Agenda

Solent NHS Trust In Public Board Meeting

Date: Monday 2 October 2023
Timings: 09:30 – 13:30
Meeting details: Meeting Room 1, First Floor- Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Board Requirement
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive**	Chair	To receive
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
			Register of Interests & Declaration of Interests	Chair	To receive
2	09:35	30mins	**Patient Story** – *Mother of a child using the Speech & Language Service*	Chief of Nursing and AHPs	To receive
3	10:05	30mins	**Staff Story –**	Chief People Officer	To receive
5	10:35	10mins	**Reflection on Patient and Staff Stories**	Chief of Nursing and AHPs	To discuss
6	10:45	5mins	• **Previous minutes, matters arising and action tracker**	Chair	To approve
Quality and safety first					
7	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
8	11:00	5 mins	**Reinforced Autoclaved Aerated Concrete (RAAC) Update –** *To provide an update on actions taken and provide assurance*	CFO	Verbal update
9	11:05	10 mins	**Solent's Learning from the Lucy Letby Case**	Chief of Nursing & AHPs	To receive

Items to receive					
10	11:15	10mins	**Chief Executive's Report** *Including:* • *BAF summary*	CEO	To receive
10-minute break					
11	11:35	5mins	**Annual Same Sex Accommodation Declaration**	Chief of Nursing and AHPs	To receive
12	11:40	10mins	**Emergency Planning Resilience Response Annual Report –** Emergency Planning Lead	COO	To receive
13	11:50	20mins	**Winter Resilience & Cold Weather Planning 2023/2023**	COO	To receive
14	12:10	5mins	**NHS Impact Baseline for Improvement and Self-Assessment**	CMO	To receive
15	12:15	5mins	**Framework of Quality Assurance for Responsible Officers and Revalidation: Annex D – Annual Board Report and Statement of Compliance**	CMO	To receive
Items to approve					
16	12:20	5mins	**EDI and Belonging Annual Report**	CPO	To approve
17	12:25	5mins	**Health & Safety Annual Report**	Chief of Nursing & AHPs	To approve
18	12:35	5mins	**Patient Safety Incident Response Framework Policy and Implementation Plan**	Chief Of Nursing & AHPs	To approve
19	12:40	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					
20	13:10	15mins	**People Committee –** *Exception report from meeting held 21 September 2023*	Committee Chair & AD People Partnering	To receive

21			**Mental Health Act Scrutiny Committee-** *Exception report from meeting held 10 August 2023*	Committee chair	To receive
22			**Audit & Risk Committee –** *Exception report from meeting held 11 August 2023* • *Freedom to Speak Up Annual Report (item 22.2)* • *Committee Terms of Reference (item 22.3)*	Committee chair	To receive
23			**Quality Assurance Committee-** *Exception report from meeting held 21 September 2023* • *Qtr 1 Safe Staffing Report (item 23.2)* • *Committee Terms of Reference (item 23.3)*	Committee chair	To receive
24			**Non-Confidential update from Finance & Infrastructure Committee–** *non confidential escalation report from meeting held 25 September 2023*	Committee chair	Verbal update
25			**Charitable Funds Committee –** *Exception report from meeting held 10 August 2023*	Committee chair	To receive
26			**Remuneration and Nominations Committee –** *Verbal update from meeting held 28 September 2023*	Committee chair	To receive
Any other business					
27	13:25	5mins	**Any other business and reflections including:**	Chair	-
28			• ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***	Chair	
29	13:30	---	**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:

- *4 December 2023*

Item 6.1

Minutes

Solent NHS Trust In Public Board Meeting

Date: Monday 7 August 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) *(virtual)* **Nikki Burnett**, Chief Finance Officer (NB) **Debbie James**, Chief Strategy & Transformation Officer (DJ) **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** **Dominic Ford**, Governance Programme Lead (DF) **Sam Stirling**, Corporate Affairs Administrator **Apologies** **Rachel Goldsworthy**, Chief of Staff, Governance & Corporate Affairs (RG) **Dan Baylis**, Deputy CEO & Chief Medical Officer (DB) **Alasdair Snell,** Chief Operating Officer (ASn) **Sorrelle Ford**, Acting Chief People Officer (SF)
Patient Story (item 2) **Maisie Fox**, Patient (MF) **Sue Fox,** Patient's mother (SF) **Sam Hemingway**, Deputy Chief of Nursing and AHPs (SH)	**Staff Story (item 3)** **Anthony Russell**, Staff member (AR)

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. It was noted that MW & GK had been appointed as designated Non-Executive Directors of the new organisation post April 2024.
2	**Patient Story - CAMHS Solent East**
2.1	MF and SF were welcomed to the meeting and introductions made. • An overview of background leading to care from CAMHS Solent East was provided. • Support received for Emetophobia, OCD and anxiety was explained and effect of conditions on MF's life was shared. It was confirmed that during time on the waiting list for CAMHS, hospital admission was undertaken, due to emergency care required. • Communication challenges were highlighted and lack of co-ordination between the hospital (for physical care) and mental health was emphasised. • Lack of mental health support following discharge from hospital care was explained. Following escalation of condition