSE and positive Trust position in relation to the strategy for reshaping, alongside quality governance. It was confirmed that the Trust was in the process of undertaking an assessment and current position was noted.
13.2	MW asked where the assessment was reported. It was confirmed that assurance of delivery was required and reporting would be submitted to NHSE, with consideration of Project Fusion to ensure the new organisation would deliver improvements.
13.3	GK queried timeline for implementation and DB explained continuous improvement journey. **The Board supported and received the NHS Impact Baseline for Improvement and Self-Assessment.**
14	**Framework of Quality Assurance for Responsible Officers and Revalidation: Annex D – Annual Board Report and Statement of Compliance**
14.1	DB explained annual statement of compliance requirements and assurance that the Trust was complaint with duties to revalidate doctors. DB shared extensive work undertaken in relation to medic job plans and thanked the team for their hard work. **The Board agreed assurance and approved the Annual Board Report and Statement of Compliance**.
15	**EDI and Belonging Annual Report**
15.1	SF presented key highlights from the report. • Co-production with the network was confirmed and SF provided an overview of the 5 workstreams in place. • Active work on patient choice linked to discrimination and lived experiences was shared. • Full review by the People Committee was noted, with feedback included. • The Board were briefed on the action plan, linked to the NHS 6 high impact actions. • Holistic approach to deliverables were highlighted and deep dive into key areas explained. • AR informed of overall Trust score/evaluation areas and the importance of ensuring meaningful activity based on feedback. • Intention to broaden discussions within the senior leadership team was emphasised.
15.2	AS provided formal thanks for comprehensive report provided and shared reflections in relation to the national picture and planning to address areas of under-representation. SF informed of briefing session being established to review.
15.3	DK asked if updates were required, following the Staff Story shared. AR confirmed full oversight and provided an overview of data/benchmarking areas. Importance of integral focus on the narrative received through networks was highlighted and SF briefed on the ongoing work to triangulate data. It was agreed to include explicit oversight of benchmarking data within the next update/annual report to ensure position was noted. **The Board approved EDI and Belonging Annual Report.** *AR left the meeting.*
16	**Health & Safety Annual Report**
16.1	An overview of the report was provided, including 3 amber areas detailed within the executive summary. Significant progress was highlighted and full oversight at the Quality Assurance Committee was confirmed. **The Board approved the Health & Safety Annual Report.**

17	**Patient Safety Incident Response Framework Policy and Implementation Plan**
17.1	Patient Safety Incident Response Framework Implementation Plan AA noted formal thanks for the significant work that had gone into establishing the Implementation Plan. AAd briefed the Board on key elements of the plan, including response to incidents reviewed against national guidance. Development together with Southern Health, in consideration of Project Fusion, was confirmed and full oversight within quality governance structures noted. DB reflected on the significant safety assurance provided and key component for driving culture and Freedom to Speak Up across the organisation. **The Board approved the Patient Safety Incident Response Framework Implementation Plan.**
17.2	Patient Safety Incident Response Framework Policy It was confirmed that the policy had been reviewed by the appropriate policy governance routes and was awaiting final ratification. Alignment to similar areas within Southern Health was confirmed and consideration of elements of difference explained. Inclusion within PTIP planning was assured.
18	**Integrated Performance Report**
18.1	ASn shared key highlights from the report. • The Board were briefed on 5 bed closures on Hawthorn's ward, due to fragility of the number of consultants and the need to ensure appropriate level of legal cover. It was noted that RC status had been changed as per legal requirements, to ensure further agility. Planning for 2 further RC status staff was highlighted. • Regarding virtual wards, ASn explained regional drive to increase provider utilisation to 80% and explained that Solent were regularly ahead of funded capacity. Continued work to ensure the Trust were covering patient by patient need was emphasised. • The Board were informed that confirmation had been received from NHSE that no further action was required in relation to the regional drive. Assurance was provided regarding strong Trust position. • An update regarding waiting times was provided. Full discussions at the Clinical Executive Group and Quality Improvement and Risk Group was highlighted, with request for services to complete a full assessment of harm. The Board were assured of executive level oversight. • ASn reported disparity across the dental service and confirmed that strategic objectives were being reviewed. Promising and innovative recruitment initiatives were shared. Significant service pressures were confirmed and ASn assured of the quality of service being delivered. • ASn informed the Board that one request for mutual aid had been declined, however strong mutual aid offer had since resumed.
18.2	DK asked about predictions for outturn of regulatory targets from an operational perspective. ASn briefed on metrics and confirmed that all but one key regulatory item would be met. The need to review against target scores within the Board Assurance Framework and understand key concerns/data trajectory was noted. Full review within Executive Performance Review Meetings was confirmed.

18.3	MW queried planning in relation to the financial deficit. NB provided an update, confirming extensive challenges going into this financial year and additional unexpected cost pressures. Continued discussions with service lines to establish remedial action plans was highlighted. NB informed that a Trust Financial Recovery Board had been stood up to ensure clear oversight and monitoring. Importance of accountability and peer learning/support was emphasised. NB briefed on actions being undertaken, including vacancy restrictions and implementation of the 'no PO no pay' initiative. Ongoing work with operational colleagues was noted and discussions across the ICS highlighted, to ensure continuation of operational effectiveness and delivery of value for money. **The Board received the Integrated Performance Report.**
19	**People Committee –** *Exception report from meeting held 21 September 2023*
19.1	MW presented the report. • Extensive discussions in relation to sickness and absence were shared. Request for assurance via targeted review was explained. • Issues in relation to international recruitment were highlighted and confirmed full discussions to be held during Confidential Board. • SF commented on strong discussions regarding the workforce dashboard and intention to use forecasting surrounding people metrics.
20	**Mental Health Act Scrutiny Committee-** *Exception report from meeting held 10 August 2023*
20.1	VA shared the report and reported backlog of Deprivation of Liberty and local authority cases. Full CQC oversight was confirmed.
21	**Audit & Risk Committee** – *Exception report from meeting held 11 August 2023*
21.1	An overview of the exception report was presented. **The Board noted the following reports:** • **Freedom to Speak Up Annual Report** • **Committee Terms of Reference**
22	**Quality Assurance Committee**- Exception report from meeting held 21 September 2023
22.1	VA informed of productive meeting held and commented on positive collaborative working following attendance from Southern Health. Extensive discussions in terms of partnership governance arrangements were highlighted and concerns escalated from the Clinical Executive Group reported, which had also subsequently been shared within Southern Health. VA shared discussions held following the meeting in relation to Project Fusion Due Diligence and assurance provided in relation to particular queried elements.
22.2	**The following Committee reports were noted by the Board:** • **Q1 Safe Staffing Report** • **Committee Terms of Reference**
23	**Non-Confidential update from Finance & Infrastructure Committee–** *non confidential escalation report from meeting held 25 September 2023*
23.1	There were no items to report.
24	**Charitable Funds Committee** – *Exception report from meeting held 10 August 2023*

24.1	The Board received the report from the Committee.
25	**Remuneration and Nominations Committee** – *Verbal update from meeting held 28 September 2023*
25.1	VA provided an update in relation to Fit and Proper Persons and associated changes. The Board received the report from the Committee.
Any other business	
26	**Any other business and reflections including:** • ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***
26.1	AS reflected on vast number of reports provided and strong discussions held.
26.2	No other business was discussed and the meeting was closed.
27	**Close and move to Confidential meeting**

Item 5.2

Solent NHS Trust, Isle of Wight NHS Trust & Southern Health NHS Foundation Trust – In Public Meeting of the Boards in Common

Date: Monday 13 November 2023
Time: 15:00 – 17:00
Location: Cedar Hall, King's Conference Centre, Upper Northam Road, Hedge End, Southampton, SO30 4BZ

Solent NHS Trust:

Chair: **Mike Watts,** Acting Solent NHS Trust Chair (MW)	
Board Members: **Andrew Strevens,** CEO (AS) **Angela Anderson,** Chief of Nursing and Allied Health Professionals (AA) **Dan Baylis**, Deputy CEO & Chief Medical Officer (DB) **Alasdair Snell,** Chief Operating Officer (ASn) **Stephanie Elsy,** Non-Executive Director (SE) **David Kelham,** Non-Executive Director (DK) **Gaurav Kumar**, Non-Executive Director (GK) **Debbie James**, Chief Strategy & Transformation Officer (DJ) **Nikki Burnett**, Chief Finance Officer (NB)	**Attendees** **Dominic Ford**, Governance Programme Lead (DF) **Sam Stirling**, Corporate Affairs Administrator **Jayne Jenney**, Assistant Company Secretary & Corporate Support Manager **Jey Williams**, Commercial Project Manager **Fiona Garth**, Communications & PR Manager **Apologies** **Vanessa Avlonitis,** Non-Executive Director **Sorrelle Ford**, Acting Chief People Officer

Southern Health NHS Foundation Trust:

Chair: **Lynne Hunt**, Southern Health NHS Foundation Trust Chair (LH)	
Board Members: **Ron Shields,** Chief Executive Officer (RS) **Michael Bernard**, Non-Executive Director (MB) **Kate Fitzgerald**, Non-Executive Director (KF) **David Kelham**, Non-Executive Director (DK) **Paula Anderson**, Finance Director & Deputy Chief Executive (PA) **Paula Hull**, Director of Nursing & AHPs (PH) **Eugene Jones**, Chief Operating Officer (EJ) **Heather Mitchell**, Director of Strategy & Infrastructure Transformation (HM) **Dr Satnam Sagoo**, Chief People Officer (SS) **Jeni Bremner**, Non-Executive Director (JB) **Ade Williams**, Non-Executive Director (AW)	**Attendees** **Anna Williams,** Associate Director of Corporate Governance & Risk (AWi) **Sarah Spooner**, Corporate Governance Coordinator **Tom Westbury**, Associate Director of Communications **Apologies** **Dr David Hicks**, Non-Executive Director **Dr Viki Laakkonen**, Acting Chief Medical Officer **Dr Subashini M**, Non-Executive Director

Isle of Wight NHS Trust:

Chair: **Melloney Poole**, Isle of Wight NHS Trust Chair (MP)	
Board Members: **Penny Emerit,** Chief Executive Officer (PE) **Tim Peachey,** Non-Executive Director (TP) **Christine Slaymaker,** Non-Executive Director (CS) **Joe Smyth,** Group Chief Officer IWT (JS) **Lesley Stevens**, Group Exec Director Community, MH & LD (LS) **Mark Orchard,** Group Chief Financial Officer & Deputy CEO (MO)	**Attendees** **Sarah Anderson**, Associate Director Corporate Affairs (SA) **Apologies** **Debbie Beaven,** Non-Executive Director **Phil Berrington,** Non-Executive Director **Inga Kennedy,** Non-Executive Director **Sara Weech,** Non-Executive Director **Christopher Tibbs,** Non-Executive Director **Liz Rix**, Group Chief Nursing Officer **Nicole Cornelius,** Group Chief People Officer, **Nikki Turner**, Group Chief Transformation Officer **John Knighton**, Group Chief Medical Officer **Anoop Chauhan**, Group Chief Research Officer

In attendance:

Caroline Morrison, Chief Strategy & Transformation Officer – ICB
Mike Barber, Director- Seagry Consultancy
Adrian Thorne, Southern NHS Foundation Trust Governor
Steph Stinton, Southern NHS Foundation Trust Governor
Steph Angell, Southern NHS Foundation Trust Governor
Paul Lewzey, Southern NHS Foundation Trust Governor
Suzanne Pepper, Southern NHS Foundation Trust Governor

1.	**Introduction to the Boards in Common and context for Boards in Common meeting**
1.1	LH welcomed all to the meeting and shared housekeeping elements for information. Introductions were made by each Trust Board. The purpose of the meeting was shared and name of the new organisation was confirmed as follows: Hampshire and Isle of Wight Healthcare NHS Foundation Trust.
2.	**Welcome, Apologies and Declaration of Interests**
2.1	<u>Southern NHS Foundation Trust</u> Apologies were received as noted above. The following declaration was noted: • David Kelham- Non-Executive Director for both Solent & Southern
2.2	<u>Solent NHS Trust</u> Apologies were received as noted above. The following declarations were noted: • David Kelham- as above • Mike Watts- Designate Non-Executive Director for the new organisation • Gaurav Kumar- Designate Non-Executive Director for the new organisation
2.3	<u>Isle of Wight NHS Trust</u> Apologies were received as noted above. The following declaration was noted: • Sara Weech- designate Non-Executive Director for the new organisation
3.	**Presentation of Project Fusion documents for approval:** • **Full Business Case** • **Post-Transaction Integration Plan** • **Patient Benefits Case** • **Board Certification**
3.1	RS presented a summary of the plan to bring together NHS Community, Mental Health and Learning Disability Services in Hampshire and the Isle of Wight. • Commitment to bringing the new organisation into actuality and strong ambitions to deliver improved services to communities served was shared. Full thanks to all those involved in work to date was provided. • Next steps following approval of the Full Business Case and positive endorsement was highlighted. • RS reflected on clear strategic case, with improved position to better meet financial challenges. Common focus on supporting change/improvements for populations served and building on the strengths within each organisation was emphasised. Opportunities to bring together resource, expertise and knowledge to maximise partnerships, community care and health benefits was highlighted. • Strengths and benefits of the new organisation were shared (as per the Benefits Realisation Case). Importance of using lived experience to shape approach for joined-up care was emphasised and non-clinical approach to integrated care explained. • Benefits of understanding unwarranted variation to build on strong practice and build resilience for communities (working with the third sector) was highlighted. • Responsibilities as an employer and importance of mobilising the Trust to support both staff and service users was emphasised. • RS fully endorsed and commended the Full Business Case for approval and onward submission to NHSE.
3.2	AS commented on the once in a generation opportunity presented to improve lives across communities. PE agreed and emphasised full partnership working required to realise this exciting opportunity.
3.3	DB endorsed comments made and reflected on programmes of work in clinical transformation workstreams, including engagement with communities, primary care and those with lived experience. Blueprints established within clinical services were confirmed and the importance of working together to deliver ambitions noted.

3.4	LS briefed on critical elements of engagement in all areas of work, including co-production, models of care, clinical delivery and lived experience within each clinical pathway. Opportunities in terms of specialised expertise, strategic decision making, and considerations of quality improvement were explained. Areas of strength within each organisation were highlighted and the importance of building on strong existing elements was shared.
3.5	In terms of workforce, SS reflected on critical partnerships and support of workforce across the system, with the new organisation an anchor institute for change.
3.6	Discussions were held regarding the financial position and challenges were acknowledged. Consideration of opportunities to use existing costs in different ways as well as ensuring growth investment and value to successfully deliver on benefits was noted. Importance of ensuring strategic decision making and considerations of re-investment in clinical services was reviewed. The Boards discussed the use of the clinical strategy and life course approach, with the importance of partnerships emphasised.
3.7	ASn reflected on the usefulness of considering variations across organisations to maximise effectiveness, capacity and consider how organisations work with local authorities. EJ agreed and emphasised the importance of identifying the best approaches to ensure they were responding to health and prevention needs.
3.8	PH highlighted opportunities for change, particularly from a governance/assurance perspective, ensuring focus on work towards benefits. AA noted continued work to build partnerships and the need to focus on safety for communities served.
3.9	KF shared personal experiences and the importance of ensuring accessible information, care and pathways. Learning scope from across each Trust was noted.
3.10	Formal thanks were stated to all involved in creating the Full Business Case and SE reaffirmed importance of ensuring community and mental health services have a platform within the local system.
3.11	CM reflected on the importance of focus on the prevention agenda from a system/ICB and national perspective. The need to ensure sustainability, best use of resource and combined knowledge was emphasised. Consideration of new opportunities in terms of system working was discussed, with focus on population health, prevention and outcomes.
4.	**General discussion in relation to the Project Fusion documents for approval**
4.1	MP confirmed that the Isle of Wight NHS Trust were content to approve and manage associated risks due to the importance of this transaction for the populations served.
4.2	LH agreed and emphasised Southern NHS Foundation Trust's commitment to achieving and full discussions held.
4.3	MW commended the work undertaken to date and the importance of ensuring delivery of a safe organisation, recognising ambitious timescales. MW reiterated Solent NHS Trust's commitment and focus on ensuring improvements for communities.
5.	**Discussion of any issues specific to each Trust and approval of the documents for submission to NHS England**
5.1	<u>Southern Health NHS Foundation Trust</u> **The Board approved:** • **The Full Business Case (and noted Letter of Support from the ICB and paragraph 3.13 (p.43 of FBC) to be removed to reflect receipt)** • **Patient Benefits Case** • **Post Transaction Integration Plan** • **Board Certification for submission to NHS England**

5.2	Solent NHS Trust **The Board approved:** • **The Full Business Case (and noted Letter of Support from the ICB and paragraph 3.13 (p.43 of FBC) to be removed to reflect receipt)** • **Patient Benefits Case** • **Post Transaction Integration Plan** • **Board Certification for submission to NHS England**
5.3	Isle of Wight NHS Trust **The Board approved:** • **The Full Business Case (and noted Letter of Support from the ICB and paragraph 3.13 (p.43 of FBC) to be removed to reflect receipt)** • **Patient Benefits Case** • **Post Transaction Integration Plan** • **Board Certification for submission to NHS England**
6.	**Questions from the public**
6.1	AT reflected on discussions held and strong commitment demonstrated. Governor considerations of ensuring appropriate processes and governance elements was explained. AT commented on the importance of ensuring outcome/community focused planning, whilst acknowledging challenges and complex elements. Next steps, clear starting point and requirement for governors to sign off the due diligence aspect of the transaction was noted.
6.2	PL thanked all for hard work to date and awareness of continued work required, including post 1 April 2024. Importance of ensuring success and the need for considerations of how governors can assist was noted.
7.	**Meeting close and thanks**
7.1	LH thanked all for their attendance and participation. No other business was discussed and the meeting was closed.

Action Tracker

Item 5.3

Overall Status	Source Of Action	Date Action Generated	Minute Ref	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
Ongoing	In Public Board	07/08/2023	5.2	AC005065	Staff and Patient Story Proposal	AS agreed usefulness of a roving Board model and suggested alternating between localities for the remaining Board meetings, prior to establishment of the new organisation. **Action- SS/JJ.**	Sam Stirling/ Jayne Jenney	December meeting being held in Portsmouth. Looking at venues to hold a meeting on the Isle of Wight in February.
Ongoing	In Public Board	02/10/2023	11.5	AC005066	Emergency Planning Resilience Response Annual Report	AS queried feedback from the peer review of the Trusts current assurance state. It was agreed that ASn provide an update a post meeting note. **Action- ASn.**	Alasdair Snell	Complete- Post meeting note provided as follows: The peer review took place at Omega House in Eastleigh. Present were Lee Havey and Taylor Coleman (Solent), Maria Miyazaki and Sarah Yearsley (SHFT) and Phil Hartwell (ICB). SHFT and Solent presented evidence and answered any questions Phil had. He was happy with what we had done, he noted that for 2024/25 if we achieved substantial compliance that would be remarkable as there will be so many unknowns and a huge amount of work to do in such a large new trust. Date was the 26th of September (18th was a pre meet with Maria)

Item 7

CEO Report – In Public Board

Date: 27 November 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

Project Fusion

A major milestone has been reached following the approval of the Full Business Case for a single NHS Trust to provide mental health, community and learning disability services to people across Hampshire and the Isle of Wight.

The Boards of Solent NHS Trust, Southern Health NHS Foundation Trust and the Isle of Wight Trust signed off the proposal for the creation of **Hampshire and Isle of Wight Healthcare NHS Foundation Trust**.

Proposals to create the new Trust are fully supported by Hampshire and Isle of Wight Integrated Care Board (ICB), and the Full Business case is now with NHS England for review. Upon this being successful, the new organisation will come into being on 1 April 2024, bringing our 12,500 members of staff and considerable clinical and operational expertise together, to best serve our communities. A summary version of the Full Business Case is available here: Full Business Case Summary

While NHS England consider the Full Business Case, our combined clinical and organisational leadership's primary focus is on maintaining safe and continuous delivery of care on day one of the new Trust. In parallel, we are reviewing the strategic priorities for the new organisation, ensuring that we deliver sustainable and equitable outcomes, informed by population need.

We continue to invite stakeholders, including the third sector, community groups and service users to provide their views and inform the development of Hampshire and Isle of Wight Healthcare NHS Foundation Trust. This can be done by contacting project@fusion.hiow.nhs.uk or by visiting www.fusion.hiow.nhs.uk.

Digital Expo

A Digital Expo was organised and hosted in early October so that we can build a strong knowledge and skill foundation in our community, ensuring everyone's voices are heard but also inspiring the future of the Trust. It was a fantastic, collaborative event involving colleagues, exhibitors and speakers.

Celebrating Allied Health Professionals

In October, we recognised, through a press release and other proactive communications, how a dedicated team of Allied Healthcare Professionals and Nurses at Solent NHS Trust was highly commended at the CAHPO (Chief Allied Healthcare Professionals Officer) Awards.

During the same month we ran a virtual AHP conference for the HIOW ICS, with 140 attendees as well as hosting a Solent AHP in-person event which was attended by 100 members of staff.

Mental Health provision expansion

In November we revealed, through a press release and social media posts, that Solent had strengthened its mental health provision for inpatients with Sharon Lewry obtaining Approved Clinician (AC) status, the first Advanced Clinical Practitioner to do so in the Trust's history.

Apprenticeship Team praised

The brilliant work of Solent's Apprenticeship Team won an accolade at the News and Chichester Observer Series Apprenticeship Awards in mid-November. The apprenticeship team took home the title of 'Large Employer of the Year' for their work in supporting over 50 apprenticeships across different areas of the NHS. We shared the achievement across internal and external channels.

NHS Staff Survey

The annual NHS Staff Survey is underway across the Trust and everyone is being encouraged through a variety of different approaches, to share their views and thoughts so that Solent can take that information forward into the future operational and clinical planning.

Section 2 – Internal matters (not reported elsewhere)

There are no matters to flag to the Board which are not reported elsewhere.

Great Care

Safety matters

There are no matters to flag to the Board which are not reported elsewhere.

Great Place to Work

Workforce matters

As part of our on-going change and engagement plan for Project Fusion, we launched the required TUPE Consultation process on 20 November, which will run for a four-week period until 17 December. Briefings and content have been shared with all staff, and we are running separate sessions to include our bank workforce in the proposals.

The BMA continue to ballot their members and we await further confirmation on any future industrial action. Whilst we have seen minimal disruption to our services at Solent, the operational pressure and organisation that is involved during every strike does have a significant impact on our workforce, particularly operational leaders.

The NHS Staff Survey 2023 closes on Friday 24 November, and we are hopeful for another high response rate with current level of completions indicating we will reach our target of 70%, consistent with previous years. The results will be known in February-March and enable us to take forward action plans and specific concerns into the new organisation. We were invited to present at the NHS People Promise Week to talk to our colleagues nationally about our successes in the survey and scoring against the people promise indicators.

Great Value for Money

Estates and infrastructure

New chapter for Jubilee House

We announced that Solent NHS Trust had opened the doors on a modern outpatient facility in heart of a Portsmouth neighbourhood in mid-October. Since Spring this year, restoration and remodelling work has been underway at the former Jubilee House site on Medina Road in Cosham to make the building and overall site ready to receive rehabilitation outpatients relocated from the Queen Alexandra Hospital (QAH) permanently. We liaised with local community members, stakeholders, politicians and members of staff during the move.

Our key risks

Board Assurance Framework

BAF Risk	Raw Score	Residual Score	Target and date
#7 -Demand, capacity and accessibility	L5 X S4 = 20	L4 X S4 = 16	L4 X S4 = 16 By End Q4 2023/24
#4 - Workforce sustainability	L4 X S5 = 20	L4 X S4 = 16	L4 X S3 = 12 By End Q4 2023/24
#1 -High quality safe care	L4 X S5 =20	L3 X S4 = 12	L3 X S4= 12 By End Q4 2023/24
#5 -Financial Constraints	L4 X S5 = 20	L3 X S5 = 15	L2 X S4 = 8 By March 2024
#8- Strategic provision of services	L5 X S5 =25	L5 X S4 = 20	L4 X S3 = 12 By End Q4 2023/24
#6 -Digital maturity	L4 X S4 = 16	L3 X S4 = 12	L3 X S3 = 9 By End Q4 2023/24

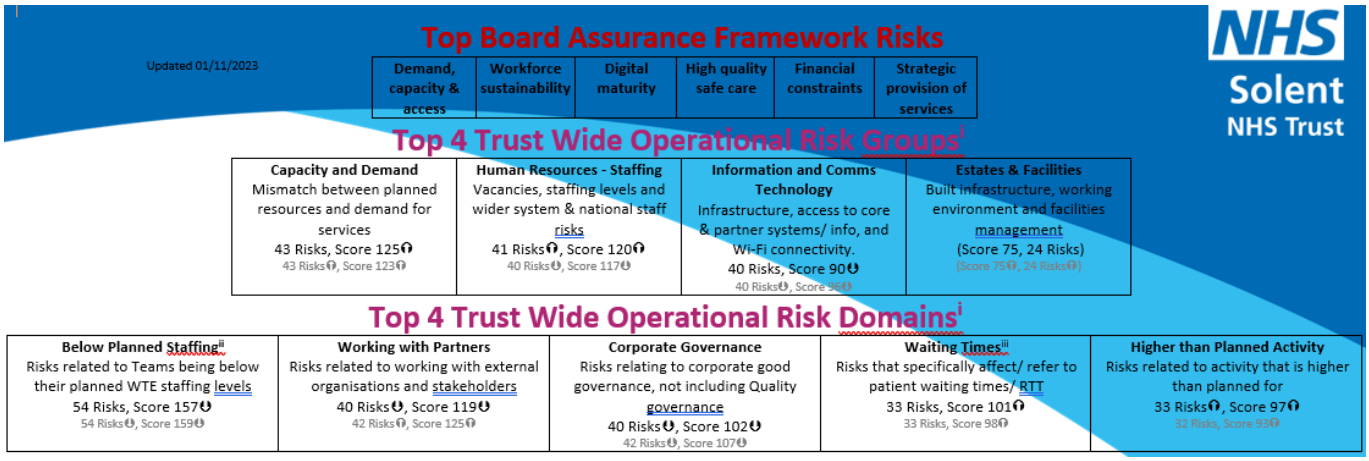
Operational Risk Register

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

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

Our top Risk Domains are:

1. Below Planned Staffing
2. Working with Partners
3. Corporate Governance
4. Waiting Lists
5. Higher than Planned Activity



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

Section 3 –System and partnership working

HIOW ICS

On 22 November, the ICS submitted its revised forecast out-turn as required following the release of funds to cover the costs of the Industrial Action. Organisations that are forecasting a position worse than their plan have been called to a national meeting on 28 November. Solent has remained on plan, although this still contains risks for full year delivery.

There are significant operational issues, with high levels of demand being experienced within UEC at all the hospitals within the system. Solent and Southern are flexing services to help mitigate these increases.

Board and Committee Summary Report

Title of Paper	2023/24 - Business Objectives- 6 Month Progress Update				
Date of paper	14/11/2023				
Presentation to	In-Public Board				
Item No.	8.1				
Author(s)	Rob Earl- Head of Commerical Operations- Programmes and Planning				
Executive Sponsor	Debbie James, Chief Strategy and Transformation Officer				
Executive Summary	This paper details Service Line and Corporate Team Business Objective Update as at September 2023. The paper provides a summary status of business objectives across the Trust, including progress against milestones and metrics. The report provides an overview of business objective monitoring, risk and exceptions/ escalations. Following the October meeting, SPC requested further detail around how the Trust monitors strategies and a further review of objectives, including a deep dive of high-risk objectives. This information is included.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The Committee is asked to review paper and agree recommendations, notably: • Note current position of business objectives across Trust.				
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 Business objectives, which incorporate actions to deliver improvements which impact positively on unwarranted variation and health inequalities.				
Previously considered at	N/A				

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)*	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	Chief Strategy & Transformation Officer							

1 Paper Purpose

Trust Board has requested a month 6 update report on 2023/24 Business Objectives ('objectives'), to be presented at the Trust's December Board Meeting. The Trust routinely gains assurance and oversight of objectives via Month 6 and Year End update reports. In addition, objectives are routinely monitored via Strategy and Partnership Committee (SPC), which may provide ad hoc escalations to Board (by exception). This paper summarises the position of Trust objectives, at September 2023.

2 Background- 2023-24 Business Objectives

As part of the 2023/24 Business Planning process, the Trust agreed 43 objectives, across both clinical services and corporate functions. Each objective was mapped to one (or more) of the Trust's 15 strategic priorities, covering 'great care', 'great place to work' and 'great value for money'. The Trust Business Objectives, as at April 2023, are shown below:

ID	Area	Objective Owner	Objective Name/ Title
ASP001	Adults Portsmouth	Nic Rawlings/ Olivia Marsh	Operational Transformational
ASP002	Adults Portsmouth	Emma Aldred	Workforce capacity and capability
ADS001	Adults Southampton	Katie Arthur	ADS Futures Programme
ADS002	Adults Southampton	Katie Arthur	ADS Futures Programme - Estates issues, Oakley Road and the WCH redevelopment.
ADS003	Adults Southampton	Katie Arthur	ADS Futures Programme - Advancing Practice.
MH&LD001	Mental Health	Abi Clarkson/ Kate Smith	Delivery of the Long Term Plan for Mental Health and Learning Disability Services
MH&LD002	Mental Health	Kate Smith/ Laura George	Continuous improvement of operational delivery in mental health and learning disability services
CND001	Chief Nurse Directorate	Sarah Balchin	Community Engagement for Health Creation
CND002	Chief Nurse Directorate	Aderemi Aderibigbe	Improve Patient Safety Culture
CND003	Chief Nurse Directorate	Sarah Balchin	Improving Practice through Learning
C&F 002	Children & Families	Richard Brown/Mia Wren	Transformation and change in CAMHS services
C&F004	Children & Families	Richard Brown/Mia Wren	CCN embracing new ways of working to maximise virtual delivery/virtual wards
COMMS001	Communications	Bex Tarrant/ Andrea Hewitt	Build new website and intranet for new community, mental health and learning disability trust.
SCDS 001	Dental	Lisa Dugan	Delivery of Recovery Plan as part of a reset and rebalance exercise
SCDS002	Dental	Hayley Wagner	Place Based Review Action Plan
E&FM001	Estates and Facilities	Mark Young	Reduce Bank and Agency Usage
E&FM002	Estates and Facilities	Mark Young	Deliver <15:1 staff to floor ratio
E&FM003	Estates and Facilities	Mark Young	Deliver a Carbon Reduction & Estate Infrastructure Roadmap
FIN01	Finance	Vicky O'Leary	Future Focus Finance Level 2 Accreditation
FIN02	Finance	Vicky O'Leary	Implement new reporting and planning tool and review processes.
ICT001	ICT/Digital	Dawn Day	Full replacement of network and user devices
ICT002	ICT/Digital	Gareth Banks	Assess and deploy new SystmOne tools

ID	Area	Objective Owner	Objective Name/ Title
ICT003	ICT/Digital	Gareth Banks	Expand Intelligent scheduling within SystmOne
ICT004	ICT/Digital	Dawn Day	Recover costs associated with provision of service to partners
IG001	Information Governance	Sadie Bell	Implementation of: 1. the cyber security elements and 2. Information Management elements of the Trust's Information Management & Cyber Security Strategy
IG002	Information Governance	Sadie Bell	Completion of IG requirements and considerations of Digital Security, for all new projects, systems and changes, as part of the Trust's digital transformation objective
MM1	Medicines Management	Arjun Grewal/ Jennifer Winfield	Widening partnership working in Primary Care (Southampton and Portsmouth City)
MM2	Medicines Management	Arjun Grewal/ Jennifer Winfield	Develop EPMA report suite
MPP001	MPP	Katy Bartolomeo	Understanding demand and maximising capacity across MPP services.
PD01	People	Sorrelle Ford	Headroom & Utilisation Review
PD02	People	Sorrelle Ford	Increase 'productivity' and measure impact of People Directorate
PBI001	Performance & BI	Zoe Pink	Increase usage of Self Service Data Reporting within BI&R
PBI002	Performance & BI	Sarah Earl	Improve Data usage and outputs within Performance and BI
PBI003	Performance & BI	Zoe Pink	Reduce and eliminate post PaaS backlog
PC001	Primary Care	Terri Russell	Achieving Financial Balance:
R&I001	Research & Improvement	Colin Barnes	Mature QI culture and Capability
R&I002	Research & Improvement	Jo Turpitt	Increase Research Capacity and Participation
R&I003	Research & Improvement	Carl Adams	Increase Partnership working
R&I004	Research & Improvement	Jeni Malpass	Extend Evaluation Hub
SH 001	Sexual health	Toby Lamb/ Kim Henderson	Systems Thinking Revolution - Implement systems thinking methodology to make improvements and efficiencies to the service improving, the patient pathway.
SH 002	Sexual health	Toby Lamb	Preparation for SARC & HIOW Procurement
STC001	STC- Commercial	Suzanne Scannell	Non-pay cost improvement
STC002	STC- Commercial	Suzanne Scannell	Contracts, procurement and PMO competency framework and training offer

3 Redesign of Governance/ Reporting (June 2023)

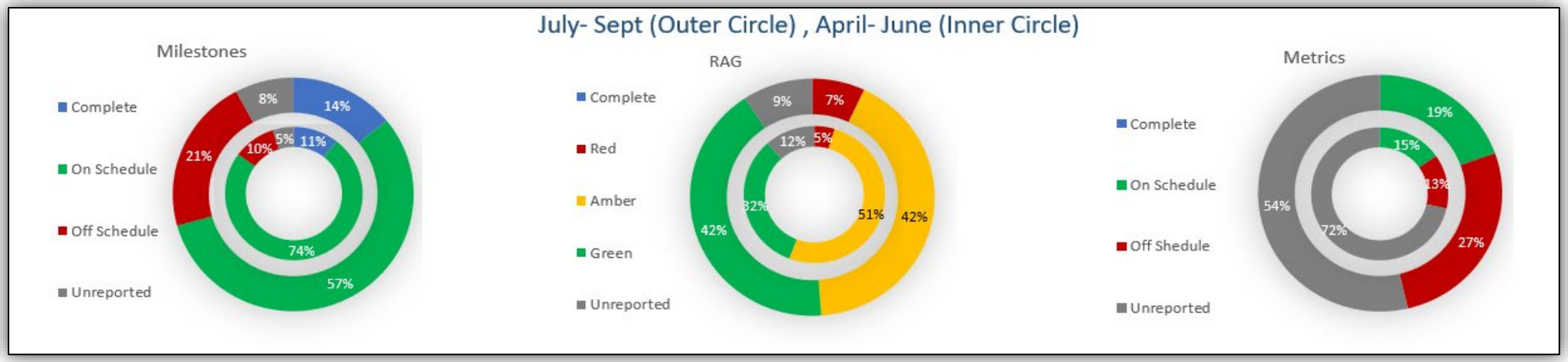
In previous years, monitoring of business objective delivery has predominantly been focused on progress reporting. This year the Trust's Project Management Office (PMO) proposed a refreshed approach to governance (see Appendix A), which includes additional focus on benefits realisation, risk mitigation, performance management and issue resolution. Objectives have been reported to SPC for a number of years, however, in June 2023, SPC approved the decision to introduce an executive led 'support and challenge' function to take place at Performance Review Meetings (PRMs) and Corporate Performance Review Meetings (CPRMs), for service lines and corporate directorates respectively. This provides greater assurance to SPC; ensuring effective reporting of performance, change control and escalations of risks and mitigations. To facilitate this process, the PMO introduced streamlined reporting, including Highlight Reports for completion by objective leads/ PMs, including updates on progress, milestones and metrics. These status snapshots provide information that is timely, useful, objective and accurate. Prior to June 2023 objective updates were obtained via Verto, but this was not mandated, and completion rate by objective owners was low. The Verto system is still used by some services to monitor projects and it also provides an administrative system for Trust committees. As part of Project Fusion integration planning, partners will consider whether the system should be used by the new organisation.

NHS Solent NHS Trust

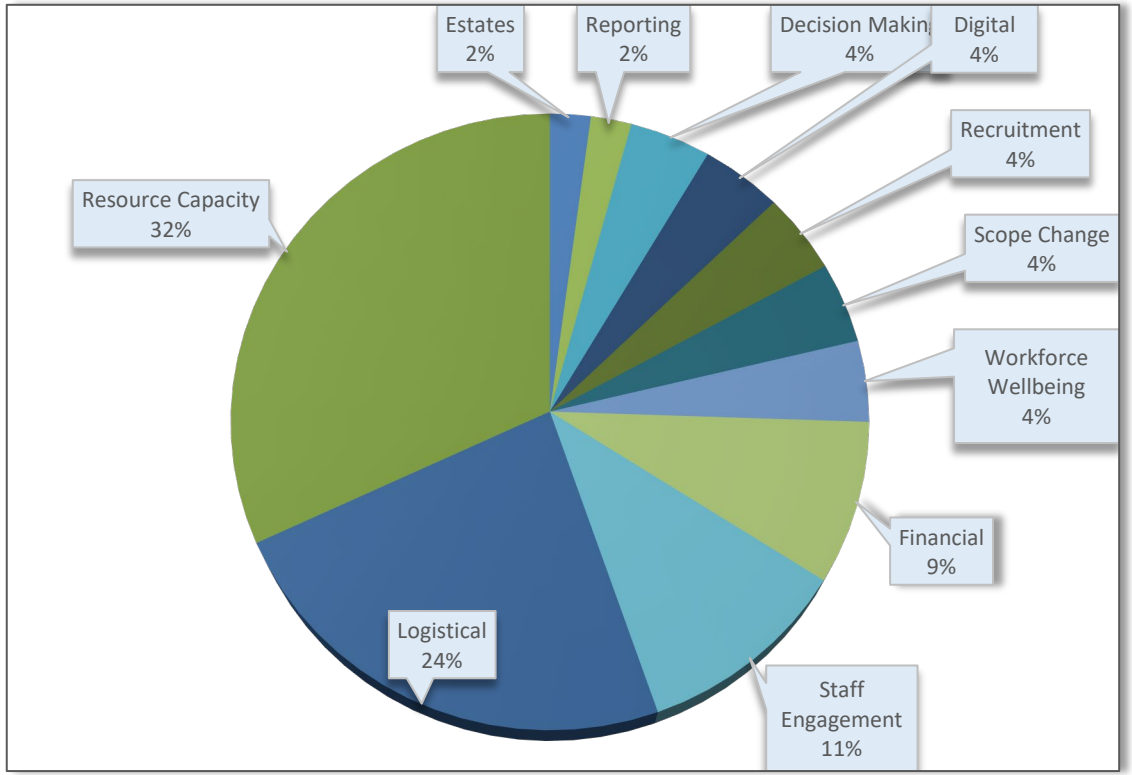
4 Performance – At Month 6 (September 2023)

4.1 Dashboards

	Service Line/Corporate Team	Milestones (191)				Metrics (82)				RAG Status (43)				BO Resource (43)	
		Complete	On Schedule	Off Schedule	Unreported	Complete	On Schedule	Off Schedule	Unreported	Red	Amber	Green	Unreported	PM Identified	OD/ Head
Clinical	Adults Portsmouth		6						4		1	1		2	
	Adults Southampton	4	13	1			1	3	3			3			3
	Child & Family	2	9	1					9		1	1			2
	Dental	2	9	5				2			1				1
	Mental Health	4	15						3			3		3	
	MPP			5				3		1					1
	Primary Care Services		2	1			2				1				1
	Sexual Health	3	3				3	2				2		2	
Corporate	Communication		1	2					1		1			1	
	Digital	3	3	5			2	1	3	1	2	1			4
	Estates and Facilities	2	3	1					4		3				3
	Finance		6	2					5		2				2
	IG		5	4				3			1	1			2
	Medicines Management	6	6				1	2				2		2	
	People	1	4	2				2	2		2			2	
	Performance & BI		11	3			4	2	1		1	2		3	
	Chief Nurse Directorate		8	4			3	2	2	1	1	1		3	
	Research & Improvement				*15				5				4	4	
	STC		4	5					2		1	1			2
		27	108	41	15	0	16	22	44	3	18	18	4	22	21



Risk Classification



4.2 Trend- Milestones, Metrics and Risks and Issues

- Milestones- At month 6, 71% of milestones are shown as 'Complete' or 'On Schedule', which is down from 85% in the previous reporting period. Some of the variance may be attributed to the redefinition and expansion of milestones, which has occurred while plans have been formalised. It is anticipated that milestone numbers will settle for the remainder of the year, which will help comparative reporting. The number of milestones has increased by 51 (36%).
- Metrics- Three objectives have no defined metrics and 27% of all defined metrics are off schedule. This is up from 13% during the last period. 54% of objectives have unreported metrics. There is a need to establish accurate baselines, realistic targets and appropriate end dates. Although this position requires attention, unreported metrics is down from 72% (from the previous reporting period). A further drive to increase metric reporting will be supported by the PMO over the next period.
- Risk- 84% of objectives are recorded as Green or Amber (compared to 83% previously). There are currently 47 risks/ issues reported across all objectives. Risks and Issues have been categorised, with the most common being 'Staff Engagement', 'Logistical' and 'Resource Capacity'. Resource Capacity (32%) is the largest category. The most common causes are quoted as being Project Fusion, BAU pressures and a lack of project management support. This area is considered further under section 5.1 and 5.2.

4.3 Performance Summary (at Month 6)

A number of objectives are far reaching, often incorporating several discreet projects across a given service line/ corporate team. There will be a variety of interdependencies for each project, which may impact achievement of milestones and metrics. Where an objective includes transformation/ review/ redesign of a service there may be multiple external influencing factors (for example, schemes linked to hospital admissions). For the larger scale objectives, it is important that there is sufficient PM resource. It is noted that 52% of objectives have a dedicated or named PM/Lead. The remaining 48% are assigned to the Service Line OD or Corporate Lead. This links into risks around capacity/ resource i.e., the absence of dedicated PMs. There is evidence, through conversations during PRMs/CPRMs, that many services remain under pressure to deliver objectives alongside other commitments.

There are some gaps in the information reported via Highlight Reports, however the position has improved slightly in the last reporting period (with the PMO and Operations Development Team providing support in this area). Incomplete information may mean that there is insufficient assurance, for example regarding mitigating actions/ plans against milestones that are currently behind schedule. The lack of narrative has been challenged during PRM/CPRM meetings. Reporting against meaningful metrics remains a work in progress. The PMO, alongside services and the performance team, will look to improve this area by offering help to owners to quantify appropriate metrics, set baselines and stand-up reporting mechanisms.

5 SPC Feedback and Actions (at October 2023)

Linked to the conversation around objective performance, SPC was keen to understand further detail around how the Trust delivers programmes. The Trust undertakes a range of 'programmes', within service lines, corporate directorates and Trust wide. The term 'programmes' is a catch all for activities that may be identified as being project, programme, change or transformational in nature. SPC previously commissioned a paper (as an action from its July meeting) to consider the current governance associated to existing programmes and how project resource is assigned and prioritised. As an output of SPC's review of this paper, alongside a review of the Business Objectives September Update Report, SPC requested that the following actions be undertaken (and reported to Board in this report):

1. Deep Dive of objectives that are classed as Red, with a high risk of non-delivery (at month 6).
2. Present the current mapping of strategies to committees and to further review how committees currently monitor performance of strategies (falling within its remit).
3. Perform high level review of objectives to consider if any should be stopped, delayed or assigned central PM resource i.e., from the Operational Development Team or PMO.

It was agreed at SPC that the PMO and Operational Development Team would work closer together, recognising synergies between the team and common objectives. In addition, the work performed by the Operational

Development Team would now report through SPC (as previously not sighted by a committee). Progress against the above listed actions is summarised below:

5.1 Deep Dive of Business Objectives

Three business objectives are RAG rated as red (as at September 2023). Additionally, there is one amber rated objective that has been included in the deep dive, due to having reported two high risk issues (at scores of 25). The PMO has consulted with the relevant objective owners/ service leads, alongside relevant corporate teams (including Performance, BI and Commercial) to further understand the reasons behind the performance issues, review appropriateness of reporting, consider additional project management support and provide recommendations/ next steps.

5.1.1 Digital (ICT004)

Title	Recover costs associated with provision of service to partners.
Description	We will implement commercial arrangements to recover costs associated with provision of service to partners.
Month 6 status (per highlight report)	*"This objective has been discussed with our commercial partner, and advised that usually 6 months' notice, before start of the financial year, is required to cross charge for activity. Reported in project as low likelihood of delivery and not covered in the planned savings. To note, the Trust receives income of £40,000 for telephony which was not planned or forecast so is a benefit"*

The objective is to recover additional costs associated with services that the ICT directorate provides to partners and third partner organisations. At the beginning of the planning process, it was estimated that the Trust would be able to recover circa £60k, however a detailed breakdown of costs per supplier was not produced at the time.

The above highlight report references £40k of unexpected income received for telephony; upon further investigation it has been determined that this income is separate to the original estimate (and deemed outside scope). Additionally, our Specialist Contracts Manager and Commercial Lead has confirmed that it should be assumed that the 40k has cost associated to it and therefore, at best, would only be cost neutral (i.e., not an additional income). It was noted that this objective does not form part of the Solent Digital CIP plan for 23-24.

In terms of the potential for income recovery, there may be the option to recoup from third party organisation for their use of Microsoft licencing. However, a substantial proportion of this value is assigned to SHFT. In light of Project Fusion, ICT have suggested that we will be unable to pursue this element. For existing agreements, where we may be charging for some costs (albeit not full costs) we would need to consider variation timescales necessary to inform supplier of additional costs. It is recognised that if Solent adopts an approach of recovery with partners, then this may encourage reciprocal behaviours. It is likely that this may incur greater cost than the intended savings.

PMO Recommendations

- ICT review of realistic recovery potential across suppliers.
- Risk/Issues to be included and managed via highlight reports and the established CPRM support and challenge process.
- It is understood that at the end of the 23-24 planning year, some costs may be a valid stream of income, and therefore this should be included in 24/25 CIPs plans (and monitored via Financial Recovery Board).
- Objective to be downgraded to Amber if mitigations or rescoping takes place after further analysis and benefits review by the Digital team.
- Subject to above actions, consideration to be given to whether Business Objective remains valid and achievable.

5.1.2 MPP (MPP001)

Title	Understanding demand and maximising capacity across MPP services
Description	Roll out demand and capacity tool in MSK, POD and Pain. Undertake demand and capacity modelling for SPA and Admin.
Month 6 status (per highlight report)	*"MSK physio – live data added to tool however data is not reliable and still mostly manually driven and so easy for mistakes to occur – not the resource or expertise within analyst team dedicate to finding the solution. Roll out paused to other areas until decision around resourcing of the demand and capacity tool is reached – the MSK team are hugely supportive of the impact that this will have and would like to continue with this work."*

The key deliverable of this objective is to initiate a demand and capacity process/tool that will enable the service to anticipate and react to demand and ensure that capacity is efficiently managed to meet this. The project involves the service working with corporate colleagues from Performance and Quality Improvement to ensure that process and data is maximised to create an agile approach to patient demand.

Following conversations with Performance Team colleagues the current situation is:

- MSK data is functioning and is routinely updated now with demand data. The service then facilitates the capacity element and determines how they will respond to the data.
- East and West Physio data feeds are complete. Specialist MSK is being worked through with the MSK Specialist Lead.
- Podiatry and Pain do not currently have a D&C model. This is being worked through by the Quality Improvement Methodologist leading the demand and capacity workstream for the Trust. Workshops have been attended by the Podiatry and Pain services to map D&C models.
- Data Quality and validating workstreams are conducted outside of the modelling process and is a BAU function within the Performance Team.

PMO Recommendations

- Risk/Issues to be included and managed via highlight reports and the established CPRM support and challenge process.
- The Project Plan is to be updated, ensuring that dates, progress and narrative updates or mitigations are completed to ensure a complete summary is provided to PRM (and onward reported to SPC). PMO will work with MPP and Performance Team to ensure a detailed plan is in place.
- Subject to a refreshed project plan, the objective may be downgraded from Red to Amber/ Green.

5.1.3 Chief Nurse Directorate (CND001)

Title	Community Engagement for Health Creation
Description	Community Engagement for Health Creation
Month 6 status (per highlight report)	*"Escalations* *-Significant resources required to progress Project Fusion which is having an impact on wider portfolio delivery. Driven from Solent perspective and taking approx. 50% of each Senior leads time. Limited resources available from partners due to other pressures with likelihood of reducing further.* *-Southern have not yet used the Band 8a backfill funding – requested plan for this funding as could be used elsewhere.* *-Increasing number of requests from across Trust for CE input – limited ability to respond reference above.* *-Inclusive Communication: No budget available and project cannot be delivered without sufficient resource. Risk reported and escalation to CND and CPR. Finance aware and working with team to resolve".*

The PMO has worked with the Director for Community Engagement and Experience and jointly determined that this objective, in retrospect, should have been reported as Amber during month 6. Following some progress in key risk areas of the plan, the RAG rating will be reduced to Amber (At risk or experiencing obstacles – Mitigation in place) by the next PRM reporting period in November.

Due to increased demand by Project Fusion, some community engagement BAU functions have required PF funding to offset and provide resource. This also encapsulates community engagement work that is not currently being provided by SHFT due to their lack of capacity. This new available PF funding had previously been allocated to SHFT but had not been utilised. However, capacity is still not at required levels to respond to all Solent service line requests. This will be reviewed in January.

The impact of the removal of funding to support accessible information/inclusive communication activity is being reviewed by the Chief Nurse to assess resource requirements. The risk to resourcing and funding arrangements have been added to the CND Risk register to be monitored within the Directorate.

The following Issue has been raised via the PRM Highlight Report. NB. Risk scores reflect the deliverability of the Objective and not always correlate with Trust level scoring and scalability.

- *Risk 1 - Project Fusion – Description - Resources required to ensure delivery is high. Risk that delivery CE wider portfolio impacted. Mitigation - Regular monitoring of delivery and reporting/ escalation framework in place, Likelihood - 2 Possible, Impact - 4 Major, Score 8.*

PMO Recommendations

- New risk to be added concerning Inclusive Communication relating to staffing. This will mirror the existing red risk on CND risk register with the intention of providing oversight/awareness in separate forums.
- Existing Project Fusion risk to remain unchanged.
- RAG to be downgraded to Amber by next reporting period.

5.1.4 Dental (SDS001)

	Title	Delivery of Recovery Plan as part of a reset and rebalance exercise - The Place Based Review
	Description	Develop and deliver a comprehensive action plan to inform a Place Based Review for Specialist Dental Services for HIOW. Achieve a levelling out across dentistry to ensure equality of waiting times for assessment and treatment for paediatrics and adult services - Measured by improved trajectory of backlog and wait times, with comprehensive review of referral and discharges process to ensure robust incremental improvements in performance against key indicators that can deliver sustainable services in line with population need. Re-launch of service as a centre of excellence - diverse effective and responsive, underpinned by joint service and commissioning arrangements measured by contract variations that will inform service suitability and preparedness for re tendering.
	Month 6 status (per highlight report)	*"Escalations* *Lack of IT connectivity across some of our non-Solent sites is hampering our ability to see patients and is adding to our waiting times as patients are cancelled last minute due to IT Failures.* *Local workarounds and BCP are being followed however they are open to incident with increased risk to staff and patients. Clinics are becoming difficult to maintain without radical intervention and a key plan to resolve.* *Cancellation of GA lists due to strikes and issues around change in weekend pay for hospital staff.* *Further resignations in service or ask to reduce hours."*

The above Dental Objective was reported as Amber following some rescoping work in partnership with the Operational Development Team. It has however been included as there are significant risks to delivery with two issues being scored as 25 indicating an extremely likely and critical failure.

The following Issues have been raised via the PRM Highlight Report. The risk score considers the risk or issue related to delivering the Objective and are also present on the Trust Risk Register as they effect general service delivery.

- *Risk 1 - Workforce Issues. Description - Workforce Vacancy factor rising / long and short-term sickness impacting. Mitigation - Staff wellbeing affected. On-going HR investigations, Comms and HR recruitment plan now in place. Advert with BDJ now live. Local roadshows across all localities booked for the week of the 25 – 28 September. Likelihood – Extremely Likely 5. Impact – Critical 5. Score 25.*

- *Risk 2 - IT Connectivity. Description - Lack of consistent IT connectivity across our non-Solent sites. Mitigation - Local workarounds and BCP are being followed, however they are open to incident with increased risk to staff and patients. Clinics are becoming difficult to maintain without radical intervention and a key plan to resolve. Likelihood – Extremely Likely 5. Impact – Critical 5. Score – 25.*

Rescoping work is being completed by the Dental Service, with support from the PMO and the Operational Development Team. This is being conducted in a phased approach to:

- Define 'Where are we now' - Intended to understand current Waiting List levels, number and reasons for DNA appointments and safe staff levels to provide service.
- Create initial plans for improvement on the above.
- Build a long-term strategy to move forward and tackle issues identified in bullet one.

The first two milestones of the Programme plan under the heading of 'To work with BI team to deliver Capacity & Demand Modelling' are now 6 months late and continue to be worked on. All other tasks and milestones are in progress and working to schedule. PMO has liaised with the Dental Analytics Lead and noted that the Performance team is still working on the ability to have bespoke dashboards per clinic/locality. This will require all R4 Information to be available in PowerBI and they are working alongside the Business Intelligence Team to implement this in the data warehouse. Work also continues between Performance and the Dental Business Manager to create a list of their requested reports in PowerBI ready for when data is available so bespoke dashboards can be created. The Performance Team has also been working with the BI team to ensure Contacts reporting in PowerBI is meaningful for Dental. This requires focussed BI work as Contacts reporting is historically configured to report SystmOne data. This has now been done and will be further refined as the service finalises what is required in reports/dashboards. Work continues to incorporate Case mix (classifications used to describe NHS healthcare activity in England) and UDA (Units of Dental Activity) data.

The PMO has reviewed the Issues with the Dental Operations Director, and the scoring for them will remain as permanent mitigation efforts are still open to problems. The issues are listed on the Trust Risk Register and are scored - Workforce 15 and IT Connectivity 12. It is common for Project risks to be higher than those listed on the Trust Risk Register as the scale of the scoring is not equal. The Operations Director will continue to manage and raise awareness through the correct channels.

PMO Recommendations

- At the request of the Dental Operational Director, risk scores are to remain at their current level. The risks are also visible in other forums and will continue to be raised at reporting opportunities.
- Redefined Milestone dates for Business Intelligence activity to be brought to next PRM in Dental highlight report with supporting information/progress.
- Expand 'Demand and Capacity Modelling and Dashboard Creation' tasks and milestones in partnership with PMO, Operational Development Team, Dental Analytics Lead and Dental Business Manager to provide greater oversight and detailed reporting of progress.
- Further conversation at PRM to consider whether objective should be RAG rated red.

5.1.5 Summary

Two of the Red RAG rated objectives within this report are likely to be downgraded, which should provide a slightly better position than reported initially at SPC. The overall position on business objectives will improve if the recommendations of this report are implemented. All objectives within this Deep Dive will continue to be monitored closely by the PMO, which will work closely with key stakeholders to reduce risks associated to delivery.

5.2 Strategy/ Committee Reporting

The Trust has a number of strategies, frameworks and standalone programmes of work, which report through to Trust committees. Each strategy incorporates its own delivery plan. The PMO initially worked with former Chief of Staff to map the reporting of strategies to Trust Committees.

5.2.1 Review of strategy reporting

The current position is the output of a review of TORs, agenda cycles and conversations with committee administrators:

Strategy/ Framework / Area	Current position
Strategy and Partnership Committee	
Business Planning/ Objectives Strategic Priorities- Delivering Commitments Project Fusion (PF)	- Terms of reference (TOR) confirm SPC duties include the implementation of the organisation's strategy and supporting enabling strategies, including monitoring of the Trust's strategic priorities and strategic transformation programmes. - SPC receives bi-monthly objective performance reports. - ICS strategy and Business Planning updates provided to SPC as required. - Progress updates regarding Project Fusion are a standing item on the current SPC agenda. - Operational Development Team transformation projects will be reported through SPC from December 2023.
Audit and Risk Management Committee	
Risk Management Framework	- The Risk Management Framework is not explicitly mentioned in TORs; however, it has been confirmed that the framework is presented to committee every two years (per agenda cycle).
Finance and Infrastructure Committee	
CIPs/ Finance Recovery Board Estates Strategy Financial Strategy Digital Strategy	- The TORs include reference to monitoring of the development and implementation of relevant elements of the Trust's Strategy specifically covering, Information Technology, Estates, Finance (CIPs) and Procurement. It recognises that primary responsibility for the monthly monitoring and review of the Trust's financial performance rests with the full Trust Board - Financial Recovery Board (FRB) will formally report to F&I from Oct 2023. - Estates Strategic Plan is monitored at Estates, Facilities and Sustainability Group (EFSG), with exception reporting via F&C or F&I (depending on value/ risk). - Procurement Strategy is reported annually to F&I (per agenda cycle).
People Committee	
People Strategy Diversity & Inclusion Strategy Comms Strategy	- People Strategy and Comms Strategy is referenced in TORs; however, D&I is not included explicitly. - Clarification required whether Comms Strategy now reports directly to Board or by escalation via People Committee.
Quality Assurance Committee	
Community Engagement Strategy Freedom to Speak Up Strategy Learning Disabilities Strategy Research & Improvement Strategy	- Learning Disabilities Strategy, Research and Improvement Strategy and Quality Improvement Projects are referenced in TOR, however Community Engagement Strategy and Freedom to Speak Up Strategy are not mentioned. - The Medicines Management Group (MMG) report bi-monthly to QIR, who report to QAC on items to escalate and complete an annual medicines management report. MMGs remit is to provide strategic advice and determine local strategy for medicine related clinical governance & medicines optimisation. - LD Strategy Implementation update via QIR annually. - Exception reports from CNO and COO highlight items to escalate from Quality Improvement and Risk (QIR) Group. - Scheduled reports received from the various annual programmes including: - Experience of Care, including community engagement and complaints.

Quality Improvement projects Medicines Optimisation Strategy	- Research & Development including Clinical Audit & Effectiveness and Quality Improvement. - Learning Disabilities Strategy updates. - Freedom to Speak Up.

5.2.2 Proposed next steps

A list of proposed next steps is shown below. We will need to consider how this work may link into the integration work already being undertaken by the Project Fusion Corporate Governance Steering Group:

1. Committees to review mapping and current position for completeness and accuracy.
2. TORs to be updated to explicitly reference reporting requirements linked to strategies/ frameworks etc (where not currently shown).
3. Inclusion of strategy/ framework reporting as a regular item within existing committee agenda cycles, including clarity around expectations e.g., potential for consistent reporting format/ approach.

5.3 Review of business objectives and reprioritisation of project resource.

Section 4 of this paper references the most commonly sighted performance issue as resource capacity. Currently, project resource may be provided by dedicated 'project' staff or 'non- project' staff (i.e., as an additional 'bolt on' to core remit). Project resource is provided from within specific service lines or 'assigned' from a central repository, although there is not an agreed prioritisation/ assessment methodology to consider which projects (and objectives) have central oversight. There is no one line of sight across all projects. The Operational Development Team undertakes a number of projects, including some business objectives. A review is being undertaken of all current and pipeline projects being managed by the team, to ensure work being delivered is transformational.

The specific action from SPC was to consider whether we cease, delay or assign resource, however subsequent conversations with the Deputy COO, responsible for the Operational Development Team, recognised that there may be some transformation capacity that may be assigned to support achievement of objectives. Accordingly, rather than make a judgement on changing the business objectives, which may or may not release capacity, the Deputy COO and PMO will work with services/ corporate functions to offer resource (in the first instance). Those objectives that require resource will be considered on a prioritisation basis, recognising that the team will not be able to respond to every ask. The initial offer will be made through PRM/ CPRMs falling due in November.

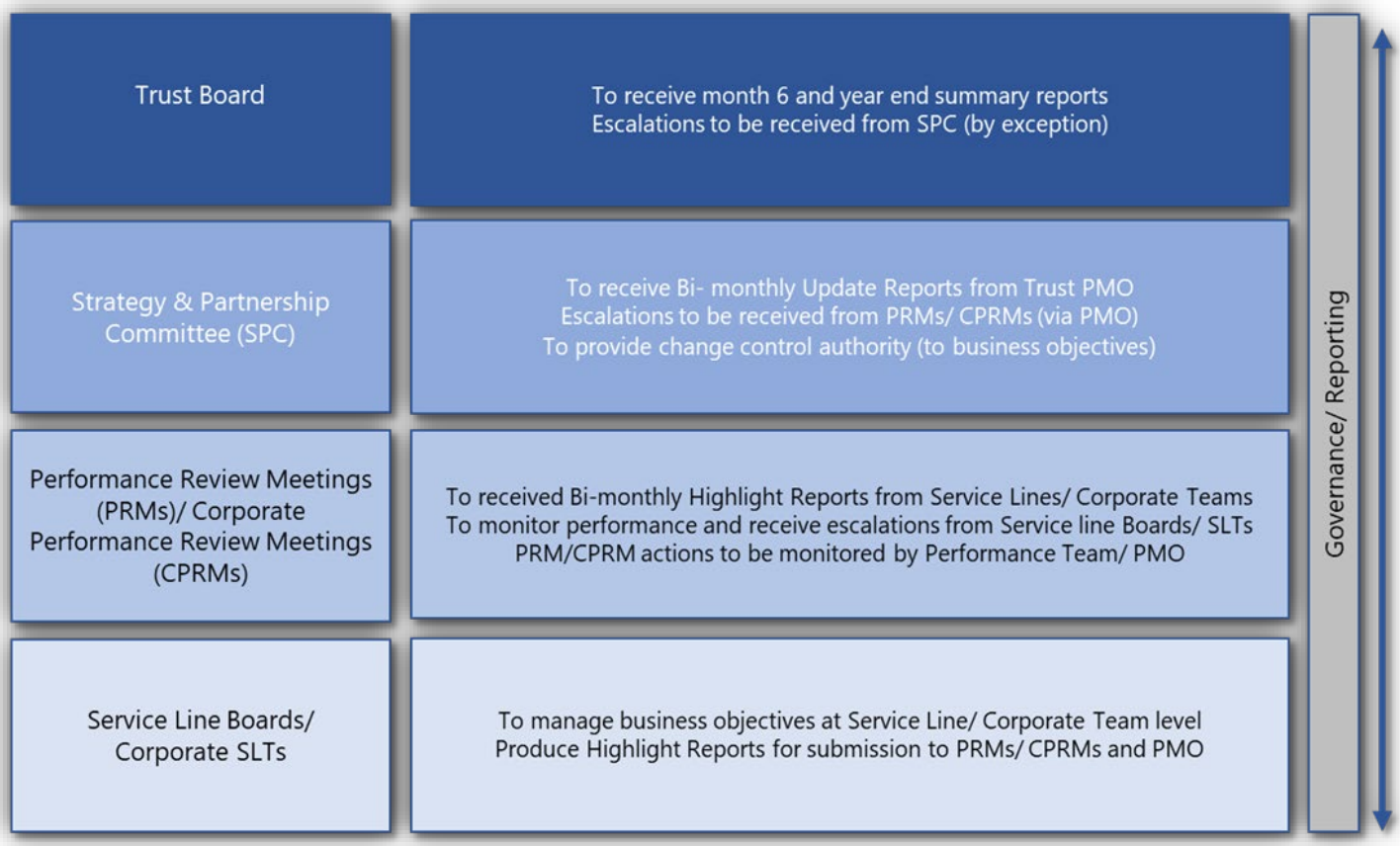
6 Conclusion

At month 6, annual business objectives should be fully embedded within service lines/ corporate directorates, with clear progress being made against milestones/ achievement of metrics. This report describes performance issues which may lead to non or late achievement of objectives. Issues are multifaceted and not unique to 2023/24. Planning engagement has its challenges and business objectives historically have been deprioritised against competing workstreams. Objectives may be far reaching and influenced by both internal and external factors. Capacity, availability of project management expertise and competing demands due to operational pressures and Project Fusion, are cited as common constraints, which are not easily resolved in the short/ medium term. The effectiveness of reporting has improved by the introduction of highlight reporting (including escalation of risks) and the 'support and challenge' functions provided by PRMs/ CPRMs.

The PMO will continue to work with service lines/ directorates to further understand the blockers on individual objectives and consider the impact of non-delivery. Where appropriate, the Operational Development team resource will be prioritised to support specific objectives (where the greatest benefit can be derived). Where objectives may no longer be relevant (e.g., where benefits are not anticipated to be realised), then it is recommended that those objectives are closed through a formal sign off process. SPC will continue to receive regular reports on progress against business objectives, including regular deep dives on high risks areas.

APPENDIX

A. Governance and Reporting Structure



Title of Paper	Information Governance & Data Security Compliance Report 2023/24 Interim Report				
Date of paper	11th November 2023				
Presentation to	Trust Board				
Item No.	9				
Author(s)	Sadie Bell, Head of Information Governance & Digital Security / Data Protection Officer				
Executive Sponsor	Nicola Burnett – Chief Finance Officer / 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 current position for 2023/24 Data Security Protection Toolkit 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 for the remainder of 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					

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	 Chief Finance Officer							

Information Governance & Data Security Compliance Report 2023/24 – Interim Report

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 **2023/24 Toolkit:** The publication of the 2023/24 DSPT, operates for the period July 2023 – June 2024; however due to Project Fusion, the Trust is required to submit its DSPT by the 31st March 2023. The Trust is also required to submit its baseline submission on the 28th February 2024.

Change Summary: This year's DSPT consists of

- 34 Assertions
- 108 mandatory evidence requirements
- 26 non-mandatory evidence requirements

There are minimal changes within the 2023-24 DSPT. The changes include:

- Key IT Suppliers and Operators of Essential Service under the Network and Information Systems (NIS) Directive now should completed.
- Evidence items have been rationalised where they are now considered 'business as usual' or where there is overlap between evidence items.
- Specific improvements on multi-factor authentication have been included to reflect updated policy.
- The staff training requirement has been changed to allow larger organisations more flexibility on how it is delivered.
  - 2022/23 Assertion: *"Staff pass the data security and protection mandatory test."*
    Measured by: *"At least 95% of all staff have completed their annual Data Security Awareness Training…"*
  - 2023/24 Assertion: *"Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training and awareness."*
    Measured by: *"Your organisation's defined training and awareness activities are implemented for and followed by all staff."*
- 37 mandatory evidence requirements have had updated wording and / or guidance.
- 7 previously mandatory evidence requirements have been removed. Reference numbers below related to the 2022/23 DSPT.

- 4 **NEW** mandatory evidence requirements
  - 3.1.2 – Your organisation's defined training and awareness activities are implemented for and followed by all staff.
  - 3.1.3 – Provide details of how you evaluate your training and awareness activities.
  - 3.2.2 – Actions are taken openly and consistently in response to information governance and cyber security concerns.
  - 3.2.3 – Your information governance and cyber security programme is informed by wide and representative engagement with staff.

Breakdown of the work required:

	Mandatory	**Non-mandatory**
No. assertions (top level requirements)	32	2
No. requirements (these sit under the assertions, break the assertion down into sections)	108	20

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 March 2024.

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

Compliance Status	**No. Requirements**
Compliant	57
Compliant (non-mandatory)	5
Compliant, but require some additional work, in order to strengthen compliance	9
Compliant, but require an annual review	14
Evidence to obtain / compliance to be confirmed	25
Non-compliant (newly mandatory or changes to requirement compliance)	3
Non-mandatory	15

3. Summary of Information Governance's Legal Requirements Compliance (Freedom of Information and Subject Access Requests) Q1 & Q2 Compliance 2023/24 * as of 11th November 2023

Concerning	Summary
SARS	• There was a 11.5% increase in the number of requests received, when comparing Q1 & Q2 2022/23 to Q1 & Q2 2023/24 • Overall compliance in 2023/24 to date: 97%, which is above the mandatory compliance rate of 95%. Each quarter met the mandatory compliance rate. • Currently 51 requests (Q2) have not been released, however they are also currently not due to be released (legal deadline); therefore, figures are subject to change.
FOIs	• There was a 12% increase in the number of requests received, when comparing Q1 & Q2 2022/23 to Q1 & Q2 2023/24 • Overall compliance in 2022/23 to date: 97.7%, which is above the mandatory compliance rate of 95% and higher than last years compliance rate of 94.2%. Each quarter has met the mandatory compliance rate. • Sessions continue to be 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	• The Trust continues to see a year-on-year increase in the number of requests received • The Trust is maintaining compliance above the 95% mandatory compliance rate

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

4. Information Governance/Security Incidents 2023/24 (Q1 & Q2) Deep Dive

4.1 ***IG Incident Summary 2023/24 (Q1 & Q2)***

Concerning	Summary 2023/24 (Q1 & Q2)
No. Incidents reported	• 337 Information Governance Incidents were reported during Q1 & Q2 • 113 (33.5% 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. • 224 incidents, within Solent NHS Trust's control were reported within this reporting period

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 (68)
	  ○ PID sent to wrong person / address (62)

Important to note	• The IG Team has recently undertaken some service engagement with regards to PID in wrong record / record error and have since circulated some learning outcomes to all services. • The Trust currently has two IG incidents being reviewed by the ICO.

Type of Incident	No of Incidents Report April 23 – September 23
PID in Wrong Record / Record Error	68
PID Sent to Wrong Person / Address	62
Other IG	36
Inappropriate Access / Disclosure	20
PID Saved / Stored Insecurely	17
Non-Encrypted Email Used for PID	10
PID Found in Public Place	8
Lost / Missing PID	2
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"

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.

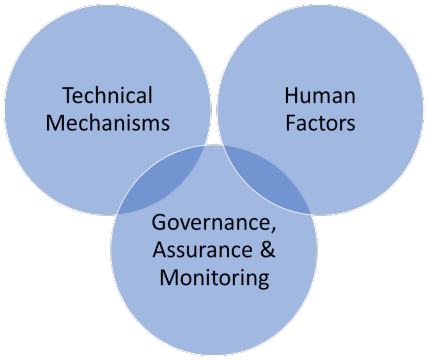
5.2 As part of this journey the Trust has established an Information Management & Cyber Security Strategy, which is a sub-strategy of the Trust's Digital Strategy. This strategy has outlined several key deliverables and achievements.

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



Since the Boards last Cyber Security Update in October 2023, the following elements have been implemented and / or commenced.

Technical	Human Factors	Governance & Assurance
• Updating of Window's Operating Model from 20H2 to 22H2 – all outstanding non-InTune laptops and desktops are to be updated to the latest operating model, to bring all devices back into full security patching support. ***Commenced*** • InTune project will continue to swap out old devices, with new devices, improving software and patching compliance. ***Ongoing*** • Remaining firewalls, not currently in security support and to be addressed by Atos. ***Commenced*** • Implementation of the remaining IT Health Check recommendations and Pen Test Vulnerability actions (pending risk assessments). ***Ongoing*** • Turning NAC from monitoring mode to preventative mode. ***Commenced***	• The Information Governance Team produced a cyber security communication plan, which will increase staff communications and learning being cascaded to staff, advising of common cyber-attacks and counter fraud alerts; with a clear process now in place to communicate such alerts efficiently and effectively. It is planned to both supports, educate can protect staff in both their professional and personal life against cyber security attacks and fraud. Bringing learning into all aspects of their lives, with the intention of making this learning part of their lives and not something they only have to think about at work. ***Commenced*** • Trust is currently working with NHS England to utilise a phishing simulation tool provided by them. ***Commenced***	• Continual vulnerability management assessments to be undertaken by the Trust's Cyber Security Manager and managed / monitored until resolved. Inclusive of monthly cyber security dashboard assessment. ***Ongoing*** • Cyber Essentials Plus Gap Analysis is to be completed in September 2023. ***Commenced*** • Continual progression of the Trust's access control projects. ***Ongoing*** • Continual in-depth assessment of the cyber dashboard to understand Solent's 'exposure' score has commenced. ***Ongoing***

6. Top Three Security Risks (Taken from the November 2023 SIRO Risk Register (Cyber security, IG, ICT and Information Management))

1. **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.

   Update: Action was confirmed as resolved on the 9th November 2023.

2. **Risk 1627: Lack of Network Access Control (NAC) in Place. (Score 10 – Active Risk):** Without NAC in place there is a risk that a malicious individual could plug a device into the network causing unknown damage. NAC has not been implemented within the environment on a monitoring only status. The Trust's ICT contractors are currently working to implement this.

3. **Patching & Cyber Security (Score 10 – 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. The Trust Cyber Security Manager is focused on assessing, monitoring and addressing the Trust's Cyber Exposure Score.

7. 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 11th November 2023

Subject Access Requests – Quarterly Breakdown

	2022/23				2023/24	
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
No. requests received	287	315	252	317	303	368
No. requests responded to within 21 days (best practice)	221	245	208	270	259	288
No. requests responded to within mandated timescale (one calendar month)	51	62	33	42	30	21
No. breaches within (legal deadline)	15	8	11	5	14	8
% Compliance – Legal Requirement (approx. 30 days)	94.8%	97.5%	95.6%	98.4%	95.4%	97.5%
Not Due	-	-	-	-	-	51

Freedom of Information Requests – Quarterly Breakdown

	2022/23				2023/24	
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
No. Requests	83	118	107	127	110	115
No. Responded within 20 working days	82	112	97	119	108	108
No. Breaches	1	6	10	8	2	3
% Compliance – Legal Requirement (21 days)	98.8%	94.9%	90.7%	93.7%	98.2%	97.3%
No. Not Due	-	-	-	-	-	4

Title of Paper	Board Assurance Framework
Date of paper	16 November 2023
Presentation to	In-Public Trust Board
Item No.	12
Author(s)	Michelle Carstairs, Finance and Performance Business Support Manager
Executive Sponsor	Andrew Strevens, CEO

Executive Summary

The Board Assurance Framework (BAF) forms part of the Solent NHS Trust risk management process to assure the Board that any risks that may jeopardise the achievement of the Trust's strategic objectives are identified and being effectively managed.

The BAF is a live and dynamic document and is:

- Reviewed and updated monthly by the relevant Executive Lead.
- Presented to the overseeing Committee of the Board at every meeting.
- Summarised within the CEO report, presented to the In-Public Trust Board meeting.
- Presented, in full, to Trust Board three times per year.

The latest summary of all BAF entries is as follows:

BAF Risk	Raw Score	Residual Score	Target and date
#7 -Demand, capacity and accessibility	L5 X S4 = 20	L4 X S4 = 16	L4 X S4 = 16 ↑ By End Q4 2023/24
#4 - Workforce sustainability	L4 X S5 = 20	L4 X S4 = 16 ↑	L4 X S3 = 12 ↑ By End Q4 2023/24
#1 -High quality safe care	L4 X S5 =20	L3 X S4 = 12	L3 X S4= 12 ↑ By End Q4 2023/24
#5 -Financial Constraints	L4 X S5 = 20	L3 X S5 = 15	L2 X S4 = 8 By March 2024
#8- Strategic provision of services	L5 X S5 =25 ↑	L5 X S4 = 20 ↑	L4 X S3 = 12 ↑ By End Q4 2023/24
#6 -Digital maturity	L4 X S4 = 16 ↓	L3 X S4 = 12	L3 X S3 = 9 By End Q4 2023/24

Action Required	For decision?	Y	For assurance?	N

Summary of Recommendations

The In-Public Trust Board is asked to

- Note the updated scoring, following a recent executive review.
- Agree that the Board Assurance Framework reflects the current key risks to Solent NHS Trust, or otherwise.
- Note the current BAF entries with a residual risk of ≥12 and confirm assurance on the mitigations underway to ensure risks are effectively managed to their target risk score, or otherwise.

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

Previously considered at	Each risk entry is overseen by the respective Committee of the Board.

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)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance, the In-Public Trust Board is asked to consider whether this paper provides: Sufficient, assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature	Andrew Strevens, CEO							

Role of the Board

The Board has a key role in respect of the BAF, ensuring it is appropriately engaged in the development, maintenance and scrutiny of the framework to ensure the Trusts principal risks are appropriately recognised and actively mitigated. The Board also has a responsibility to ensure that the BAF is a meaningfully embedded tool and is utilised appropriately in driving the agendas for the Board and overseeing committees of the Board.

The Board should consider the following in respect of the BAF:

- Whether there are any specific **reputational risks** to the organisation (reputational risks can severely compromise the Board)
- The **status of and reliability of assurances** provided in respect of the risks articulated and their associated mitigation plans
- Whether in respect of the **highest scoring strategic risks ≥12**, **appropriate focus and resource is being allocated** to mitigate the risks to a tolerable level, and
    - whether any additional action (further/faster) could be taken
    - whether additional scrutiny/oversight is required via the 'Overseeing Committees'
    - whether the Board has any role in supporting any escalations in respect of these risks

Current position and matters to note

Contemporary Updates

The full BAF is included within Appendix 1, with amendments for October and November 2023 highlighted as indicated; these include updates to raw/residual/target scores, following an executive review in November 2023. A summary of BAF scoring and updates is provided below.

BAF Risk	Raw Score	Residual Score	Target Score
Demand, capacity and accessibility #7	L5 X S4 = 20	L4 X S4 = 16	L4 X S4 = 16 - By End Q4 2023/24
There were no amendments to the controls, assurances, gaps or mitigating actions for BAF risk #7 -Demand, capacity and accessibility, following the October and November reviews. During the additional executive review session in November, the executives agreed to increase the target risk score from 12 (L3xS4) to 16 (L4xS4) acknowledging, and reflecting, the associated overall net increases with waiting lists/times.			
Workforce sustainability #4	L4 X S5 = 20	L4 X S4 = 16	L4 X S3 = 12 - By End Q4 2023/24
Work continues to progress around workforce planning, workforce summits are scheduled for service lines with high vacancies/agency usage, to review alternative options; winter forecasting and 24/25 operational planning also commenced in October 2023. All areas are closely scrutinised at the new Finance Recovery Board meeting. During the executive review, the residual score for BAF risk #4 - Workforce sustainability increased from 9 (L3xS3) to 16 (L4xS4) and the target score increased from 6 (L2xS3) to 12 (L4xS3). This was predominantly to reflect the difficulties recruiting to vacancies, noting the national shortage of staff and the strategic aim to reduce bank and agency usage; the uncertainty around fusion with staff retention also contributed to the scoring amendments.			

Digital Maturity #6	L4 X S4 = 16	L3 X S4 = 12	L3 X S3 = 9 - By End Q4 2023/24
Minor updates to gaps and mitigating actions were recorded for BAF risk #6 -Digital maturity during October 2023, acknowledging the ICT FOM close-down report/1-year implementation plan is due to Finance and Infrastructure Committee in November 2023 and Trust Board in December 2023. Actions plans are also in place to mitigate the impact of legacy systems awaiting switch-over. Recognising the current overall position within ICT, the executive team agreed to reduce the raw score from 20 (L4xS5) to 16 (L4xS4).			
High quality safe care #1	L4 X S5 =20	L3 X S4 = 12	L3 X S4= 12 - By End Q4 2023/24
Mitigating actions for waiting list management were updated in both October and November. Following a review of unsustainable waits at QIR, it has been identified that some services require the completion of further detailed work. Data collection is underway for MHOST (The Mental Health Optimal Staffing Tool) with the second collection scheduled for Q3. In addition, the second data collection, for the safer staffing caseload tool for district nurses, is planned for November 2023. Community inpatient wards have also completed training for the revised safer nursing care tool (SNCT), with the first data collection planned for Q4, 23/24. Acknowledging the link to both to BAF risk #7 Demand, Capacity and Access to Services/BAF risk #4 Workforce Sustainability, and the subsequent impact to high quality safe care, the executive team agreed to increase the target score from 9 (L3xS3) to 12 (L3xS4).			
Financial sustainability #5	L4 X S5 = 20	L3 X S5 = 15	L2 X S4 = 8 - By March 2024
The October BAF review for BAF risk #5 -Financial Constraints, captured the external control for the overall ICS deep dive financial review following M6 reporting, as well as recording the internal assurance around the implementation of the Finance Recovery Board; monthly meetings with the first scheduled for October 2023. The target risk score date was amended from October 2023 to March 2024 to accurately capture the position. During the executive review in November 2023, the executives felt assured with the scoring and agreed no further amendments were required.			
Strategic Provision of Services #8	L5 X S5 =25	L5 X S4 = 20	L4 X S3 = 12 - By End Q4 2023/24
Updates recorded during the October BAF review represented the mitigating actions, implemented, and planned, for the risk associated with retention of key personnel. An additional gap, ltrust and confidence, was documented and corresponding mitigating actions noted; the residual risk score was increased from 12 (L3XS4) to 16 (L4xS4) to support this. The November BAF review attracted a further mitigating action, noting the process agreed across all parties for reporting and resolving concerns. During the executive score review in November, the executives agreed that to accurately record the significant transition and restructure of the new organisation, as well as note the uncertainty around system design due to the ICB restructure, the scoring was amended as follows: - raw score increased from 20 (L4xS5) to 25 (L5xS5). - residual score increased from 16 (L4xS4) to 20 (L5XS4). - target score increased from 9 (L3xS3) to 12 (L4xS3).			

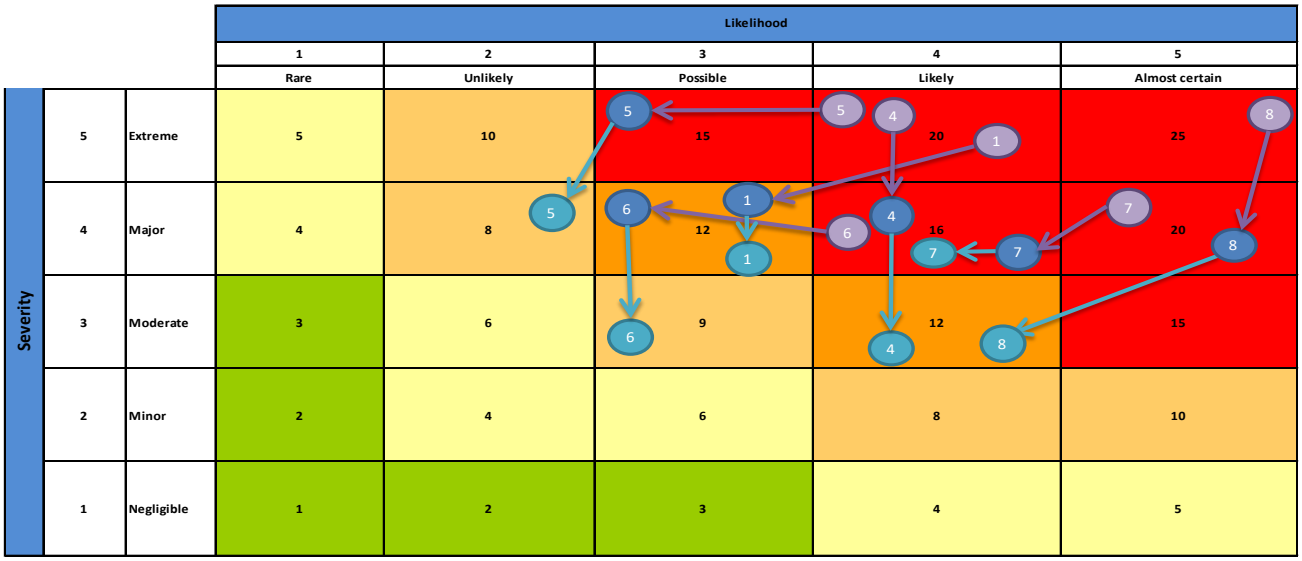
[BAF Analysis (Residual Score spread)]

Residual scores (of all BAF risks)

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Severity	5	Extreme	5	10	15 5 - Financial sustainability	20	25
	4	Major	4	8	12 1 - Provision of consistently high quality, safe care etc. 6 - Digital Maturity	16 7 - Demand, Capacity and Access to services 4 - Workforce sustainability	20 8 - Strategic Provisions of Services
	3	Moderate	3	6 3 - 3rd Party Contractor Assurance	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

target risk score achieved

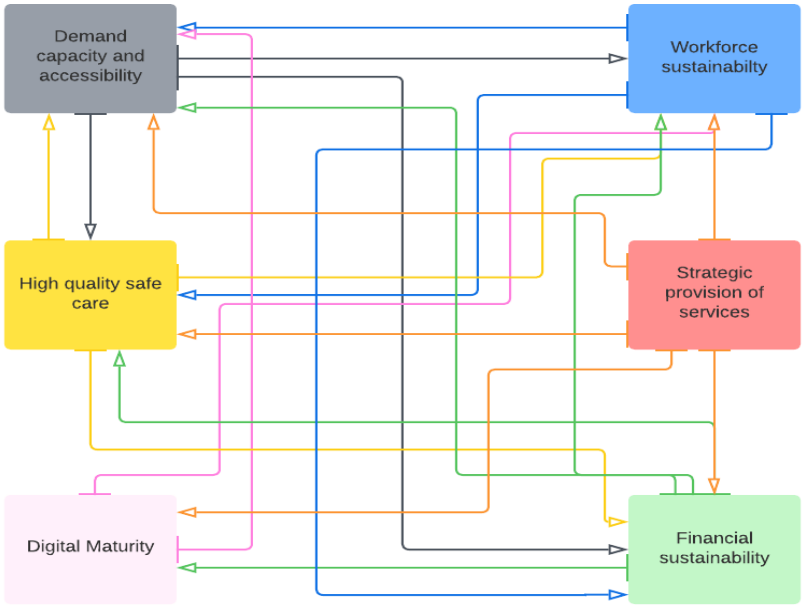
Target Movement



For residual BAF's scored 12 or above

Risk Map – Dependencies

It is acknowledged that many risks are interconnected and as such, lapses in controls may impact and compromise other risks. The below diagram illustrates the connections and dependencies between risks, should they materialise.



Board and Committee Summary Report

Title of Paper	NHS Impact Self-Assessment				
Date of paper	16 November 2023				
Presentation to	In-Public Trust Board				
Item No.	13.1				
Author(s)	Sarah Williams				
Executive Sponsor	Dan Baylis				
Executive Summary	This paper outlines the self-assessment made against the NHS Impact Framework in October 2023 and is a result of a Trust wide consultation exercise with clinical, operational and improvement leads to gain consensus. An NHS IMPACT working group has been established across HIOW linked to the National Improvement Directors Network. This will design and develop the HIOW learning and improvement system and network. The principles of NHS Impact have also been considered and incorporated into Fusion plans including the Clinical Strategy and Organisational Development Plan.				
Action Required	For decision?	(Y/N)	For assurance?	(Y/N)	
Summary of Recommendations	The Board is asked to: • Note and Consider Next Steps				
Statement on impact on inequalities	Positive impact (inc. details below)	x	Negative Impact (inc. details below)		No impact (neutral)
Positive / negative inequalities	Focus on extending service user input into continuous improvement				
Previously considered at	*QIR*				

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		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	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)*	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	 Chief Medical Officer							

Item 13.2

Continuous Improvement: Current State & Next Steps

Author: Sarah Williams

Exec Sponsor: Dan Baylis

Presented to: Trust Board, December 2023

NHS Solent NHS Trust

Context

- This paper outlines the self assessment made against the NHS Impact Framework in October 2023
- It is the result of a Trust wide consultation exercise with clinical, operational and improvement leads to gain consensus
- An NHS IMPACT working group has been established across HIOW linked to the national Improvement Directors Network. This will design and develop the HIOW learning and improvement system and network.
- The principles of NHS Impact have also been considered and incorporated into FUSION Plans, for examples the Clinical Strategy and Organisational Development Plan.

Solent NHS Trust

- Has a strong improvement and learning culture
- Has a strong sense of values and high engagement with organisation's vision,
- A workforce that feels able to speak up, and empowered to make change
- An Advanced Academy model that integrates approaches to improvement methods, facilitating improvement capability across services – ownership of improvement work lies with services
- Members of programmes already affiliated with NHS Impact (GIRFT, Health Foundation Q Community, National Audit Programme, PSIRF, Demand & Capacity)
- Increasing integration between quality and performance oversight, with a focus on improvement
- A Network of improvement leads, aligned to quality leads across the organisation
- Successful related strategies (Clinical, Digital, People etc)

The self assessment process

Each provider scores themselves against a number of statements, according to level of ‘maturity’

The statements are divided into 5 domains:

Building a shared purpose and vision
Investing in people and culture
Developing leadership behaviours
Building improvement capability and capacity
Embedding into management and systems

These scores relate to five ‘levels’

Starting
Developing
Progressing
Spreading
Improving and Sustaining

Building a Shared Purpose & Vision

What this looks like in practice:

- Create a vision and shared purpose in an inclusive and transparent way ensuring meaningful input from all, including those with lived experience. The executive leadership of the organisation must drive this work, but it cannot be designed and created by one team.
- Find ways to involve diverse communities, people improvement work is focused on the shared purpose and vision and question any work which does not align to these. Start by focusing on the current NHS priorities and your own organisation's context, including the pressures it is facing.
- Create a powerful, purpose-driven context and narrative for improvement work so that people are more likely to engage, based on commitment to the purpose rather than compliance with a process.
- Understand the world in which your staff are working, their challenges, their successes, and the improvement they'd like to see to guide this shared purpose and vision through methods of co-design and collaboration.
- Take account of the current quality indicators (for example, staff survey scores, Care Quality Commission well-led framework, value-based healthcare with lived experience and staff as partners in the design of the vision and shared purpose.
- Find ways to make the shared purpose and vision practical, so that they are lived everyday by its people and are underpinned by core values.
- Ensure all) and where there are areas for improvement.
- The shared purpose and vision should allow staff to understand the importance of their work and to see it from the patient or service user's perspective. Celebrate and share good practice where possible.

Building a shared purpose & Vision

THEMES	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Board and executives setting the vision and shared purpose	We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our executive team. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan	Our board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.	Our board, executive leaders and senior management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrIcs (e.g. Operations, Quality, Financial and People / workforce).	Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated to and understand our shared vision in a way that means something to them.	Our vision and shared purpose is well embedded and often referred to by the board and other leaders, who are able to bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.
Improvement work aligned to organisational priorities	Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all of our teams.	Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them	Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.	Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.
Co-design and collaborate - celebrate and share successes	We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.	The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.	Our improvement goals are developed and refined through a collaborative engagement process, which at least involves leaders and most managers and a two-way feedback process.	We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Our leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.
Lived Experience driving this work	There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully	People using services, unpaid carers, staff and the community are involved in the design and communication of our shared purpose and vision, and may have a role in setting improvement priorities	Patients, carers, staff and public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Patients, carers, staff and public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective	Patients, carers, staff and public have a voice which influences the strategic improvement agenda and decision making at board level, including setting the strategic direction of the organisation and

Investing in people and culture

What this looks like in practice:

- Set the expectation (for example, through new joiners' welcome and induction process) that all staff should have a common understanding of improvement, that it is a priority for the organisation and that they will be supported to make improvements in their own area of work.
- Engage with people who work in healthcare roles and organisations and those with lived experience to design and implement the improvements based on what matters to them.
- Facilitate opportunities for people to visit other organisations to understand different ways of operating and different organisational cultures.
- Invest in and support people to understand and own their work, enabling them to make improvements in their own area of work.
- Undertake planned and deliberate cultural readiness work prior to any improvement programme or activity, to establish and maintain a shared set of values that everyone can align to.
- Use a coaching-based approach to leadership in areas where improvement is required, encourage idea generation and run PDSA (Plan, Do, Study, Act) cycles regularly. Encourage the use of measurement to evaluate improvements and to learn.
- Have a locally agreed method to measure and assess organisational improvement culture, including drawing on current quality indicators (for example, staff survey scores, Care Quality Commission well-led framework) to support organisational development and learning.

Investing in people and culture

THEMES	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Pay attention to the culture of improvement	There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and executive level.	Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (e.g. using a cultural survey or the NHS staff survey) and readiness for improvement	Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.	Leaders and managers at all levels understanding their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when they are 'walking the floor' (e.g., during 'go & see' visits).	We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (e.g., NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits people using services and unpaid carers. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.
What matters to staff, people using services and unpaid carers	Our ways of understanding what matters most to staff, people using services and unpaid carers tend to be reliant on formal mechanisms (e.g., surveys) and the link to improvement is not strong or systematic.	We understand well as an organisation what matters most to staff, people using services and unpaid carers (e.g., through two-way engagement) and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.	Most of our services and functions have a good understanding of what matters most to staff, people using services and unpaid carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g., through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient sand carers into improvement priorities or goals.	Most of our teams have a good understanding of what matters most to staff, people using services and unpaid carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have to participate in improvement activity which matters to them. People using services have a role in the development, prioritisation and monitoring of delivery of improvement goals	Most of our staff can describe what matters most to them, people using services and unpaid carers and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for people using services, which is energising. People with lived experience often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.
Enabling staff through a coaching style of leadership	There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.	There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g., through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes	A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g., to help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis	Leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers and clinicians participate in improvement, celebration and learning	A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support

Developing Leadership Behaviours

What this looks like in practice:

- Have a clear leadership and management development strategy in place, outlining capability requirements and access to training.
- Understand current leadership styles and approaches through Board and executive development sessions identifying strengths and gaps for each individual and as a team.
- Create Board and executive leadership stability and continuity of approach.
- Support senior leaders and managers to live and breathe the values and behaviours of the organisation focussing on enabling all staff to improve their daily work. Regularly visit staff in their place of work.
- Hold senior leaders and managers to account for behaviours, not just improvement outcomes through a clear framework and agreed expectations.
- Clearly agree and outline the support which is in place for people to improve their own services.
- Provide induction, training and development for everyone who has a formal leadership or management role so they have skills and experience of delivering improvements and can role model leading for improvement.
- Encourage Board development to better understand how current senior leadership and management behaviours are demonstrating organisational values, identifying strengths and gaps.
- Engage with peer support networks to understand different approaches to the issues, as well as leadership and management behaviours.
- Empower teams delivering on the ground to carry out and test improvement projects.

Developing Leadership Behavious

THEMES	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Leadership and management development strategy	Our board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model	Our leadership team have started to develop their improvement knowledge and are gaining an understanding in how it can impact their role	Our leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement	Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.	Our board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our board are visibly linked to future planning at a system level
Leadership and management Values and behaviours	Our leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach	Leadership values and behaviours are agreed across our organisation	Leadership values and behaviours are agreed, and role modelled by leaders and managers across the organisation	Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to	A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation
Leadership and management acting in partnership	Our Leadership works to competing and misaligned goals lacking in clarity	Most of our leaders work in partnership with their fellow leaders and managers.	Our leadership team have shared goals with commissioners and work effectively with systems partners	Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy	Our board and system focus on constancy of purpose through multi-year journey with improvement at its core
Board development to empower collective improvement leadership	Our board discusses improvement at board meetings, but it is not a regular occurrence	Our board has received some improvement training and visit to parts of the organisation at least monthly. Improvement is discussed at every board meeting	Our leadership works with managers and teams across the organisation to enable and co-ordinate improvement	Our leadership and management teams actively enable staff to own improvement as part of their everyday work	Our leaders and managers - CEO through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care / operational work is done
Go and see visits	Some senior leaders spend time on the ‘shop floor’ from time to time to engage directly with staff and teams but it is not routine or widely practiced	Our leaders understand the importance of 'walking the floor' to 'go & see'; but we have variation in leader participation; some leaders and managers use our improvement tools	Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management	All levels of leadership and management 'walk the floor'/'go & see’ as a matter of routine and the insights they gain informs decision making and problem solving to support improvement	Leaders undertake 'walk the floor'/'go & see’ visits for external bodies to visit their site and to observe different ways of working

Building improvement capability & capacity

What this looks like in practice:

- Identify or create an improvement methodology to use across your entire organisation, ensuring a local and systemic way of practising improvement.
- Give all people access to induction, improvement training and support, so that everyone can run improvement projects and continuously improve their daily work.
- Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience.
- Demonstrate the impact of co-producing improvements with people who use services as an integral part of daily work.
- Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace.
- Create and embed a training strategy to increase improvement capability.
- Senior leaders and managers attend team huddle boards and work to unblock issues which teams are facing.

Building improvement capability and capacity

THEMES	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Improvement capacity and capability building strategy	We do not have a structured training or capability building approach for improvement skills Training is ad hoc and focused on small central teams We have some use of external resources (e.g. Academic Health Science Networks and Institute for Healthcare Improvement Open School)	Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around improvement Staff have access to induction on joining, improvement training and a small group of staff support capability building	Training is a balance of both technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology Some learning is shared across the organisation A system exists to identify, engage and connect all those people that have existing improvement capability	Sustainability is addressed via 'in-house' training and development approaches including train the trainer models, Improvement capability building for 'lived experience' service user partners is underway; they are seen as contributors to improvement teams The programme is working towards being self-sustaining through developing its own improvement coaches	There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with >80% coverage Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation consistently shares capability, building learning with other sites, regionally and nationally
Clear improvement methodology training and support	No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.	There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS Impact components, alongside a dosing formula and skills escalator to support capability building ambitions	Clarity exists on which improvement methodology and approach is being consistently applied. A longer term commitment exists to a training and development system for building capability at scale. Service users and carers are recognised as key stakeholders	Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation Staff, people with lived experience and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers	Learning from improvement activity is driving continuous improvement There is a common improvement language across the organisation Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy
Improvements measured with data and feedback	Our organisational approach to reviewing and tracking progress against goals has yet to be defined, At present Improvement doesn't feature in whole organisational measures	We are seeing minimal improvement in our organisational measures We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad-hoc and stakeholders do not feel it supports them to deliver	We are tracking improvement over time for some of our organisational measures We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive	Improvement is sustained for most organisational measures Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required	Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively Our goals around longer term sustainability are reviewed regularly at organisational level
Co-production	We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors with no lived experience partners co-producing improvement	People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvements, but this is rarely shared across departments	People with lived experience and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach Staff, people with lived experience and other stakeholders have access to improvement capability development	Stakeholders including people with lived experience are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively together	Stakeholders are both supported and challenged to ensure success. People with lived experience and wider stakeholders are embedded within teams and are an integral part of the capability building process
Staff attend		There is a plan in place for team huddle to	All clinical frontline areas have continuous improvement team huddles established.	All operational/support/corporate areas	There is a cascade of huddles for all teams from Executive to frontline teams (clinical,

Embedding into management & systems

What this looks like in practice:

- Develop an explicit management system that aligns with the strategy, vision and purpose of the organisation at Board level, throughout and across all services and functions.
- Put systems in place to identify and monitor early warning signs for all organisational process and quality risks. Ensuring clear standard processes of how to respond to these.
- Set up the management system as a standard way of operating that enables ongoing continuous improvement of access, delivery, quality, experience, value and outcomes whilst ensuring financial sustainability.
- Build a management system with a consistent and coherent set of systems and processes that enables the organisation to respond to system and national priorities more easily and with greater agility.
- A committed Board and senior leadership team who own and use this approach to manage the everyday running of their organisation, including simple and visual ways of understanding performance with tracking progress.

Embedding into management and systems

THEMES	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Aligned goals	Where improvement plans exist they are very locally determined and driven. Our business planning is an activity conducted at board and senior leadership level but executives' and functions goals are often not well aligned with each other	Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.	Our organisational goals are established to support our overall vision; our departmental goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.	Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.
Planning and understanding status	Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.	Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource	Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. HR, Finance, Comms, InformatICB) are also aligned to our improvement priorities	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective Staff and assets from enabling services (e.g. HR, Finance, Comms, InformatICB) are also aligned to improvement priorities and are shared across the system in an agile way	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams, and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.
Responding to local, system, and national priorities	We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead it is perceived as reactive or firefighting	Across the organisation, we believe having a management method (e.g., Lean) is important to our success. Some of our leaders are using management methods daily, which is recognised to be helping.	Most leaders and managers in the organisation use our management methods to manage and run their departments, including responding to problems that may arise or to take account of changing priorities.	Our management method is well embedded in how we work in all parts of the organisation, to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables Our technology, staff and facility decisions are aligned with our management system goals.	All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (e.g., SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.
Integrating	Improvement is seen as separate to the day to day delivery of services.	Improvement is starting to be more integrated with day-to-day delivery and	Improvement is starting generally well integrated with day-to-day delivery across the organisation and is increasingly the basis	As part of our management system, all parts of the organisation are using improvement methods, and learning occurs	The way we understand, manage and improve performance across the organisation – including how we use

Summary

- We place ourselves somewhere between Developing (2) and Progressing (3) on most indicators
- This reflects our improvement culture and places us in a group of more mature provider organisations
- Fusion may slow the pace of overall maturity in the short term but current work to mitigate includes
  - Integrating continuous improvement into OD plan, Clinical Strategy and Quality Assurance Framework
  - Extending reach of training and support offer to SHFT and IOW Colleagues, with co-delivered sessions
  - Integrated support (Academy model) signed off via Clinical Steering Group
  - Working group forming to agree on overarching principles and an ‘offer’ for clinical teams

Suggested initiatives

- Ongoing development of skills based leadership development & build improvement principles into induction
- Extension of Demand, Capacity & Flow support to operational leaders, and team based support (ongoing, but extending due to demand)
- Extended training and project support on co-production (co-delivered with service users)
- Liaison with IT re digital tools to support analysis and information led services (SPC, D&C)
- Links with business planning
- Proposed enhanced alignment with transformation team
- Bespoke programmes for teams/ services – co-designed
- Agree improvement approach and core principles

Item No.	14	Presentation to	Trust Board – In Public
Date of paper	24 November 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)
September – October 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	Target	Oct-23 Current Performance		Oct-23 Trending Performance	Oct-23 Variance	Sep-23 Current Performance		Sep-23 Trending Performance	Sep-23 Variance
Safe	Occurrence of any Never Event	E	0	0				0			
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	0				0			
	VTE Risk Assessment	E	95.0%	97.0%				88.0%			
	Clostridium Difficile - variance from plan	E	0	0				0			
	Clostridium Difficile - infection rate	E	0	0				0			
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	E	0	0				0			
	Escherichia coli (E.coli) bacteraemia bloodstream infection	E	0	0				0			
	MRSA bacteraemias	E	0	0				0			
	Admissions to adult facilities of patients who are under 16 yrs old	E	0	0				0			

b. Key Performance Challenges

Incident Reporting

The overall trend in incident reporting remains upward with 1.1% more incidents reported in September/October 2023 compared to the same period in 2022, as shown in figure 1 below. Whilst the overall trend remains upward, the increase noted this period is lower than in previous periods which may suggest the incident reporting levels could be beginning to stabilise at a revised level of activity. The Quality and Safety team will continue to review this going forward.

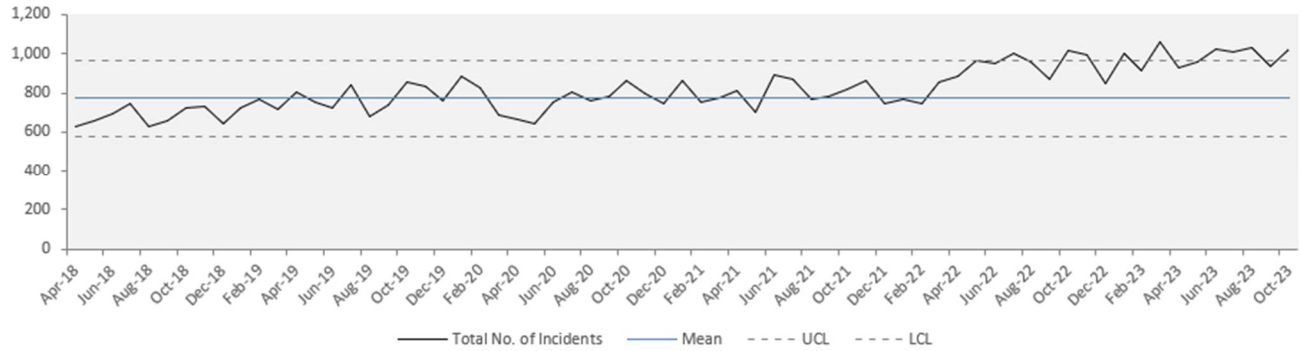


Figure 1: Total number of incidents reported by month

The number of incidents reported per 1,000 patient contacts continues to exceed the upper control limit as shown in figure 2 below.

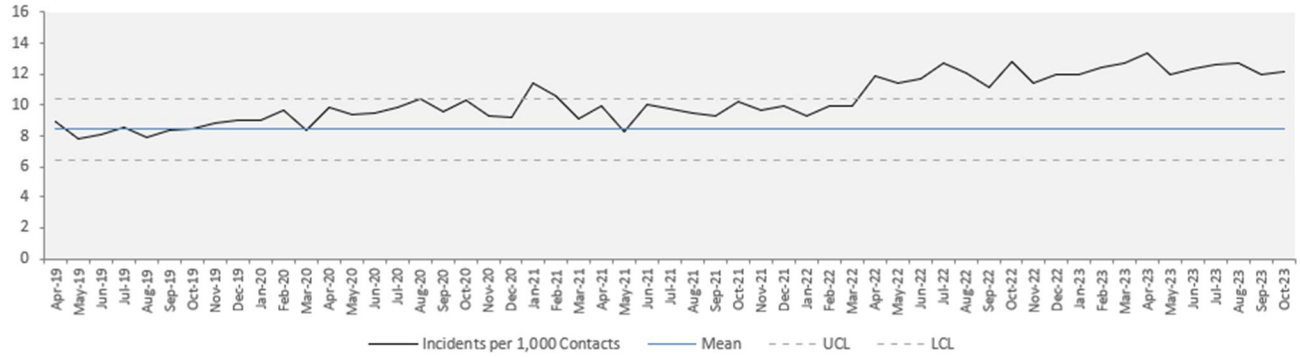


Figure 2: Incidents per 1,000 patient contacts

Acknowledging the historical increase in incidents across the trust, the Quality and Safety team have been asked to recalculate the control limits using data from April 2021 onwards, which on initial review suggests the current level of incidents per 1,000 contacts would remain within the control limits and that there is therefore no cause for concern/action. Prior to April 2021, Safe Staffing incidents were not being routinely raised and since this date we have seen a significant increase in the complexity of patients within our acute mental health services, resulting in a consistently higher level of incidents relating to violence and aggression.

Despite this, Solent is an outlier in terms of the number of reported incidents relating to aggression. Shared learning from colleagues at Southern Health NHS Foundation Trust, and local policing leads, is being arranged to manage the expectations of staff about what behaviour is and isn't reasonable to accept from patients.

Since the introduction of the new NHS England guidance around categorisation of incidents, there is a continued increase in the number of incidents being reported as causing Low Harm or above. This is expected and is not an area of concern, however this will be closely monitored to ensure it does not continue to grow exponentially.

Level of Harm Reported	2022/23 (Sep – Oct)	2023/24 (Sep - Oct)	Difference	% change
No Harm/Near Miss	1,337	1,208	-129	-9.6%
Low Harm or above	699	853	154	22.0%

Figure 3: Number of incidents reported by level of harm

2. Caring

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Oct-23 Current Performance		Oct-23 Trending Performance	Oct-23 Variance	Sep-23 Current Performance		Sep-23 Trending Performance	Sep-23 Variance
Caring	Community FFT % positive*	E	95.0%	98.2%				97.5%			
	Mental Health FFT % positive*	E	95.0%	97.0%				100.0%			
	People Pulse Survey - Advocacy Theme (Recommended for Care & Employment)	E	0	-				7.2			
	Mixed Sex breaches*	E	0	0				0			
	Plaudits	I	-	84				91			

b. Key Performance Exceptions

Nothing of note.

3. Effective

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Oct-23 Current Performance		Oct-23 Trending Performance	Oct-23 Variance	Sep-23 Current Performance		Sep-23 Trending Performance	Sep-23 Variance
Effective	Bed Occupancy - Brambles (Community)	I	92.0%	95.8%				95.7%			
	Bed Occupancy - Fanshawe (Community)	I	92.0%	95.7%				97.0%			
	Bed Occupancy - Jubilee (Community)	I	92.0%	99.0%				99.7%			
	Bed Occupancy - Spinnaker (Community)	I	92.0%	98.2%				96.5%			
	Bed Occupancy - Brooker (OPMH)	I	85.0%	56.5%				65.0%			
	Bed Occupancy - Hawthorns (Adult MH)	I	85.0%	85.0%				84.7%			
	Bed Occupancy - Maples (Adult MH)	I	85.0%	45.8%				69.3%			
	Bed Occupancy - Kite (Acquired Brain Injury)	I	92.0%	70.6%				81.0%			
	Bed Occupancy - Snowdon (Neuro Rehab)	I	92.0%	98.6%				97.6%			
	Length of Stay - Brambles (Community)	I	24.0	26.2				30.9			
	Length of Stay - Fanshawe (Community)	I	24.0	25.9				25.7			
	Length of Stay - Jubilee (Community)	I	18.0	45.0				50.1			
	Length of Stay - Spinnaker (Community)	I	24.0	20.3				20.2			
	Length of Stay - Brooker (OPMH)	I	78.5	28.5				39.2			
	Length of Stay - Hawthorns (Adult MH)	I	34.9	11.8				15.7			
	Length of Stay - Maples (Adult MH)	I	48.6	12.2				22.5			
	Length of Stay - Kite (Acquired Brain Injury)	-	-	0				216.7			
	Length of Stay - Snowdon (Neuro Rehab)	-	-	43.0				28.4			
	Non-Criteria to Reside (NCtR) [patient count]	-	-	22				29			

Bed Occupancy – Brambles, Fanshawe, Jubilee, Spinnaker

As previously reported, pressure in both the Portsmouth and Southampton systems is being seen throughout the acute trusts and into the community inpatient wards and community services. The high occupancy rates reflect the drive to move patients into community-based care to free capacity within the acute hospitals. This will only continue to increase as we move into the winter months.

Length of Stay (LOS) – Jubilee

The average LOS remains high across all our community wards, reflecting system pressures, and delays in long-term packages of care preventing patients from being discharged in a timely way. The impact on the length of stay Jubilee Unit is more significant for a variety of reasons.

Jubilee offers a greater provision for patients requiring D2A beds, with approximately 70% of patients being admitted on this pathway. The estimated LOS for D2A patients is 4-6 weeks, much greater than the Jubilee average LOS target. There is a shortage of both social workers (due to vacancies and sickness) and care home beds in the Portsmouth system, resulting in lengthy patient discharge delays. Portsmouth Social Care are gradually changing their social care model to increase flexibility to the greatest areas of need; however, this has been detrimentally impacted by the loss of locum staff. The reduction in care home beds, over the last year (156 beds), has limited the availability to our patients and adds to the backlog of patients waiting to be discharged.

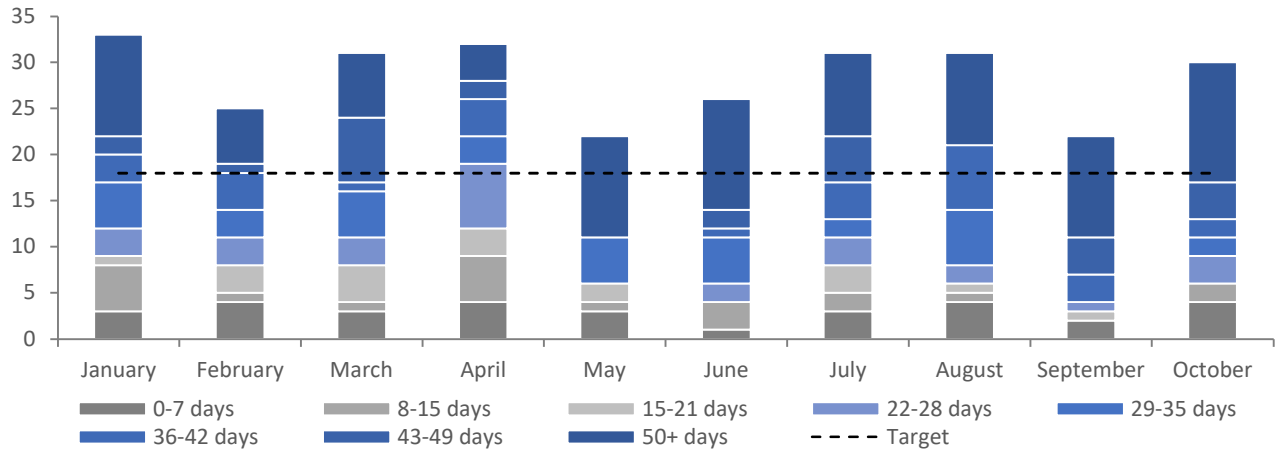


Figure 4: Number of patients discharged from the Jubilee Unit by LOS group

b. Key Performance Exceptions

Elective Recovery Framework (ERF)

During the current period, the ERF baselines were republished (version 6) accounting for the adjustments requested for our services at the start of the year. This was extremely positive and allowed us to recalculate actual performance against the revised baseline. Local data indicates we are achieving around 120% of the baseline which is extremely positive for both Solent and the contribution we are making towards the HIOW ICB target.

	Activity actual	Activity Plan	Activity variance	Income actual	Income Plan	Income variance
Cardiology	757	741	-17	£144,587	£141,531	£3,056
CPMS Child Protection/LAC	695	421	274	£134,135	£81,253	£52,882
CPMS General Paediatrics	118	42	76	£29,146	£10,374	£18,772
CPMS Neuro-disability	641	470	171	£123,713	£90,710	£33,003
Diabetes	34	69	-35	£4,862	£9,867	-£5,005
Pain Management	630	502	128	£144,900	£115,460	£29,440
Physiotherapy	11,870	10,674	1,196	£290,910	£2,060,082	£230,828
T&O	7,207	5,225	1,982	£1,297,260	£940,500	£356,760
	21,952	**18,144**	**3,808**	**£4,169,513**	**£3,449,777**	**£719,736**

Figure 5: Cumulative ERF performance (local data) at M7 compared to baselines v6

Following this publication of revised data, a letter was sent to all trusts by NHS England on 8 November, outlining the actions being taken to address the significant financial challenges created by the Industrial Action during 2023/24. This letter requested that ICBs reduce the elective activity targets to the national average of 103% of the baseline value (ERF baselines version 7). The impact to Solent is that our target will reduce to 100% of our baseline. The financial impact is being calculated and the revised baselines will be updated once formally confirmed by the ICB.

Urgent Community Response (UCR) – 2-Hour Performance

The Southampton UCR team have seen an increase in UCR 2-hour performance following the implementation of an action plan a few months ago. Despite vacancies within the service and system pressure redirecting the workforce to support the virtual ward at times, performance has been maintained for the past 3 months.

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	YTD
2 Hour Referrals	318	331	381	351	416	384	401	431	454	433	334	323	4557
Compliant	213	219	241	217	242	249	243	273	285	317	272	269	3040
Compliance %	67%	66%	63%	62%	58%	65%	61%	63%	63%	73%	81%	83%	67%

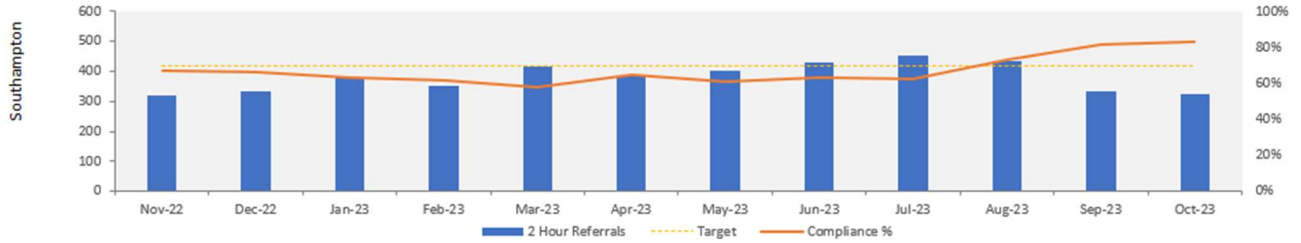


Figure 6: Southampton UCR 2-hour compliance, previous 12 months

In Portsmouth, in agreement with the local system in response to ongoing pressures, the teams have been prioritising admissions to the virtual wards and flexing the workforce, which has detrimentally affected performance against the UCR target. All patients are triaged to ensure care is centred around the patient needs and managed safely.

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	YTD
2 Hour Referrals	349	421	336	266	291	264	281	259	301	303	270	328	3669
Compliant	246	222	215	186	229	206	226	171	213	215	171	184	2484
Compliance %	70%	53%	64%	70%	79%	78%	80%	66%	71%	71%	63%	56%	68%

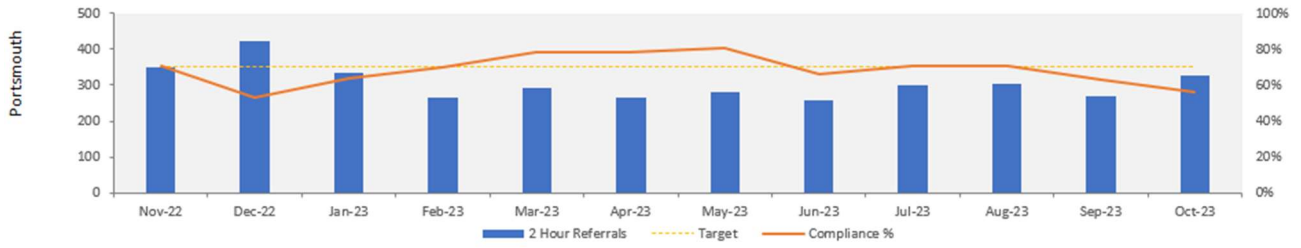


Figure 7: Portsmouth UCR 2-hour compliance, previous 12 months

Virtual Wards

The position on our virtual wards remains consistent with that previously reported, where occupancy rates are being stretched, utilising capacity from the workforce in Community Nursing and Urgent Community Response to support the areas of greatest need. The Southampton virtual ward is seeing demand reduce slightly and occupancy has been below 150% for more than a month, following a period of several weeks

between 150-200%. Our community virtual wards have been operating significantly over the funded capacity due to pressures within the system. Workforce is being flexed from the Community Nursing and UCR teams to support the area of greatest need, however this is having a negative impact on the patients accessing those services.

Figure 8: Southampton Virtual Ward Occupancy and average Length of Stay

Figure 9: Portsmouth Virtual Ward Occupancy and average Length of Stay

c. Corporate Performance Review Meetings (CPRMs) – Key Areas of Exception

People Services

Occupational Health Recruitment

The future operating model of Occupational Health services is being considered, using a joint approach across Hampshire and Isle of Wight providers. Further recruitment into the current Occupational Health service has been placed on hold whilst the new model is developed.

Project Fusion TUPE Process

The work that has been undertaken within Solent around TUPE to the new Fusion organisation has been brilliantly managed by Gemma Pegram and Fiona Garth and demonstrates a great piece of collaborative work across teams. The consultation is now live, running from 20th November to 17th December.

Quality

Interpreting Tool

A new interpreting tool is being piloted to improve communication within clinical services. As part of this, a review is being undertaken to assess the current spend on interpreting services which has identified services are using other providers in addition to the trust-wide contract with Prestige. This is proving challenging to identify the overall cost to the trust and consider whether the new tool would be suitable alternative. Initial feedback from the pilot has highlighted that the tool is best utilised for immediate translation of information at reception/appointment check-in, which is beneficial, but may not be sufficient to replace the existing provision.

Thematic Escalations

Project Fusion Impact

The Full Business Case for Project Fusion was approved by all contributing organisations on 13th November. As work culminated towards this submission and focus increases on delivery of the integration tasks outlined in the Post-Transaction Integration Plans, there is an increase in sickness absence and feelings of burnout in teams and a noticeable impact on the delivery of business-as-usual tasks. The People services team are offering support to the workforce during this time.

4. Responsive

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Oct-23 Current Performance		Oct-23 Trending Performance	Oct-23 Variance	Sep-23 Current Performance		Sep-23 Trending Performance	Sep-23 Variance
Responsive	Patients waiting > 18 weeks	-	-	6498			H	6267			H
	Accepted Referrals	-	-	28384				27080			
	Formal complaints per 1000 WTE	-	-	2.4				4.4			
	Number of complaints	I	15	7	●	?		13	●	?	
	Number of complaint breaches	-	-	1				4			
	RTT incomplete pathways*	E	92.0%	76.6%	●	?	L	78.8%	●	?	
	Maximum 6-week wait for diagnostic procedures	E	99.0%	49.0%	●	?	L	100.0%	●	?	
	Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0	●	?	L	0	●	?	
	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50.0%	100.0%	●	P		75.0%	●	?	
	Talking Therapies - Proportion of people completing treatment moving to recovery	E	50.0%	50.0%	●	P	L	52.0%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 6 weeks	E	75.0%	93.0%	●	P		98.0%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 18 weeks	E	95.0%	99.0%	●	P	L	100.0%	●	?	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score*	E	95.0%	87.2%	●	?		87.3%	●	?	

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

b. Key Performance Exceptions

Patients waiting > 18 weeks

The position of our waiting lists continues to deteriorate for the reasons previously detailed.

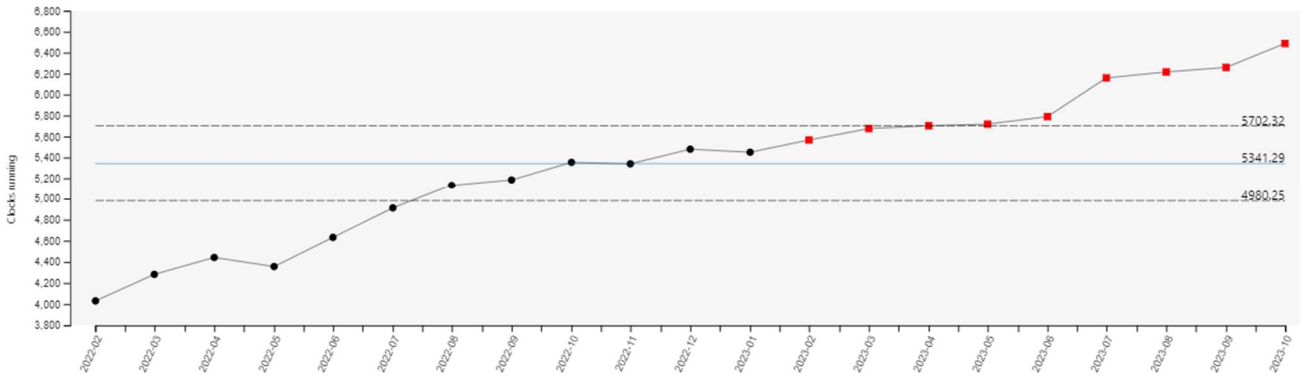


Figure 10: Monthly snapshot of the number of patients waiting for more than 18 weeks – Trust-wide (excluding Dental Services)

Plans to implement a Quality Improvement (QI) programme around demand and capacity are in an embryonic phase, aimed at targeting the highest risk waiters across the Trust. This is not expected to resolve the waiting list position quickly and is the start of a long-term remediation plan.

Specific recruitment has been approved in the Pelvic Health service, outside of funding. Other impacted services continue to review and triage as appropriate, however without significant investment or change to service provision, the patients waiting more than 18 weeks will continue to deteriorate and flag a Special Cause Variation.

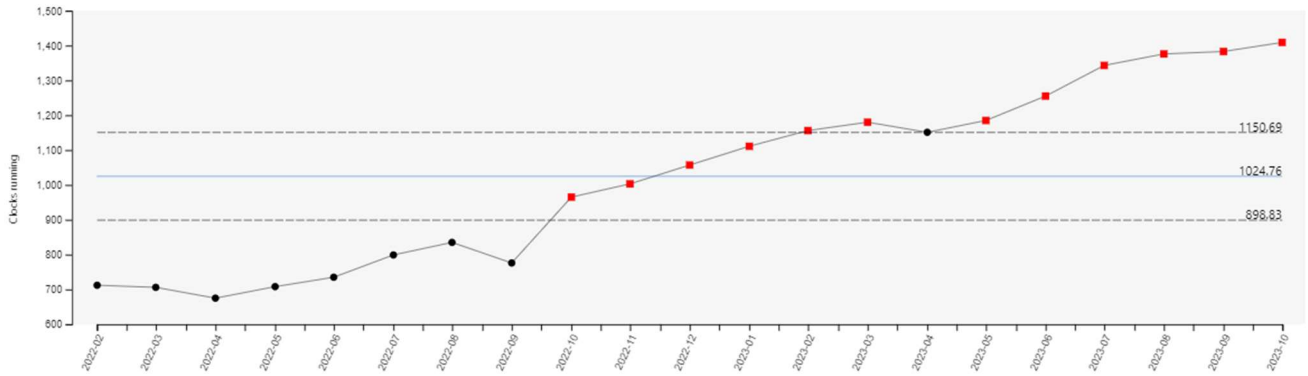


Figure 11: Monthly snapshot of the number of clocks running (>52 weeks) – Trust-wide (excluding Dental Services)

RTT Incomplete Pathways

Patients waiting for an RTT eligible service continue to breach the 92% target to be seen within 18 weeks and performance continues to be below the lower control limit, due to the ongoing challenges within the Community Paediatrics Medical Service (CPMS).

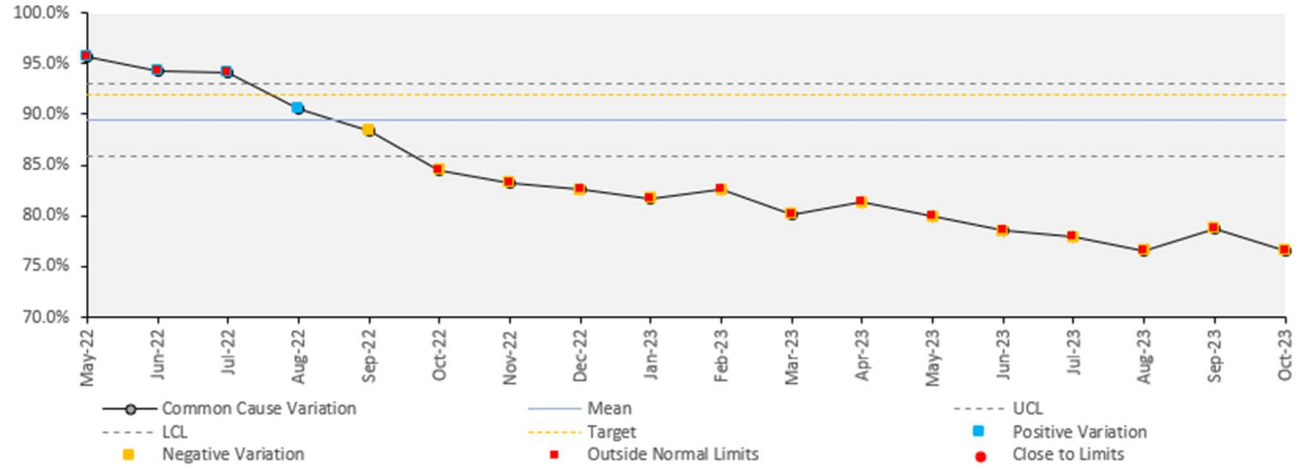


Figure 12: RTT Incomplete pathway performance

Processes are in place to triage patients to ensure those with the greatest need are prioritised, however even if there were significant improvements made within service, it would take some time for the RTT incomplete pathway performance to improve because of the large number of patients on the backlog waiting more than 18 weeks.

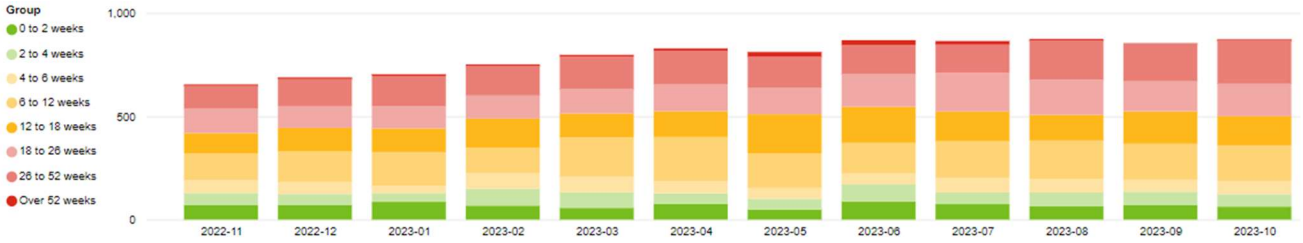


Figure 13: Number of patients waiting at month end for the Community Paediatrics Medical Service

The service has been working hard to reduce any patients from waiting more than 52 weeks, and the small number of exceptions to this have specific, individual circumstances. A focus on General Paediatric activity in the Southampton service has been implemented as this cohort of children are harder to triage without being seen.

Long-term sickness within the team continues to be the main factor for the worsening position, and the need to redirect staff capacity to deliver statutory pathways. The East service have focussed on improving the RTT performance, and as a result have longer waiting times for follow-up appointments, however the West service are applying a more balanced approach between first and follow-ups. The West team have gained agreement to recruit to a fixed term post to cover the long-term sickness of one member of the team who is known to be absent for 9-12 months.

Maximum 6-week Wait for Diagnostic Procedures

It was reported some months ago that the third-party contract for the provision of diagnostic Echo-Cardiography scans was decommissioned at the start of 2023/24, and consequently additional patients were being referred into Solent's Cardiology GPSI service, without an equivalent increase in funded capacity. The data for the additional activity has now started to flow into the national DM01 reporting, following the implementation of new processes to specifically identify the new diagnostic activity.

As forecasted, this has had a significant negative impact on the trust's achievement of the 6-week diagnostic waiting time standard. Where the trust's performance has been consistently above the 95% standard for some time, during September this dropped to 49%. Support has been sought from University Hospitals Trust (UHS) to provide additional capacity to reduce the current backlog and support the development of a sustainable long-term plan.

Talking Therapies

Proportion of People Completing Treatment and Moving to Recovery

Waiting Time to Begin Treatment – within 18 weeks

A special cause variation has been identified on the above two metrics in October due to reduction in performance in these areas. For the proportion of patients completing treatment and moving to recovery, performance remains in line with the 50% standard, however achievement has been below the mean for consecutive months. This has been highlighted to the service for investigation.

Performance against the 18-week waiting time to begin treatment has flagged the special cause variation because October's performance is outside of the lower control limit. Achievement, however, is still comfortably above target (4%) and there is currently no cause for concern.

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

Adults Community Services – Portsmouth

Increasing Staff Sickness

Sickness has increased within Adults Portsmouth for 4 consecutive months, as a result of staff burnout due to the prolonged pressure in the Portsmouth system. Whilst this hasn't yet seen an increase in bank and agency usage, it is anticipated that this will be seen in the coming months, as the pressure is expected to worsen as we move into the Winter period. In order to improve the absence issue in Adults Community Services Portsmouth an Organisational Development Programme is being implemented, ringfencing time for supervision is being prioritised, however the sustained pressures on the Portsmouth system and our response team is significant and impacting wellbeing. Progress against this plan will be bought back to PRM in January.

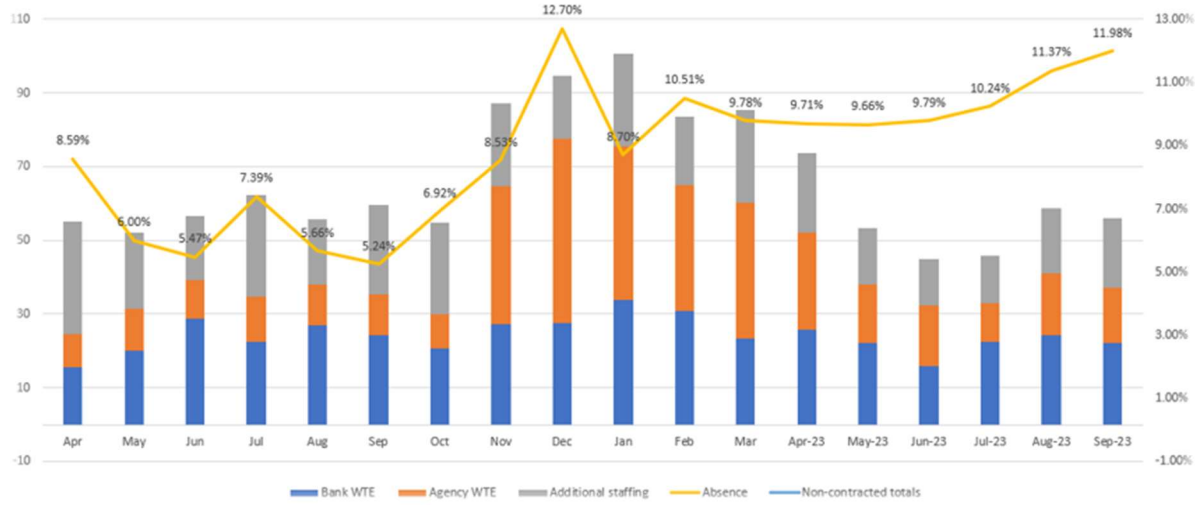


Figure 14: Additional staffing usage and sickness absence rates in Adults Portsmouth

Winter Resilience Planning

There is an Executive-led Programme to support staff to take a greater level of risk in services as we identify which services can be reduced or ceased in order to release sufficient capacity to manage the increased demand over the winter period.

Adults Community Services - Southampton

Non-Criteria to Reside (NCtR) Trends

The charts below show the number of non-criteria to reside patients at UHS by their intended discharge destination highlighted variation across the area, with greater unmet demand for Hampshire patients (figure 15) and packages of care supported by Southampton City Council (figure 16). There is a need for oversight and understanding of more granular data, such as below, to identify and resolve any inefficiencies in pathways and flow across partners.

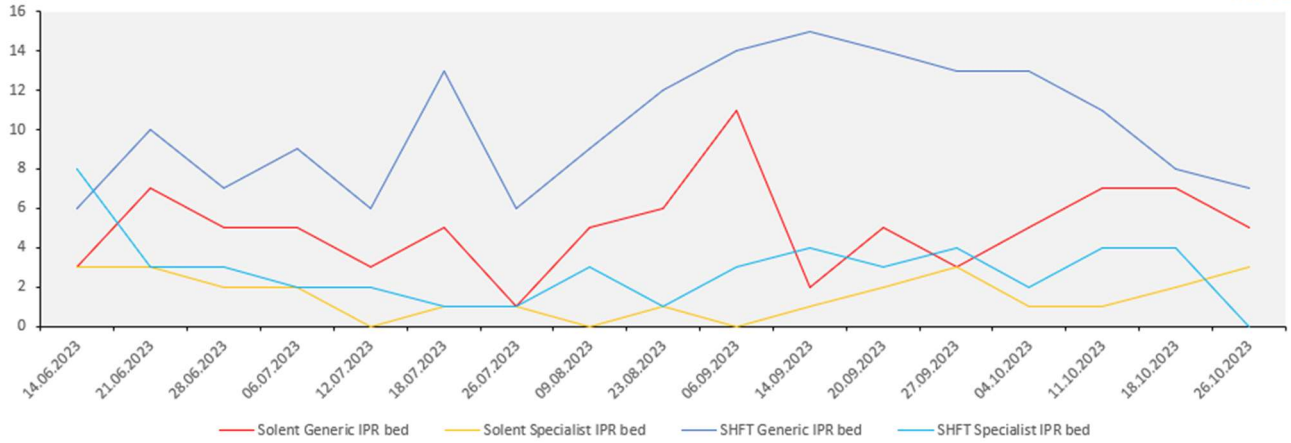


Figure 15: Number of NCtR at UHS by intended discharge destination

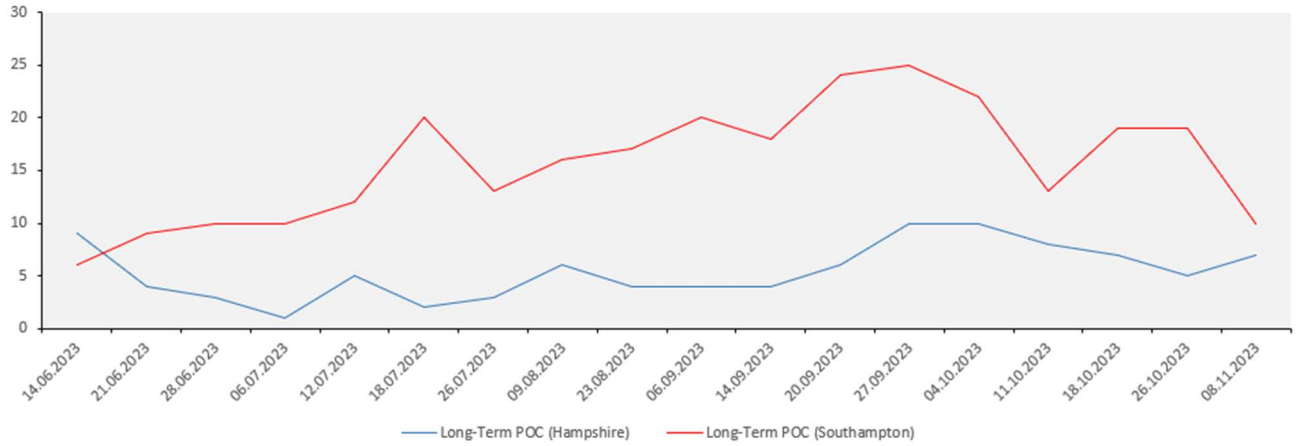


Figure 16: Number of NCtR at UHS requiring a long-term package of care

Childrens Services

ADHD Assessment and Medication Pathway

The waiting lists for both ADHD assessment and subsequent medical treatment have grown significantly in Southampton, leading to more than 400 children waiting for up to one year for assessment and a further 400 children waiting up to two years for medication. The pathway for medication has been severely impacted by national shortages in ADHD medications and the challenges are replicated across other providers, however the long waiting lists for assessments in the Southampton service are exacerbating the medication issues. The Portsmouth service have an MDT pathway approach to neurodiversity which supports flow through the service better and is not seeing the same level of impact.

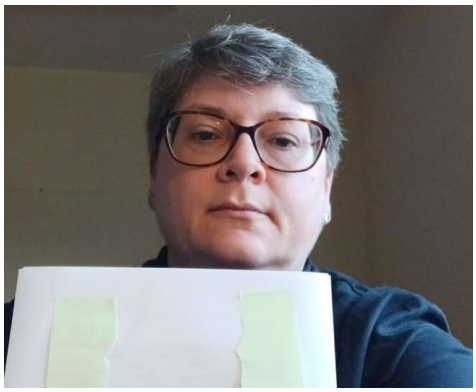
The service has developed a case for change and submitted a QIA, seeking to close the service to referrals for up to one year and redesign the ADHD pathway in its entirety, creating sufficient capacity across both cities, providing both assessment and medication provision, where required, within 18 weeks. The ICB have been consulted and are, in principle, supportive of this approach. Corporate colleagues are supporting the development of a business case to fully set out the proposed pathway and subsequent return on investment.

The service have proactively engaged Re:Mind and the Portsmouth Parent Group to offer additional support to families who are experiencing long waiting times, before any change to the service is implemented. This has noticeably reduced the number of service concerns being received by the service on this matter, however

this is not likely to be sustainable and it is anticipated that service concerns and formal complaints will increase in the near future.

Mental Health Services

Approved Clinician Status



Sharon Lewry is the first Advanced Clinical Practitioner in the Trust's history to achieve Approved Clinician (AC) status. This is a major achievement and strengthens Solent's mental health provision for inpatients. An Approved clinicians are mental health professionals that have been approved by the Secretary of State, or a person or body exercising the approval function of the Secretary of State. Some decisions under the Mental Health Act can only be taken by people who are approved clinicians. This will help the service because filling AC roles has historically been difficult in the Acute Care Pathway. Sharon will also be able to mentor others to follow in her footsteps, creating a new development pathway for other clinicians to become ACs.

A2i Waiting Times

The waits in A2i have consistently been above the 5-week target for more than a year and have been breaching 10 weeks for the past 3 months, as a result of severely reduced capacity from vacancies and long-term sickness within the service. A review of the caseload has identified varying practices between clinicians and some patients being kept on the caseload for longer than intended. These cases have been reviewed and discharged as appropriate however further work is required as there remain a number of patients on the open caseload for nearly 2 years.

The service has considered multiple options to turn this position around, aiming to find a long-term sustainable solution. Staff have now been recruited and this should give additional capacity should from December. The leadership role for this service has been extended to support the development of a strategic plan to improve and maintain the waiting list, with the implementation of weekly waiting list reviews. Consideration is also being given to the implementation of a telephone triage within 48 hours of referral to ensure patients are waiting for the most appropriate service for their needs. With all the above factors, the trajectory suggests the waiting time could be within the target timescale by the new financial year.

Figure 17: Average waiting time (weeks) for the A2i service

Special Care Dental Service

Waiting Times and Staffing

As frequently reported, the lengthy waiting times for clinic assessments and subsequent GA procedures, where appropriate, continue to be a significant area of concern for the service. Recruitment continues with some positivity; however, the current workforce continues to be challenged by further long terms sickness and turnover. A new report has been set up to demonstrate the forecasted impact on the clinic waiting list sizes and waiting times, if the capacity of the service remains as is, between now and the end of March (see figure 18 and 19 below).

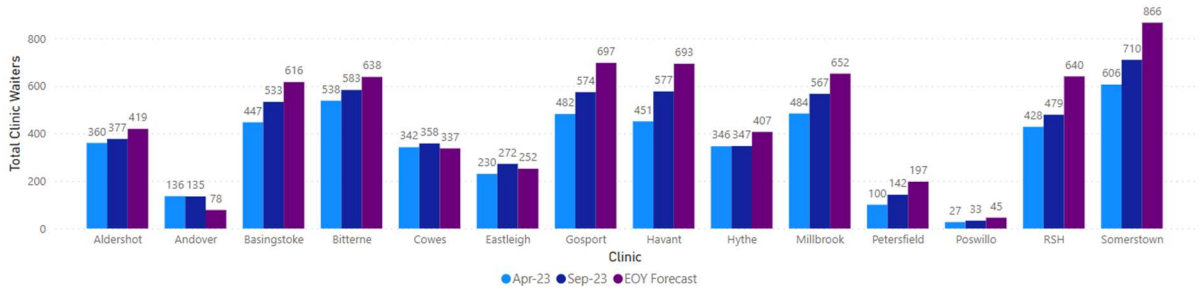


Figure 18: The number of patients waiting for assessment by clinic, as at April 2023, now (September 2023) and the forecast position at year end.

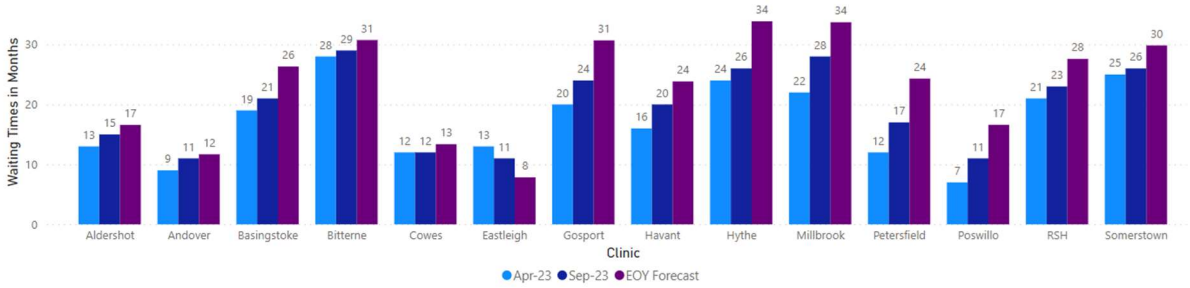


Figure 19: Waiting time for assessment (months) by clinic, as at April 2023, now (September 2023) and the forecast position at year end.

The output from a recent deep dive has been shared with commissioners and the ICB, however feedback has been limited. The Local Dental Network, of which the service is part of, have been tasked with designing a new children's pathway for special care dentistry, and work is underway to seek direction from other providers who have already successfully remodelled. This is an exciting piece of work for the service, however, will take some time to design, approve and implement, and the impact will not be seen until some way in the future.

The service has reviewed the criteria for referral acceptance and have implemented a scoring system, supported by a clinical triage, to determine if patients can be redirected back into general dentistry, rather than added to the special care waiting list. This has, however, not resulted in a significant decrease in the number of referrals being accepted. Given the sustained increase in the waiting lists for this service it is important that the flow is stemmed further. The service has therefore been tasked with identifying potential options available to reduce demand within the next few weeks.

Primary Care Services

GP Access

Following recent updates regarding the intention to shift patient access to the GP Practice over time, rather than focussing on same day access, the service is pleased with recent data demonstrating the impact their efforts have had. Appointment bookings are now being opened 6 weeks in advance, allowing practitioners to offer suitably timed, follow up appointments several weeks in advance. This has allowed the service to reduce locum usage and better utilised the staff in post. Performance is now in line with, or slightly above the national and ICB averages. The desire is to further reduce the volume of patients accessing on the same day; however, it is acknowledged this this is dependent on patient education and will not be a rapid shift.

All activity	April	May	June	July	Aug	Sep
Same day	29%	27%	56%	52%	43%	43%
1 day	14%	15%	8%	7%	10%	8%
2-7 days	19%	22%	17%	19%	21%	20%
8-14 days	11%	16%	8%	9%	11%	14%
15-21 days	9%	10%	4%	6%	5%	6%
22-28 days	10%	6%	3%	4%	4%	3%
>28 days	8%	4%	4%	3%	6%	6%

Figure 20: Proportion of patients seen with each waiting time group

MPP Services

Podiatry Waiting Lists

The Podiatry service continue to see demand outstripping capacity as previously reported. The waiting times for routine patients are lengthy, where urgent cases are given priority access, however the risk of routine patient's symptoms deteriorating during their wait is starting to become an issue. Referrals numbers into the service are stable, as is the waiting list size for the past 7 months, however the length of wait is now increasing (see figure 21).

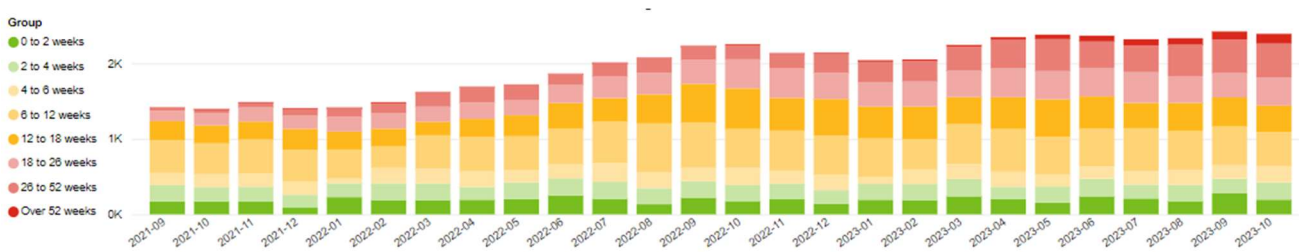


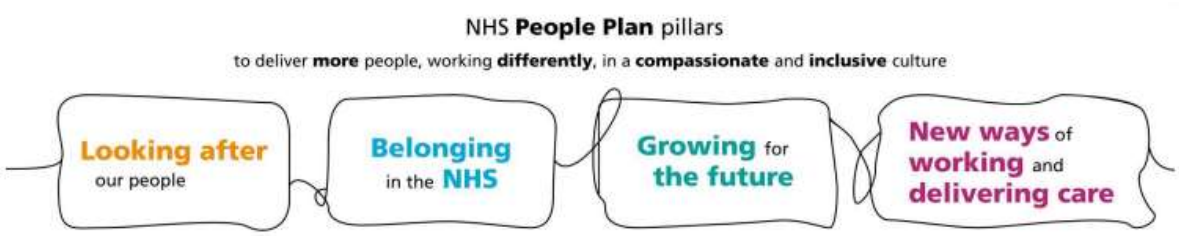
Figure 21: Number of patients waiting for Podiatry, by week group.

The service is progressing with the initiatives previously detailed, such as recruitment initiatives and demand and capacity modelling. In addition, some appointment times are being reduced specifically to see routine patients using the new cohort of band 5 podiatrists, who have less experience in dealing with the complex cases. Not only will this start to reduce some of the routine backlog, but it will also free up experience podiatrist to focus on urgent referrals.

The service has been asked to produce a trajectory to demonstrate what impact this will have within the next few weeks.

Equality, Diversity, Inclusion and Belonging (EDIB) People Promise Review

The NHS People Plan has four strategic objectives that we have commitments against for Solent in our Great Place to Work strategy. NHS People Plan pillars – to deliver more people, working differently, in as compassionate and inclusive way.



Service lines have been asked to review their data and provide feedback on strengths and identified areas of development at every other PRM. It was apparent in the majority of service lines that as this was the first time this data had been scrutinised, further consideration needs to be given to the consequences of the data and the potential impact their workforce information has on their service delivery.

Some areas of good practice identified included monthly learning events being held in Childrens and the 'COLIN' collaborative innovation group in Primary Care, encouraging all staff to participate in to share good practice and ideas for innovation, the implementation of a standardized induction programme for all staff in Primary Care, ensuring adequate time is spent with all teams to ensure a broad overview of the functions is gained, and active encouragement for staff to participate in the Staff Networks across multiple services.

Some challenges identified were whether the Staff Networks were truly inclusive to those staff who cannot attend when due to be working clinically, the impact on service delivery where there are underrepresented staff groups in some service lines, compared to population being served. A similar discussion also too place across several service lines about the number of staff who did not wish to disclose their disability status. This posed the question of psychological safety and are we as a trust doing enough to support staff to trust they can be honest and seek support if required.

All service lines committed to adding a regular review of this information to their internal governance and to explore how this can be used in an intelligent way to identify trends or opportunities for better supporting staff.

5. People

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Oct-23 Current Performance		Oct-23 Trending Performance	Oct-23 Variance	Sep-23 Current Performance		Sep-23 Trending Performance	Sep-23 Variance
People	Sickness (annual)*	I	4.5%	5.5%				5.4%			
	Sickness (in month)	I	4.5%	5.5%				5.4%			
	Turnover (annual)*	I	14.0%	12.4%		P		12.5%			
	Turnover (in month)	I	1.2%	0.9%				1.0%			
	New starters (FTE)	-	-	45.49			L	45.58			
	Proportion of Temporary Staff (in month)	I	3.6%	4.6%			L	4.8%			

b. Key Performance Exceptions

Sickness Absence

Our sickness absence profile is increasing further to 5.5%, above the target of 4.5%. This is in line with the assumed seasonal peaks with an increased pressure from cold viruses prevalent in communities and therefore our workforce. It will be an important focus for the Trust on our Winter Resilience Campaign, which includes an increased offer from Occupational Health & Wellbeing on the Flu Campaign but also support in managing wellbeing through the winter months.

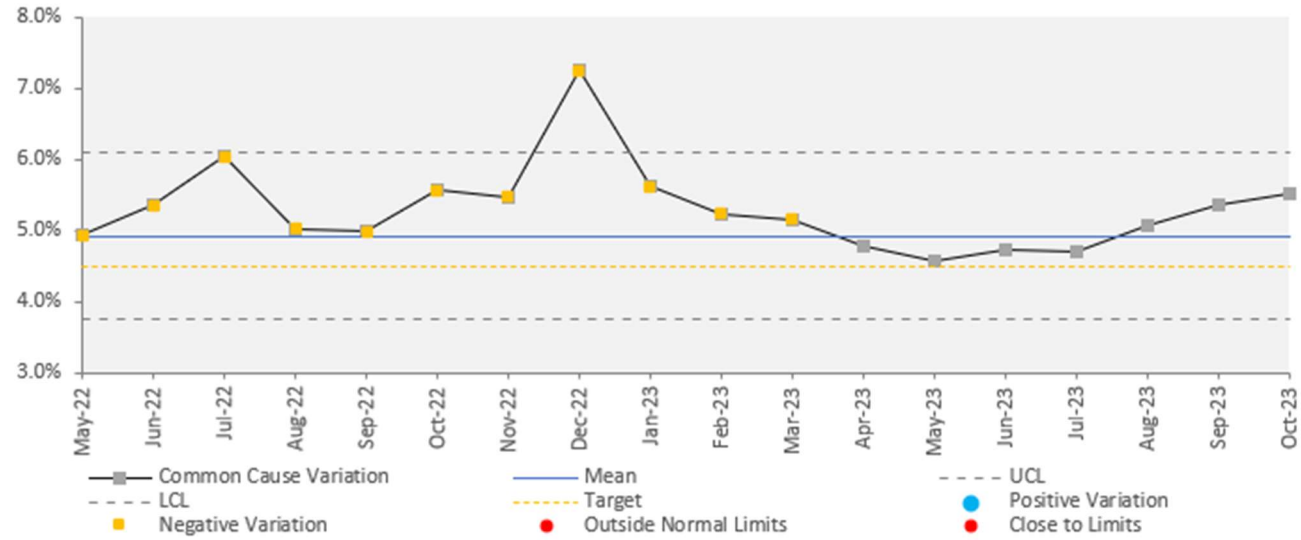


Figure 22: Trust-wide sickness absence rates

The Trust continues to present a high proportion of sickness due to mental health related conditions, but further work and discussions with services as part of our 'Wellbeing Bubbles' has provided insight that this is predominantly not work related, but due to external home-related pressures. This correlates with societal pressures from the cost of living and complex family dynamics. The Trust Reward week planned for December

will provide an opportunity to spotlight different support options available, including Vivup and the Employee Assistance Programme (EAP).

With the release of the new BI workforce dashboard, we will be utilising the capacity of workforce analysts to consider investigatory pieces of work to further delve into our sickness absence data, identifying more granular trends in episodes and reasons and correlating with turnover, protected characteristics and service lines.

Temporary Staffing

The usage of temporary staffing continues to be a focus area for the Trust in supporting the Financial Recovery Plan. There are multiple programmes of work led by both the ICB and internally at the Trust to look at managing agency use more effectively with providers as well as placing tighter controls in place for the booking of shifts.

The revised target of 3.6% from NHS England has been updated this month. The Trust is performing reasonably well in relation to this at 4.8%, ahead of other providers in Mental Health & Community benchmarking.

6. Finance

a. Performance Summary

	Indicator Description	Internal /External	Target	Oct-23 Current Performance		Oct-23 Trending Performance	Oct-23 Variance	Sep-23 Current Performance		Sep-23 Trending Performance	Sep-23 Variance
Finance	Year to date surplus/(deficit) Actual v budget	-	-	-1.4%			L	-2%			
	Agency spend % pay	I	3.5%	4.0%	●	?		7.4%	●	?	
	Cash balance	-	-	£7.3			L	£5.2			
	Aged debt (over 90 days)	-	-	845.0			H	802.0			
	Use of Resources Score	-	-	3				3			

b. Spotlight On: Month 7 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 £173k, £10k adverse to plan. Year to date the Trust is £1.8m adverse to plan. The main drivers behind the variance are the unfunded costs of the agenda for change pay award, inflationary pressure across our leasehold estate and the underachievement of the trusts cost improvement plans (CIP).

Agency Spend

There was an increase in the agency spend as a percentage of the total pay spend in September, out of line with the usual trend. This was due to a correction of incorrectly assigned agency spend from previous months. This was compounded by an increase in off-framework agency usage during September within the Children's service line, to cover specific hard to fill consultant roles.

Cost Improvement Plans (CIP)

The trust has an internal efficiency programme of £23.9m, made up of 27 schemes. M7 CIPs underperformed by £838k and are £3.5m under performing year to date, much of the underperformance is being driven by schemes developed post planning as part of the trust's financial recovery plan.

Capital

The capital plan for 23/24 is £21.9m, consisting of £4.1m internally funded, £13.1m Public Dividend Capital (nationally) funded, and £4.7m Integrated Care System funded.

Month 7 capital spend £1.4m, £1.2m underspend against plan. YTD spend £4.8m, £1.7m underspend compared with plan. Whilst M07 was less than expected, actuals spend has started to re-align with plan and it is expected that the overall capital programme spend will fully utilise the trust's capital allocation.

Cash

The cash balance was £7.3m as at 31 October 2023, a £2.1m increase from September primarily due to SCC paying £2.6m in month for outstanding invoices.

Aged Debt

The Trust's total debt was £6.3m at the end of October, a decrease of £2.7m from September, due to half of the £5.3m invoices raised during September being paid in October. 91+ days overdue debt at the end of October was £0.8m, £0.04m increase from September. SBS continue their normal procedures to chase, along with internal finance team 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 October 2023 the Trust paid 95.3% of volume of invoices within target and 93.8% of value.

Scan date to payment date was 119.8 days, 98 days higher than September. This was due to some invoices on hold from 2021/22 being paid, also several invoices from 2022 which did not go on to the system until very recently were paid.

7. Research & Improvement

a. Performance Summary

Since April 2023, 212 participants have been recruited into 21 studies, comparable with similar size Trusts across the Wessex region. A further 3 studies are due to open imminently. The majority of participants are typically recruited in the winter and therefore it is anticipated that there will be a significant uplift in participant numbers by the end of the financial year.

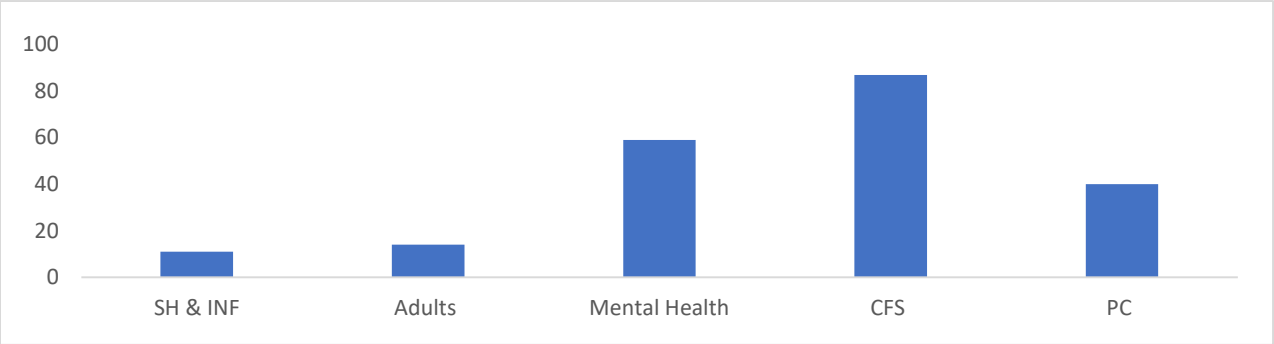


Figure 23: Research recruitment by Service Line since April 2023

b. Spotlight on: Adults Research Studies

Studies currently in set-up

- EvolvRehab – MoveWell virtual platform for stroke survivors - This study is testing a remote tele-rehabilitation programme for patients that have had a stroke, considering how well the system works for improving arm function and quality of movement in people who have recently experienced strokes and assessing how cost effective it would be for the NHS to incorporate the system.
- Parkinson's and Movement Disorders Families Project (PFP) - This research aims to understand more about the genetics of Parkinson's and other movement disorders, to develop better tests and medications that could help slow, stop or prevent Parkinson's.
- REDUCE Trial: Reducing the impact of diabetic foot ulcers - A randomised controlled trial to test whether a psychological and behavioural intervention is more effective than usual care in the time patients remain free from diabetic foot ulcers.
- SOCKSESS - This research is co-designing a digital health intervention: smart sensing socks for monitoring diabetic feet and preventing ulceration.
- VenUS 6 Compression therapies for treatment of venous leg ulcers - The purpose of this randomised controlled trial is to compare different compression therapies to investigate the clinical and cost effectiveness for treating venous leg ulcers. Participants will be randomised to receive 2- layer bandages, evidence -based compression (4-layer bandages/ 2-layer hosiery) or compression wraps.

Studies in the pipeline:

- TRICEPS – This is a randomised controlled trial aiming to find out whether non-invasive Transcutaneous Vagus Nerve Stimulation (TVNS) improves arm function after stroke when it is used alongside rehabilitation therapy over 12 weeks.

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 - 2023/24 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, is in System Oversight Level 4, highlighting the additional support being received from NHS England with regards to managing the financial deficit of the ICS through a Recovery Support Programme. The metrics reported below are those included within the 2023/24 updated technical guidance, for which Solent contributes towards the HIOW ICS performance.

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	Oct-23				Sep-23			
				Current Performance		Trending Performance	Variance	Current Performance		Trending Performance	Variance
Quality, Access & Outcomes	S035a: Overall CQC rating (provision of high-quality care)	-	-	Annual Metric							
	S007c: Elective Activity - Value weighted elective activity growth (ERF Income v Target v6)	E	100.0%	120.9%		P		119.3%		P	
	S009d: Patients waiting more than 65 weeks to start consultant-led treatment	E	0	0		?		0		?	
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	E	100.0%	58.5%		F	H	58.5%		F	H
	S121a: NHS Staff Survey compassionate culture people promise element sub-score		0	Annual Metric							
	S121b: NHS Staff Survey raising concerns people promise element sub-score	I	0.0%	Annual Metric							
	S124a: Percentage of occupied adult beds occupied by patients who no longer meet the criteria to reside	-	-	Metric under development							
	S125a: Long length of stay for adult acute mental health (discharges with LOS over 60 days / all discharges)	E	0.0%	0.0%		?		4.3%		?	
	S125b: Long length of stay for older adult mental health (discharges with LOS over 60 days / all discharges)	E	0.0%	7.7%		?		40.0%		?	H
	S126a: Diagnostic activity waiting times – percentage of patients who have been waiting more than 6 weeks	E	95.0%	49.0%		?	H	100.0%		P	H
	S128a: Virtual wards – percentage occupied	-	-	Metric under development							
	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: Talking Therapies access (total numbers accessing services)	E	542	567		?		398		F	
	S084a: Children and young people (ages 0-17) mental health services access (number with 1+ contact)	-	-	Metric under development							
	S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (3 months rolling)	E	0	0		?		0		?	
	S107a. Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	E	70.0%	69.6%		?		73.3%		?	

	Indicator Description	Internal /External Target	Target	Oct-23 Current Performance		Oct-23 Trending Performance	Oct-23 Variance	Sep-23 Current Performance		Sep-23 Trending Performance	Sep-23 Variance
Looking after our people	S072a: Proportion of staff agree their organisation acts fairly on career progression, regardless of ethnic background, gender, religion, sexual orientation, disability or age	I	58.6%	Annual Metric							
	S063a: NHS Staff Survey Safe environment - Bullying and harassment theme score	I	790.0%	Annual Metric							
	S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	I	0.0%	Annual Metric							
	S063c: Proportion of staff who say they have experienced harassment, bullying or abuse at work from patients/service users, relatives or other members of the public	I	0.0%	Annual Metric							
	S067a: Leaver rate	I	14.0%	12.4%		P		12.5%		P	
	S068a: Sickness absence (working days lost to sickness)	I	5.0%	5.5%		?		5.4%		?	L
	S069a: NHS Staff Survey Staff engagement theme score	I	700.0%	-				-			
	S071a: Proportion of staff in senior leadership roles who are from a BME background	I	12.0%	7.1%		F		8.1%		F	
	S071b: Proportion of staff in senior leadership roles who are women	I	62.0%	71.4%		P		70.9%		P	
	S071c: Proportion of staff in senior leadership roles who are disabled	I	3.2%	6.0%		P	H	5.8%		P	H
	S133a: Staff Survey – We Are Compassionate and Inclusive People Promise element score	I	0.0%	Annual Metric							
Finance and Use of Resources	S118a: Financial Stability	E	-	Metric under development							
	S119a: Financial Efficiency	E	-	4.9%				7.2%			
	120a: Finance – Agency Spend vs agency ceiling	E	100.0%	0.0%		P		0.0%		P	
	120b: Agency spend price cap compliance	E	100.0%	0.0%		F		0.0%		F	

Key

In-month Performance Indicator

Metric is achieving the target

Metric is not achieving the target

Trending Performance Indicator

P — Target has been consistently achieved, for more than 6 months

F — Target has been consistently failed, for more than 6 months

? — There is a variable and inconsistent performance against the target

Variance Indicator

H — 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

H — 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

L — 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

L — 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	Mental Health Act Scrutiny Committee Exception Report				
Date of paper	23 November 2023				
Presentation to	In Public Board				
Item No.	16				
Executive Summary	This report is presented to the In Public Board to summarise the key business transacted at the Mental Health Act Scrutiny Committee held on 16 November 2023.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The In Public Board is asked: • To receive the summary of business transacted.				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Previously considered at	N/A				

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: Sufficient Assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Non-Executive Sponsor Signature	Vanessa Avlonitis, Non-Executive Director & Committee Chair							

Summary of business transacted:

The **Mental Health Act Report** was received and exceptions/comments shared.

- The Committee discussed the report content and assurance at length including consideration on report design for the Hampshire and Isle of Wight Healthcare NHS Foundation Trust and agreement that learnng from Solent's MHASC should be taken into the new organisation.

- Police Force changes have increased detention numbers in Portsmouth and the Isle of Wight, stations without liaison and diversion services seems to be the cause.
- Increase in both s2 and s3 cases during the reporting period, which is not unusual during the summer months.
- The Committee were assured that s5.2's are monitored closely. 2 cases were reviewed and actions to address both were confirmed.
- 136 detentions have increased, primary cause believed to be Police force changes.
- Ethnicity was discussed including an update on regular monitoring and work starting with Solent MIND on Chinese society and the shame associated with mental illness.
- The Committee was advised that their first Approved Clinician had been appointed, which will provide additional support for AMH inpatient units.
- It was confirmed that no s4's were used during the reporting period.
- The Committee received assurance that s5 holding powers and legislation adherence are improving due to ongoing AMP team discussions and a new Consultant.
- It was confirmed that s62's in particular SOAD's were also improving, which reflects a more robust clinical model on inpatient wards.
- The Committee received an update on Associate Hospital Manager activity including recruitment of lived experience people.

Standard scrutiny of the **Restraint and Seclusion Assurance Report** took place.

- An overview of restraint numbers and types was provided for the reporting period. The Committee was provided with an overview of the restraint process providing assurance.
- It was noted that acuity was high across the summer months with an unusually high number of patients with emotional dysregulation. Full assurance of scrutiny and review process confirmed.
- An overview of seclusions was provided with assurance that all were in line with policy and the MHA code. The Committee also received an overview of the seclusions process for assurance.
- The Committee discussed the range of time in seclusion in the report, including data comparisons year on year and benchmarking against equivalent organisations.

- The **Committee Annual Effectiveness Appraisal** was received.

- The **Terms of Reference Annual Review** was received.

- There were no risks to report in relation to the **Board Assurance Framework (BAF).**

Decisions made at the meeting:

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

Recommendations (not previously mentioned):

There are no specific recommendations to note.

Other risks to highlight (not previously mentioned):

There are no risks to highlight.

Board and Committee Summary Report

Item 17

NHS Solent NHS Trust

Title of Paper	Audit and Risk Committee Escalation Report						
Date of paper	November 2023						
Presentation to	In Public Trust Board – December 2023						
Item No.	17						
Executive Summary	The aim of this paper is to update the In-Public Trust Board on items discussed at the Audit and Risk Committee meeting during November 2023.						
Action Required	For decision?		For assurance?	Y			
Summary of Recommendations	The In Public Trust Board is asked to: • Take assurance from the escalations reported by the November Audit and Risk Committee.						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	x	
Previously considered at	N/A						

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 In-Public Trust Board is asked to consider whether this paper provides: Sufficient assurance, and, whether any additional reporting/ oversight is required by a Board Committee(s)							
Non-Executive Sponsor Signature	Andrew Strevens, CEO, on behalf of David Kelham. David Kelham, Non-Executive Director and Audit and Risk Committee Chair							

Audit and Risk Escalation Report

Summary of business transacted and escalations to report to December In-Public Trust Board meeting.

Finance Assurance update - The committee received an update on all STW's processed since the last meeting, totalling £71,137, as well as an overview of the one Loss/Special Payment made in Q2, 23-24 of £130.
The Committee received assurance from the STW and Losses and Special Payments reports.

Absorption Accounting – The committee were informed of the key areas to note for the accounting treatment used when one NHS organisation transfers into another NHS organisation, a transfer by absorption.
The Committee received assurance from the Absorption Accounting report.

Internal Audit Update – The committee were briefed on the key areas from the November 2023 Internal Audit Progress report, including the timescales associated with all reviews.
The Committee received assurance from the November 2023 internal audit progress report.

External Audit Update – The committee received an outline of the key high-level information from the November 2023 progress report and noted that the planning process is due to commence week commencing 13 November.
The Committee received assurance from the external audit progress report.

Counter Fraud, Bribery and Corruption update – Audit and Risk were advised of the key areas of focus from the November 2023 Counter Fraud Progress report including an overview of the timeline for completion. An action has been escalated to the Quality Assurance Committee in relation to agency nurse verification.
The Committee received assurance from the Counter Fraud Progress report.

Update on external reviews / (un)announced visits – The committee accepted there were no external reviews /(un)announced visits to record.
The committee received assurance from the update provided.

Risk Management Q2 Report 23/24 Report – Audit and Risk Committee facilitated in-depth discussions regarding the Trusts operational risks, including reporting, scores, movements, mitigating actions, deep-dives, and governance routes for escalation.
The committee noted the updates and received assurance from the Risk Management Q2 Report 23/24 Report.

Self-Assessment of Committee's effectiveness – The committee considered the Self-Assessment of Committee's effectiveness report and suggested the number of questions could significantly reduce.
The committee received assurance from the responses within the report.

Well Led Progress Report – The committee received an update on the Well Led review, including progress against the action plan. The recommendation to close actions 54, 55, 57, 58 was approved.
The Committee received assurance from the Well Led Progress Report and agreed to close actions 54, 55, 57 and 58.

HR, People Operations Audit Report – The committee were briefed on the purpose of the report and received an update on the progress and notable improvements to date. The committee praised the achievements and agreed to receive the next report in 6-months.
The Committee received assurance from the update on People Operations Audit Report.

Board and Committee Summary Report

Title of Paper	Quality Assurance Committee Exception Report				
Date of paper	November 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 23 November 2023.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The In Public Board is asked: • To receive 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** to report. Changes in Freedom to Speak Up leadership arrangements were reported.

- **Urgent Matters of Safety-** The Chief of Nursing and AHPs briefed the Committee on matters identified:
    - It was confirmed that a regulation 28 prevention of future deaths notice had been received and circumstances were explained. The Committee were assured of full learning taking place across organisations.
    - Following reports at the Audit and Risk Committee, an update was shared in relation to identification of a fraudulent case. Full review of systems/processes was highlighted and the Committee were assured of continued monitoring, together with the Local Counter Fraud Specialist.

- There were no **Partnership Governance Arrangements** to share. It was confirmed that the Project Fusion Full Business Case had been signed by the Boards and feedback from recent NHSE observations would be provided in due course.

- The Committee **noted** the following regular reports presented:
    - **Freedom to Speak Up Annual Report**
    - **Safeguarding Annual Report**
    - **Experience of Care (including Patient Experience/Complaints & Community Engagement) – Q2 Report**
    - **Safe Staffing Q2 Report** *(item 18.2)*
    - **Infection Prevention & Control Q2 Report**

- **Performance & Quality Exception Report-** key escalations were presented, including:
    - Cardiac Echo wait times- continued review of risk, increased scoring, consideration of harm and appropriate prioritisation/triaging of waits was confirmed.
    - Dental Service pressures- ongoing review and oversight of challenges was noted.
    - Pelvic Health Service- The Committee were informed of issues and ongoing discussions in place regarding escalation processes.
    - S75 Review within Child and Family Services- oversight and potential increase in safeguarding activity expected was shared.
    - Falls- delays in falls sensor equipment and appropriate escalation was noted.

- There was no **Ethics and Caldicott Panels** held to report.

- There were no **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)** to report.

- The **Committee Annual Report** was noted.

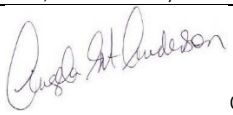
- The **Board Assurance Framework (BAF) consideration and oversight of risks Report** was reviewed and updates to risk target scores noted.

Board and Committee Summary Report

Title of Paper	Quarterly Safe Staffing Report Quarter 2 July – September 2023				
Date of paper	13/11/2023				
Presentation to	In-Public Board				
Item No.	18				
Author(s)	Samantha Hemingway/Jill Young				
Executive Sponsor	Angela Anderson				
Executive Summary	• Staffing levels across the nursing & AHP workforce in Solent NHS Trust were maintained at minimum safe staffing levels and where there were concerns mitigations were put in place including use of temporary staffing. There will continue to be close scrutiny of staffing levels and the impact of the recruitment strategies in place to ensure timely appointment of staff into current vacancies. • Based upon the data and information available it is evident that it is difficult to evidence patient harm as a direct result of staffing levels. However continued attention needs to be given to retaining staffing with the necessary skills and competence to meet the increasing complex patient need identified. • Following feedback the report now includes the breakdown of temporary staff usage by registered and non-registered has been achieved. • There were challenges to collate the workforce data within Q2 as with Q1, this is specifically in relation to the vacancy data. • The progress continues to be made in the implementation of the acuity and dependency safer staffing tools with a planned implementation of the Safer Nursing Care Tool for the physical health inpatient units. • Inpatient clinical nursing establishments reviews have been completed with the exception of Brooker ward and presented to the Safer staffing assurance meeting, all have been signed off in terms of safe staffing requirements, further finance work is required ahead of taking to finance and commercial. With a proposal that the Community Nursing Services present their establishment, quality and workforce reviews.				
Action Required	For decision?	(Y/N)	For assurance?	(Y/N)	
Summary of Recommendations	The Quality Assurance Committee is asked to: • To receive assurances regarding the current position of safe staffing within the organisation				
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	Quality Improvement and Risk Group and Quality Assurance Committee				

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		9.Belonging to the NHS		13. A greener NHS	
	3. Outcomes that matter	x	10. New ways of working		14. Supportive Environments	x
	4. Life-course approach		11. Growing for the future	x	15. Partnership and added value	
	5. One health and care team	x				
	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	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	 Chief of Nursing and Allied Health Professionals							

Executive Summary

This report provides the Trust Board with an overview of the Nursing & AHP staffing status for quarter 2, July – September 2023.

It provides assurance that arrangements are in place to safely staff the services in line with the National Quality Board (2018) safe staffing requirements.

It also seeks 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.

Within this quarter the monthly Safer Staffing Assurance meeting has continued to evolve and develop strengthening the overall governance process around safer staffing. The meeting is a formal forum operating within the Trust governance framework as a subgroup of the Quality Improvement & Risk (QIR) Group to provide oversight of the organisational safe staffing position.

It is noted that there have been some challenges obtaining data for the purposes of the report. A programme of work has been commenced to review the workforce and activity data, including validation of how the trust currently reports both at a trust wide and local unit level, this includes the vacancy, Unify and Care Hours Per Patient Day (CHPPD) data that is shared externally. This is reflected in the absence of the Adult Portsmouth inpatient wards data and community services vacancy data. It is expected that this will be corrected within Q3.

There are ongoing challenges with a high level of temporary workforce in some areas, vacancy levels higher than planned for some teams and sickness rates compounding these factors, this can be reflected in the overall risk profile relating to staffing, however the quality data is showing a downward trend in terms of staffing related incidents with reporting into safe staffing meetings that mitigations in place are continuing to be successful to sustain staffing levels.

Within the quarter there has been significant work to support roster and temporary staffing solutions into both our physical and mental health inpatient units, recruitment and attraction and overall reduce use of temporary workforce with an emphasis on off framework agency.

Adult Community Nursing continues to be stretched in terms of capacity and demand across both cities and is reflected within their individual service level risk registers. Safe staffing and patient safety has been mitigated through effective daily management of patient acuity and dependency, caseload, and flexible working. Service lines continue to explore how recruitment strategies can be employed to generate interest and career development pathways.

The adult and mental health service lines have presented their workforce establishment reviews to the safer staffing assurance meetings and agreed a plan for future reviews in line with business planning, where the establishment has been agreed resulting in a variance in budgeted establishment the case for change will escalate into finance and commercial.

Within Q2, the second Mental Health Optimal Staffing Tool (MHOST) has been completed and analysis is ongoing.

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 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**

2.1 Safe staffing meetings have continued during this reporting period. A number of services have daily huddles/sitrep's with escalation processes in place via the service line and organisational assurance framework.

2.2 Safe staffing meetings schedule has continued throughout this quarter, demonstrating the benefits of bringing similar teams together from across the trust. This has presented 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.

2.3 The national guidance had changed in relation to SAR-CoV-2 within Q1 and fully implemented within Solent NHS Trust since the beginning of Q1, with mitigation measures such as routine universal wearing of respiratory masks ceasing and testing guidance for staff and patients updated.

During Q2 there were 2 SARS-CoV-2 outbreaks reported with Adults Southampton, Lower Brambles Ward, both incidents affected staff and patients, however staffing levels were sustained. Further details regarding this can be found within the Q2 Infection Prevention and Control Report.

2.4 The concerns raised within the Acute Mental Health ward in 2022/23, relating to medical capacity, patient and staff safety and wellbeing have had an ongoing comprehensive action plan in place which has had executive level oversight. Within Q2 the Maples ward leader continued to provide senior leadership cover across both units and the practice educator team has undertaken a more visible clinical presence on the units. The clinical update days and skill slots have been delivered within the ward setting. Hawthorn ward is awaiting a new Band 7 team leader to onboard in October 2023.

2.5 Within the Safer Staffing Assurance meetings, the Matrons for Adults Portsmouth Inpatients and for the Acute Mental Health Wards presented reviews of the safe staffing establishment and skill mix for their areas. Following the presentation and opportunity for discussion, the agreed safe staffing allocation was formally signed off by the Chief of Nursing & AHP. Within Q3, it is anticipated that

Older Persons Mental Health and adult Community Nursing will present their proposed establishment and skill mix reviews.

3.0 Workforce

3.1 The following tables represent the workforce data within the quarter. Due to previously noted challenges in Q1, it is not possible to present a complete comparison to Q2.

3.2 Community Nursing Services

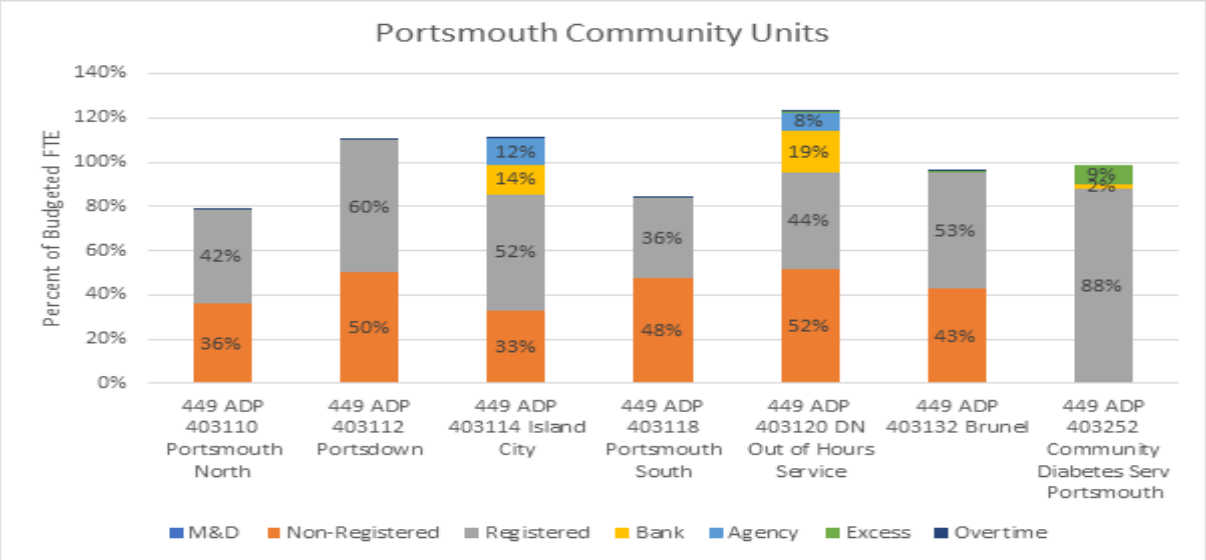


Table 1 Workforce by % Q2 2023 -2024

Table 1 demonstrates the Portsmouth Community services workforce distribution of permanent staff and temporary staffing. The data demonstrates overall static position of staff in post. There is a variance across the city which may be explained by known changes to budgetary/establishment that haven't pulled through, temporary staffing usage attributed to specific teams however deployed across the city.

Table 2 Q2 Bank and Agency usage across Community Nursing Services

The only services showing bank usage for Q2 are Island City, DN OOH and Community Diabetes Service. With a significant change from Q1 data in Island City, where usage decreased in terms of registered staff from 3.4 FTE down to 2.4 FTE.

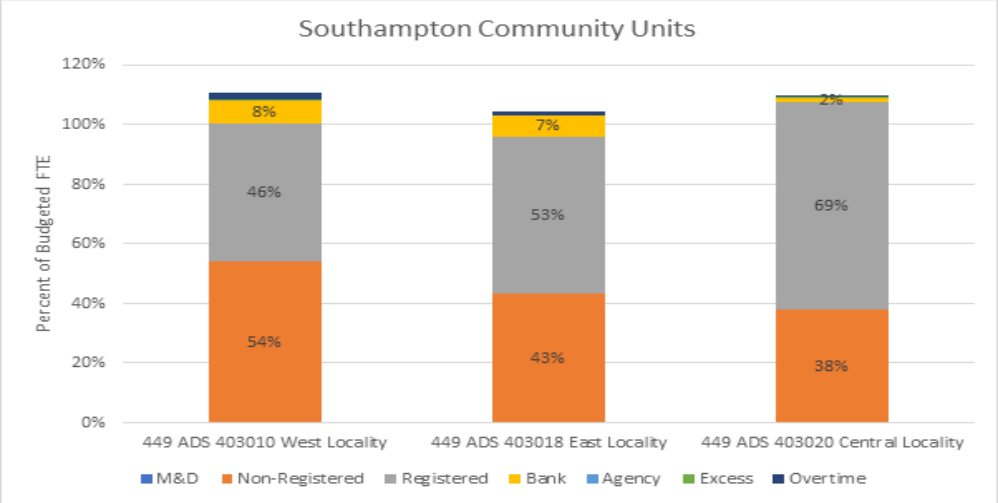


Table 3 Q2 2023 – 2024 Southampton Community Nursing Service Workforce distribution.

The data shown indicates the Southampton community nursing teams are working above budgeted FTE however this is not reflective of their overall service demand and have an agreement in place to recruit at risk above budgeted establishment, service narrative highlights a number vacancies held within this.

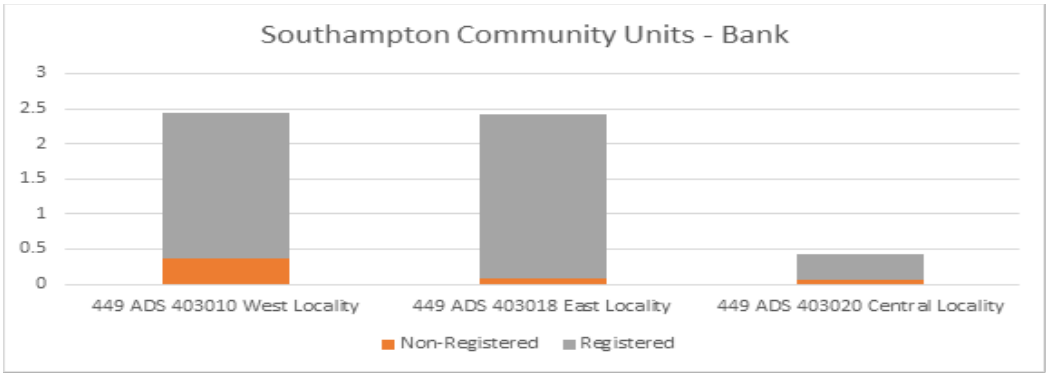


Table 4 Q2 2023 – 2024 Bank Staff Usage

There was a slight decrease in Bank usage for registered staff from Q1 in the Southampton community teams except for West Locality, which had an increase of 0.3 FTE.

There was no utilisation of Agency staff across Q2 within the Southampton community teams.

3.3 Adult Inpatient Wards

The table below shows the workforce distribution across the inpatient wards.

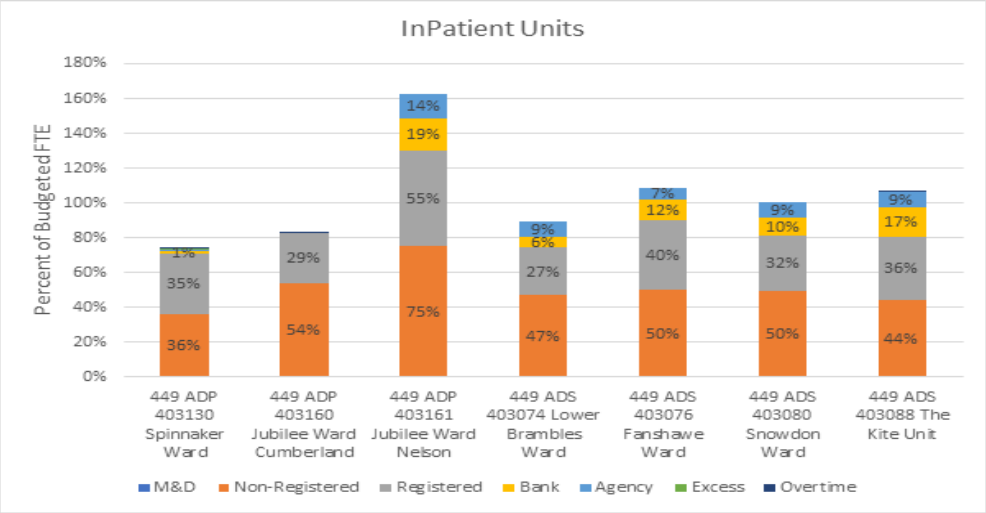


Table 5 Q2 2023 -2024 Workforce distribution Adult Inpatient Wards

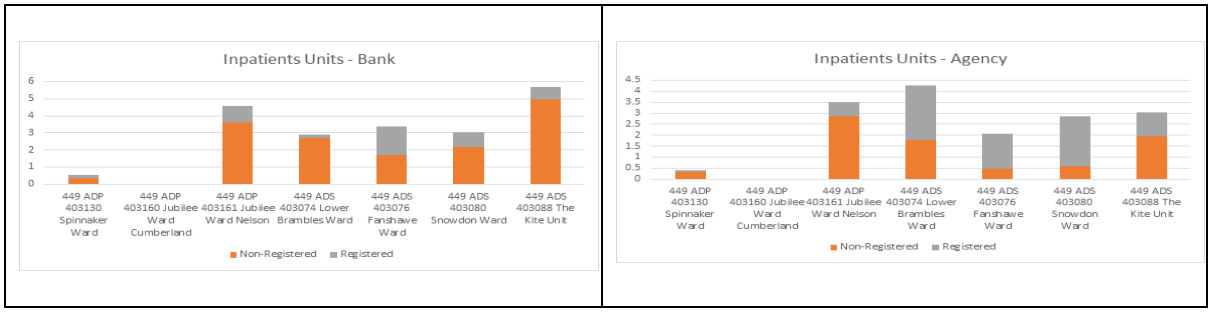


Table 6 Q2 2023 – 2024 Bank and Agency usage Adult Inpatient Wards

There are ongoing issues with temporary staffing data for Jubilee unit and therefore difficult to make any conclusions from the figures above however worth noting the temporary staffing usage appears high for Nelson and nil usage for Cumberland which does not match the locally held data.

The largest reduction in temporary workforce usage was seen in Spinnaker ward with both agency Non Registered and Registered shifts, reducing by 0.40 FTE and 0.78 FTE respectively and bank by 0.38 FTE Registered shifts.

From the data available the largest increase in non-registered temporary staffing is in The Kite unit seeing an increase of 0.65 FTE bank and 0.72 FTE agency where have had a consistent requirement of enhanced observations over this period which is reflected in the changing requirements within their establishment review along with an increase in parenting leave.

For registered temporary staff the largest increase was seen across the RSH units with Fanshawe, having an increase of 0.63 FTE bank staffing, with a reduction in non-registered shifts of 0.56 FTE and Lower Brambles an increase of 0.93 FTE agency usage.

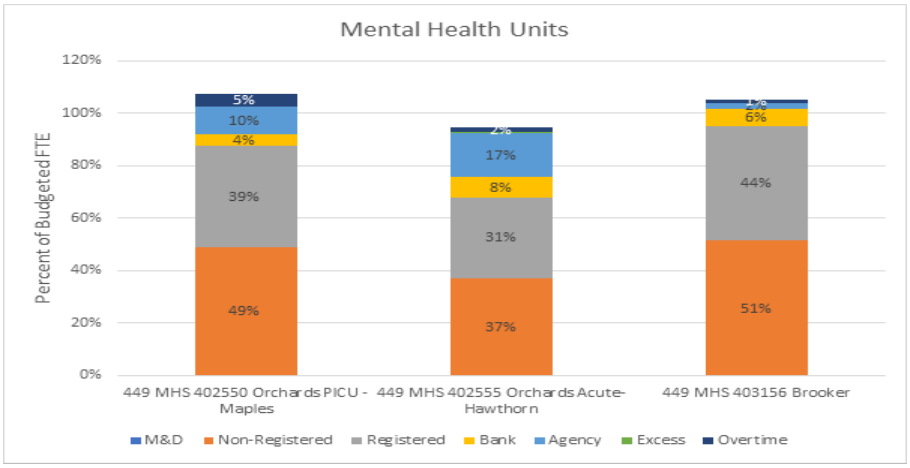


Table 7 Q2 2023 – 2024 Workforce Distribution Mental Health Wards

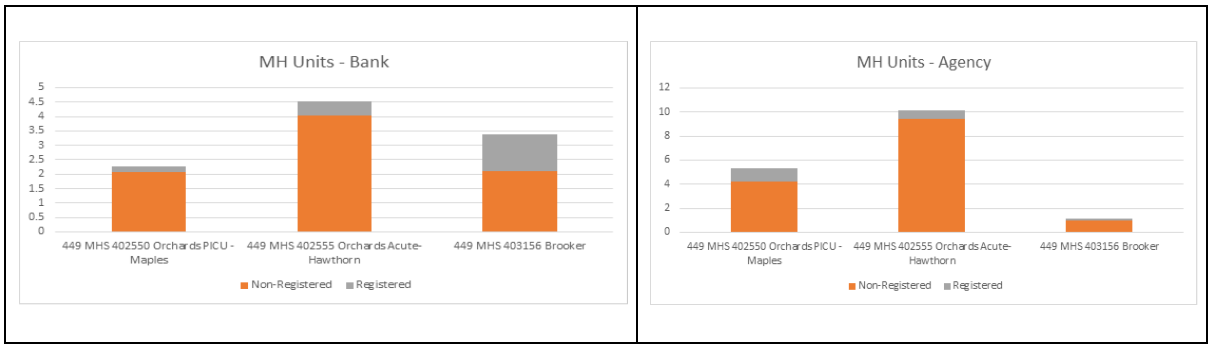


Table 8 Q2 2023 – 2024 Bank and Agency usage Mental Health Wards

4.1 the data in table 7 and 8 in comparison with Q1 data shows an increase of temporary staff usage in quarter for Registered nurses on Brooker, with an increase of 0.41 FTE bank and 0.03 FTE agency staff availability data highlights an increase in sickness which would explain this change. However it has seen a comparable overall decreased reliance on use of temporary staffing for non-registered staff by 2.41 FTE.

Table 8 highlights the use of non-registrant temporary staff on both Hawthorn and Maples which is an increase within the last quarter, with an increase of 3.71 FTE agency staff on Hawthorne and 1.04 FTE bank on Maples, this is reflected in the number of HCSW vacancies reported and action taken with a focused HCSW recruitment campaign ongoing. September MHOST data collection highlighted within the report, acknowledges an significant increase in the number of patients requiring enhanced observations, accounting for a proportion of the increase in temporary staffing use in comparison with Q1.

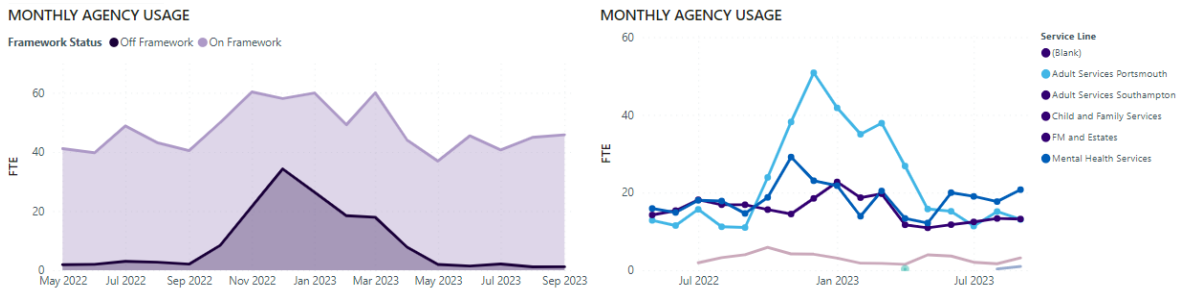


Figure.1 Monthly Agency usage

The figure above highlights the ongoing work to strive to reduce reliance on agency staffing, especially off framework agency staff and remain proactive with substantive recruitment. The Mental Health Inpatient wards have held successful interviews for HCSWs, and this will continue throughout Q3.

It must be noted that senior nursing and AHP roles are not normally included in this data so would not account for those 'heads of' and 'matron' roles present in the workplace.

5.0 Care Hours Per Patient Day (CHPPD)

5.1 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.

5.2 There has been inconsistencies with the CHPPD data throughout 2022 / 23. An initial review and comparison of the CHPPD, establishment / E Rostering and Unify data has been undertaken in Q2 which identified that further work is required.

The predominant concern is the incorrect data for Cumberland and Nelson and the data does not reflect the separation of the 2 wards. In addition, there is a lack of data for August and September for Maples and Hawthorn.

	Jul-23			Aug-23			Sep-23		
WardName	Registered Nurses/Midwives	Non-registered Nurses/Mid	Overall	Registered Nurses/Midwives	Non-registered Nurses/Mid	Overall	Registered Nurses/Midwives	Non-registered Nurses/Mid	Overall
Total									
ADP Jubilee House Continuing Care	1.0	1.9	2.9	0.6	0.9	1.5	0.6	1.1	1.8
ADP Spinnaker Ward	3.4	4.0	7.3	3.1	5.0	8.1	3.4	4.0	7.4
ADS Fanshawe Ward	3.1	3.4	6.5	2.9	5.0	7.9	2.9	3.7	6.6
ADS Lower Brambles Ward	2.3	4.0	6.3	2.4	3.0	5.4	2.3	4.3	6.6
ADS Snowdon Ward	3.4	5.1	8.5	3.3	9.5	12.7	3.7	5.4	9.1
ADS The Kite Unit	5.1	8.5	13.6	7.9	12.4	20.3	6.0	11.7	17.7
MHS Brooker	5.8	9.9	15.7	5.8	10.2	16.1	4.9	8.2	13.0
MHS The Orchards Acute - Hawthorn	2.6	7.0	9.6						
MHS The Orchards PICU - Maples	8.0	11.8	19.7						

Table 9 Q2 2023 -2024 CHPPD Data

The care hours reported remain broadly consistent across the quarter. Further work will be undertaken to ensure the reporting for Cumberland, Nelson, Maples and Hawthorn are reflected in the Q3 report.

6.0 Non-Productive / Unavailability

6.1 A key factor in managing safe staffing is the management of the unavailability of staff to support the roster period. Currently, the trust's funded headroom for non-productive working is set at 22%. Within the 22% allocation there are specific trust targets for annual leave, study leave and sickness.

6.2 The data in tables 10 – 17 show the unavailability by theme across Q2. The trust target of 22% has been added to table to demonstrate where teams have exceeded the target. It is noted that parenting leave is not included within the non-productive percentage for the trust however, this has had a significant impact on some clinical services across the quarter, with 50% of the services / teams reporting an excess of 2% parental leave guidance (range 4 -14%).

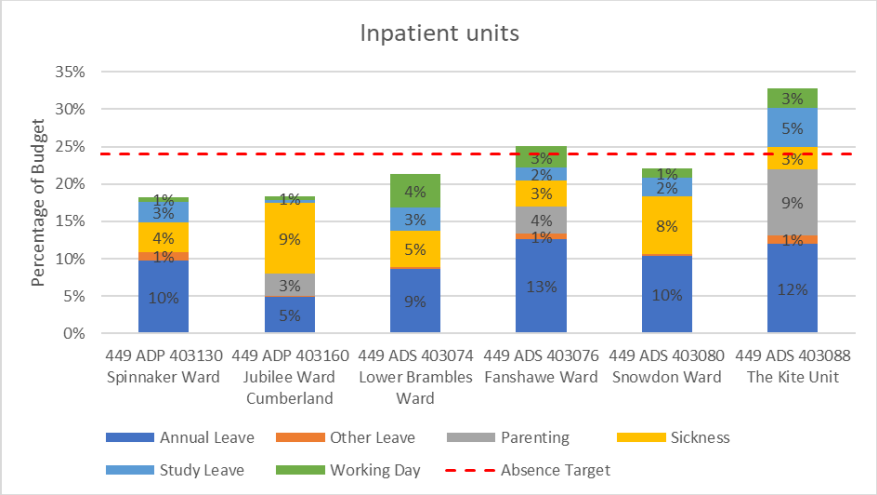


Table 10 Q2 2023 -2024 Adult inpatient unavailability by theme

6.2.1 Included in this quarters report is a comparison of availability between Q1 and Q2.

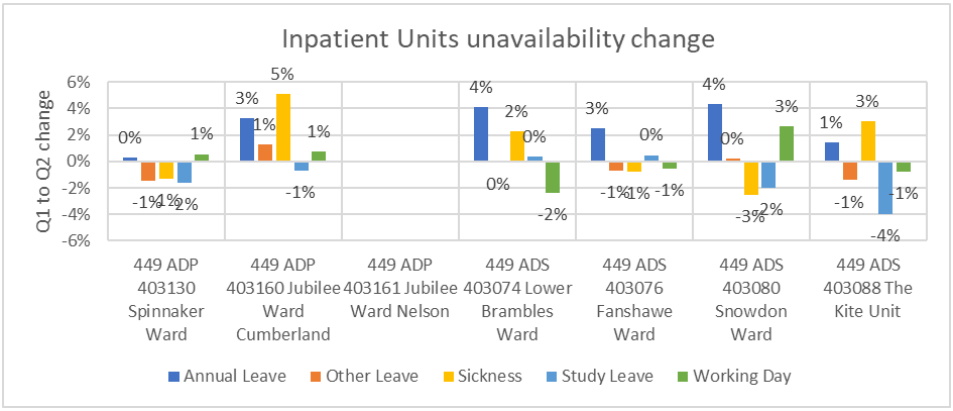


Table 11 Comparison of availability Q1 - Q2 2023 -2024

There is no comparison data for Nelson due to the unavailability of the data in Q1. There has been increases in sickness absence and annual leave across Cumberland, Lower Brambles and Kite Unit.

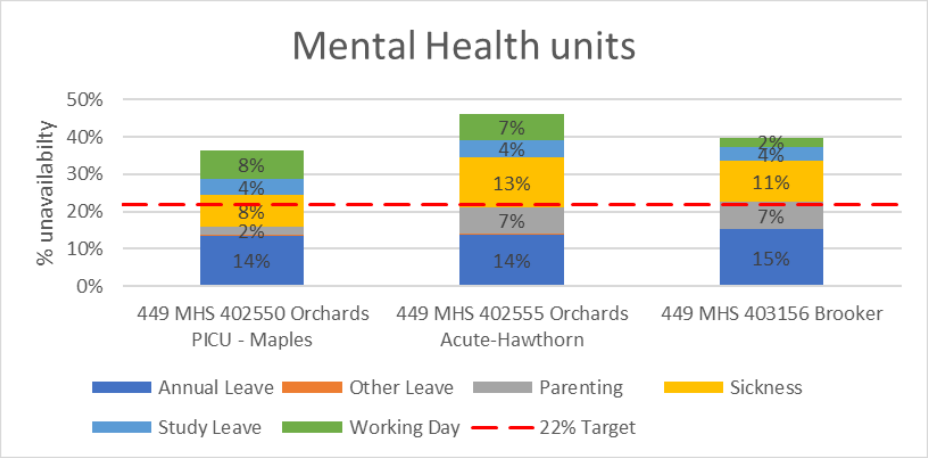


Table 12 Mental Health Inpatient Unavailability by theme

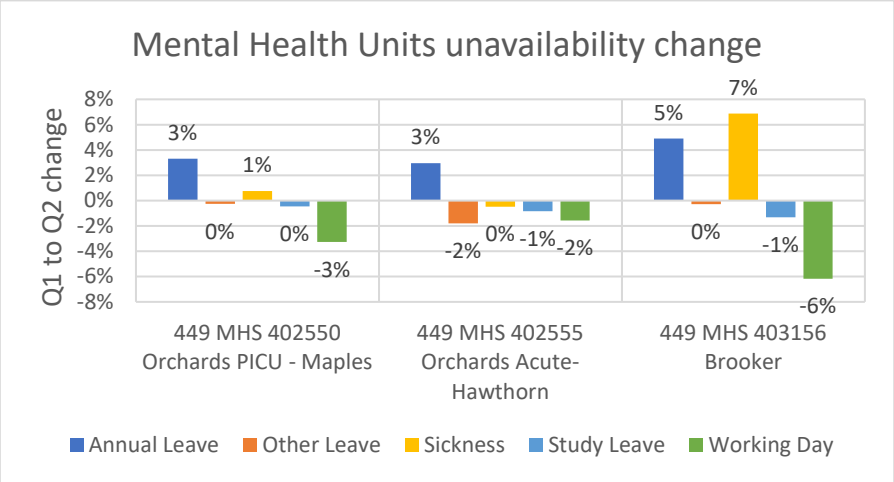


Table 13 Comparison of availability Q1 - Q2 2023 -2024

6.2.2 Within the Mental Health Inpatient areas, absence is noted to be high within Brooker and a converse decrease in the working day percentage.

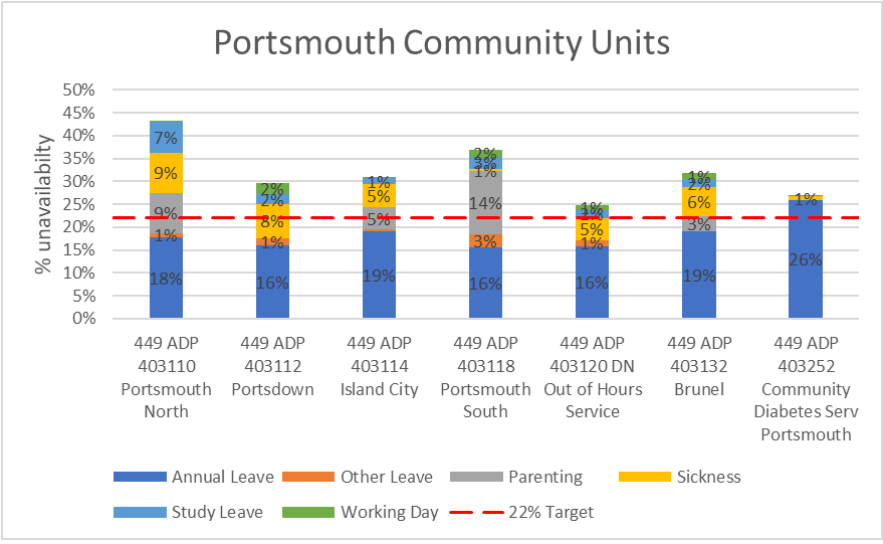


Table 14 Portsmouth Community Teams Unavailability by theme

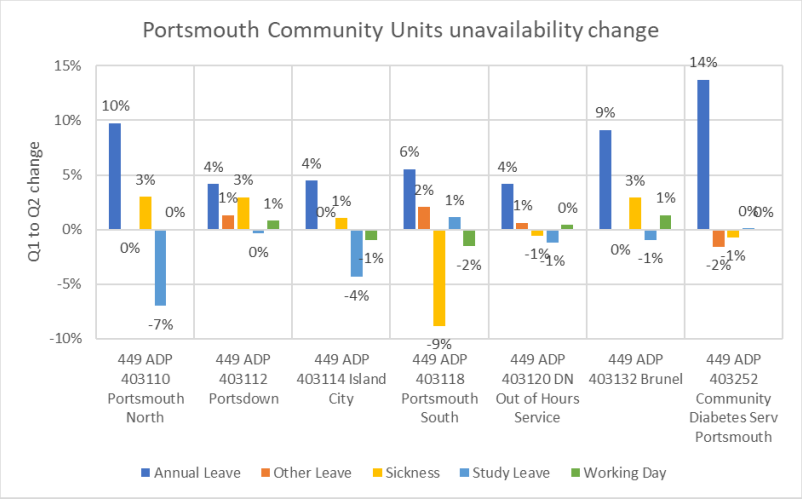


Table 15 Comparison of availability Q1 - Q2 2023 -2024

6.2.3 It is noted that there was an increasing trend of annual leave within the quarter, acknowledging it included a significant school holiday period. Sickness absence also saw a slight increase between quarters, with the exception of Portsmouth South team that saw a significant decrease. Please note the high percentage of sickness in the Diabetes service that is reflective of the impact of a single member of staff in a small team.

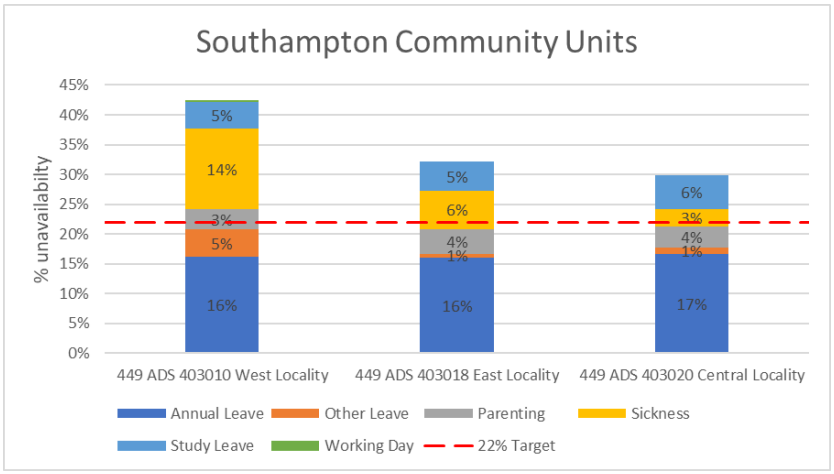


Table 16 Southampton Community Teams Unavailability by theme

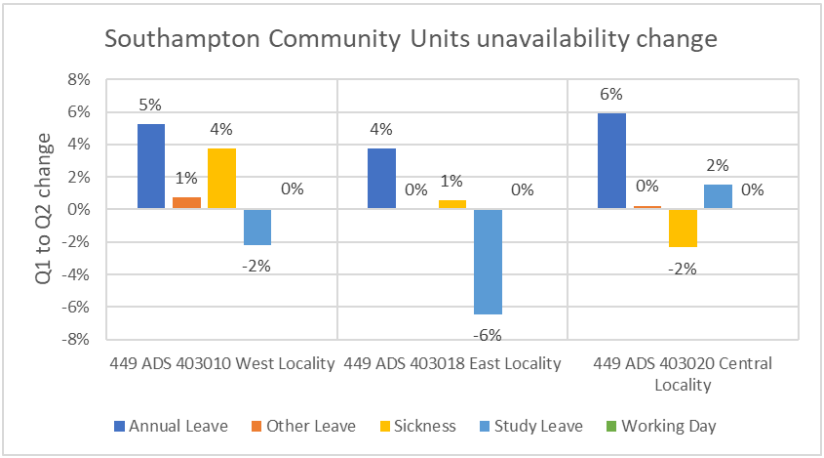


Table 17 Comparison of availability Q1 - Q2 2023 -2024

As reflected in the Portsmouth data set an increase in seasonal annual leave and sickness absence is noted.

7.0 Recruitment and Vacancies

7.1 Recruitment and retention remain a challenge across several service areas, as referenced above the workforce data issues have impacted on the ability to reflect the current position however, services have undertaken recruitment events and Safer Staffing meetings have received monthly progress up-dates and escalations.

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

7.3 International Recruitment (IR) continues within 2023/24 with a planned recruitment of 4 inpatient RNs for the Southampton units.

7.4 The first community clinical induction programme for nurses commencing roles in either the Mental Health & Adult Community services commenced within Q2 and has received positive feedback. Following evaluation, the second course will take place in November.

Due to data challenges within the vacancy data available we have been unable to share vacancy data.

There has been focused recruitment across all services supported by the recruitment and attraction teams, with Acute Mental Health services undertaking a significant recruitment drive within the quarter for HCSWs with recruitment of 13 to date and this will continue into Q3.

8.0 Acuity & Dependency

8.1 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.

8.2 Mental Health Optimal Staffing Tool (MHOST)

Following the first "formal" data collection in Q1, the Mental Health Inpatient wards completed their second data collection in September.

Whilst the data has been collated, the Head of Nursing (Professional Leadership) is working collaboratively with the Matrons and Ward Leaders with regards to the process and analysis of the audit results and triangulating with quality and safety matrix.

Initial results in the tables below show an increase in the acuity and dependency of patients across all three wards and an increase in the number of patients requiring enhanced observation.

Brooker Ward

Dep / Acuity Level	May		September		Variance	
	Daily Average	%	Daily Average	%	Daily Average	%
1	0.34	1.6	0.00	0.00	0.34	1.6
2	1.76	8.4	1.10	8.0	0.66	0.40

3	7.45	35.5	12.37	89.9	4.92	54.5
4	0.21	1.0	0.30	2.2	0.09	1.2
5	0.00	0.00	0.00	0.00		

Table 18 Variance between data collection periods.
G = decrease in daily average / % R = increase in daily average / %

The table above demonstrates the predominate level of acuity and dependency in September was Level 3, with no patients at Level 1 or 5. This reflects the May data however it is noted there is a significant increase of level 3 patients.

Hawthorn Comparison May to September

Dep / Acuity Level	May		September		Variance	
	Daily Average	%	Daily Average	%	Daily Average	%
1	5.47	29.9	2.23	10.5	3.24	19.4
2	7.63	41.7	7.70	36.2	0.7	5.5
3	2.50	13.7	3.80	17.9	1.3	4.2
4	0.30	1.6	1.00	4.7	0.70	4.4
5	0.70	3.8	3.77	17.7	3.1	14.1

Table 19 Variance between data collection periods.
G = decrease in daily average / % R = increase in daily average / %

There has been a shift towards the higher levels of dependency / acuity from May's data to September within Hawthorn. The major change has been the number of patients receiving 2:1 care, with only 2 patients requiring this in May to 39 patients receiving 2:1 care across September.
The average bed occupancy increased from 16.6 in May to 18.6 in September.

Maple Comparison May to September

Dep / Acuity Level	May		September		Variance	
	Daily Average	%	Daily Average	%	Daily Average	%
1	0.97	9.7	0.20	1.9	0.77	7.8
2	4.30	43.0	2.60	25.1	1.70	17.9
3	2.50	25.0	2.30	22.2	0.20	2.8
4	0.30	3.0	0.60	5.8	0.30	2.8
5	1.03	10.3	1.80	17.4	0.77	7.1

Table 20 Variance between data collection periods.
G = decrease in daily average / % R = increase in daily average / %

Within September there was an increase in the Level 4 & 5 patients within Maple and a decrease in Levels 1-3 (accepting a marginal decrease in L3).
The average bed occupancy was slightly lower in September at 7.5 from 8.2 in May.
In May, over the month, 31 patients required 1:1 care and this was spread relatively evenly over the month. However, in September there were 2 concentrated periods where multiple patients required enhanced observation / support (1st – 8th & 15th – 19th).

Overall, the second data collation shows an increase in acuity and dependency across our mental health services which matches the clinical narrative and discussions within the safer staffing meetings.

8.3 Safer Care Nursing Tool (SCNT)
It has been agreed to implement the SCNT for our adult inpatient wards in January 2024 with training planned in Q3. This is a move away from the original plan to await a national update as the timelines for this remain unclear.

8.4 The Community Nurse Safe Staffing Tool (CNSST)
An intensive training schedule for CNSST has continued during Q2 in anticipation of the second data collection in November 2023.

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

9.1 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.

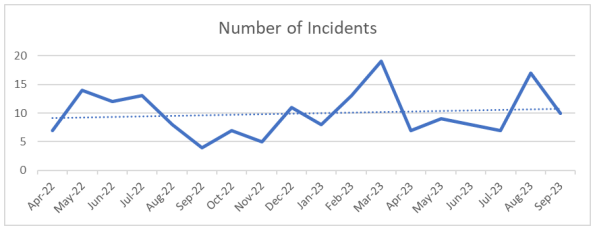
9.2 The NSIs / incidents are reported within the quarterly Patient Quality and Safety report and by individual services via their assurance framework. For the Safe Staffing report, incidents directly relating to staffing levels affecting patient care and affecting staff will be identified.

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**

9.2.1 Table 21 below shows the incident reporting trend across the inpatient areas relating to safe staffing issues. There has been a significant variance in the reporting of incidents relating to safe staffing levels within the quarter however, most incidents are reported as near miss or low harm, none have been escalated to a Serious Incident.

There was a general increase in the number of incidents reported from 24 in Q1 to 34 in Q2.



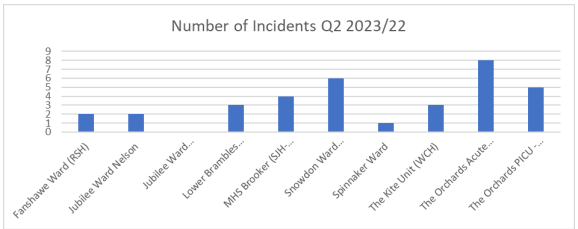


Table 21 Incidents trends and Q2 incidents citing staffing levels inpatient units Q2 2023 - 2024

9.2.2 The Orchards and Snowdon reported the highest number of incidents within the quarter.

Of the incidents reported across the quarter, the themes for the Mental Health wards relate to decrease in availability of staff, skill mix and increased acuity and dependency, especially patients requiring enhanced observations.

Of the incidents reported by the physical health inpatient units a theme of incidents relating to staffing/vacancies within the therapy services and late cancellation, failure to attend of bank/agency staff or late notice of sickness absence with mitigations put in place.

All incidents were reviewed by the senior leadership team.

9.2.3 The trend within the Community Nursing incident reporting has also reduced within the quarter.

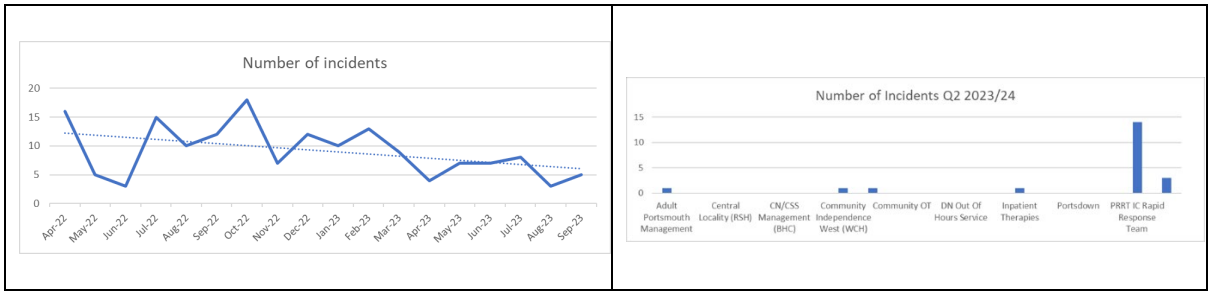


Table 24 Incidents trends and Q2 incidents citing staffing levels across Community Services 2022 / 2023

9.2.4 Within Q2, PRRT continues to record the highest number of incidents relating to safe staffing, with 14 incidents reported in Q2, compared to 6 in Q1. The themes of the incidents relate to:

- Combination of sickness absence, AL and vacancy impacting upon capacity of team to meet demand. Mitigation: support from ADP Community Nursing Teams and Agency staff.
- Delays to initial physiotherapy assessments being undertaken due to a vacancy, AL and member of staff moved to acute provider to support.
- Reduced administration cover. Mitigation: clinical staff undertaking administration tasks however impacting upon clinical capacity.

9.2.5 The West Locality Community Team also reported 2 incidents relating to staffing levels and capacity. Both were mitigated within the wider community teams and patients safely re-allocated visits.

10.7 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.

In Q2 an audit will be added to Tendable to support measuring our compliance with CQC Regulation 14 and the NHS England eight National Standards for Healthcare Food and Drink with an anticipated six-monthly schedule with an initial pilot on one of the inpatient units.

11.0 Complaints and Service Concerns

11.1 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) are categorised to three areas:

- Communication

- Patient care
- Values and Behaviours of Staff

11.2 Within Q2, following analysis of the 10 service concerns received in the reporting period there appears to be no service concerns directly relating to safe staffing levels.

11.3 There were 8 complaints received within in Q2 relating to the values and behaviours of staff across the whole organisation. Of the complaints received, 2 related to Mental Health Inpatients and 1 to Fanshawe Ward. Following a review, none of the complaints directly relate to the safe staffing levels.

12. 0 Risks Escalated to Risk Register in Relation to Safe Staffing

12.1 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. Below Planned Staffing remains the highest risk within the Trust. The table below identifies the number of risks currently recorded, where staffing is reported as being below planned levels.

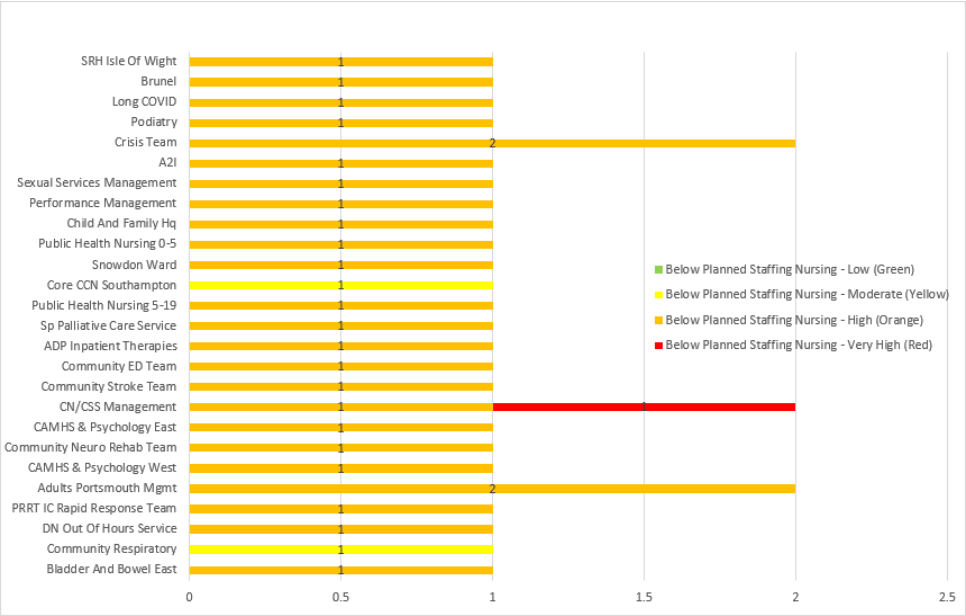


Table 25 Risks citing staffing levels within Q1 2023 / 24 impacting upon patient care / service delivery.

12.2 Within Q2's scheduled staff staffing meetings, teams were asked to ensure a thorough review of their risks relating to safe staffing, to ensure the risk rating reflects the current staffing situation. Adult Inpatient teams had reported a successful recruitment and therefore anticipate their risk rating could be reduced.

Teams report their mitigation include:

- Use of bank, agency & locums.
- Prioritising bank as they have familiarity with service processes and procedures.
- Block booking agency, again to ensure greater familiarity with processes and procedures.

Longer term solutions include:

- Standard recruitment processes, plus inventive ways of encouraging applicants e.g. building rapport & familiarity with agency staff & encouraging them to apply
- linking in with T -Level colleges, apprenticeships & internal development

- Clinical Practice Educator to help newly qualified practitioners into specialised teams

The Head of Risk and Litigation continues to meet monthly with the 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.

There continues to be one risk 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. Monthly review and ongoing recruitment at risk with processes in place to measure/escalate. Performance reporting against safer staffing and escalation via SLB and Safe staffing with Chief Nurse.

Table 26 Very high risks relating to staffing affecting patient care / service delivery.

13. Conclusion

In Q2 of 2023/24 workforce concerns relating to safe staffing is the top risk across the organisation and whilst significant progress has been made in addressing the staffing challenges faced in specific services across the Trust it is recognised that more work needs to be done. There are clear escalation and governance processes in place.

Concern remains about the staffing levels across both inpatient and community services and the continued reliance on temporary staffing to ensure safe staffing levels. There will continue to be close scrutiny of staffing levels and the impact of the recruitment strategies in place to ensure timely appointment of staff into current vacancies.

The inpatient clinical establishments reviews have been completed with the exception of Brooker ward and presented to the Safer staffing assurance meeting, all have been signed off in terms of safe staffing requirements with some further work required for a number in terms of finances ahead of taking to finance and commercial. It has been proposed within Q3/4 that the Community Nursing Services present their establishment, quality and workforce reviews.

Based upon the data and information available it is evident that it is difficult to evidence patient harm as a direct result of staffing levels. However, service managers cannot be complacent and continued attention needs to be given to retaining staffing with the necessary skills and competence to meet the increasing complex patient need identified.

The work on standardising the acuity and dependency tool used across the Trust is progressing well seeing the second or third data collections into Q3.

Board Recommendation

The Board is asked to note this report.

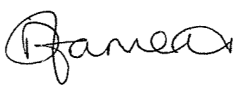
Board and Committee Summary Report

Title of Paper	Charitable Funds Committee Exception Report				
Date of paper	23 November 2023				
Presentation to	In-Public Board				
Item No.	20				
Author(s)	Belinda Brown, Executive Assistant to Chief Executive				
Executive Sponsor	Gaurav Kumar, Non-executive Director and Committee Chair Debbie James, Executive Sponsor				
Executive Summary	The report is presented to summarise the business transacted at the Charitable Funds Committee held on 9 November 2023.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The In-Public Board is asked to: • Receive the report from the committee				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Previously considered at	N/A				

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	x	9.Belonging to the NHS		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 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	 Chief Strategy & Transformation Officer							

The committee:

- **Received** an update on latest conversations regarding the resourcing of the charity and **discussed** the collaborative work between Solent NHS Trust and Southern Health NHS Foundation Trust, including steps to be taken to merge the charities of the two organisations.
- **Received** the Quarter 2 (Q2**)** Finance Report covering the period 01 July 2023 to 30 September 2023
- was **informed** that the charity received public donations totalling **£2968.00,** including six donations to the Specialist Palliative Care team (£1,436.00), further donations to staff member Colin Edwards bike ride to Paris (£932.00, in addition to £746.00 raised in previous quarter), three donations to the cardiac services team (£550.00), and various other donations (£50.00)
- **Agreed** to carry on membership to NHS Charities Together, up to March 2024
- was **informed** of charity expenditure within the month, including funding (£590.00) for an annual celebration event to thank Young Ambassadors, linked to the Solent CAMHS service
- **Received** an update on the COVID 19 appeal grants**,** including confirmation that the Stage 3 recovery bid submitted by the charity had been approved, (£88K), and that provisional approval had been given for the application to the development grant (£30K).
- **Received** the Solent NHS Charity Annual report and **agreed** for it to be signed by the committee Chair
- **Received** the Charitable Funds committee effectiveness review (2023)
- **Reviewed** a bid application made by the Estates team for circa £158K, to construct an external gym area for Jubilee House, and gave support in principle, with the following areas to be explored: engagement with community, patients and staff, fund raising opportunities, costs and ROI
- **Received** an update from Communications
- **Received** the updated Terms of Reference of the Charitable Funds committee
- **Discussed** governance arrangements of the final Charitable Funds committee in February 2024

Board and Committee Summary Report

Title of Paper	Remuneration and Nominations Committee Non-Confidential Report				
Date of paper	9 November 2023				
Presentation to	In Public Board				
Item No.	22				
Non-Executive Sponsor	Vanessa Avlonitis, Non-Executive Director (Committee Chair)				
Executive Summary	Paper presented to summarise the business transacted at the Remuneration and Nominations Committee held on 9 November 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	x	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	x	10. New ways of working	x	14. Supportive Environments	x
4. Life-course approach		11. Growing for the future	x	15. Partnership and added value	
5. One health and care team	x				
6. Research and innovation					
7. Clinical and professional leadership	x				

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:

- The Committee discussed the **Fit and Proper Persons Test**, in particular the process of writing references for departing non-executive and executive directors. It was agreed that Dominic Ford provide a paper to the Confidential Board to explain the process.

- The Committee received a **Governance Overview Report** that provided an update on the Board and committee composition, NED lead roles and tenures and executive portfolios.

- The Committee considered whether it appropriate for the CEO to be a member of Board Committees or whether arrangements should be to attend when invited. It was agreed that the Terms of Reference of all Committees are review to reflect CEO attendance as an attendee and not a member.

- The Committee noted the **Committee Effectiveness Review.**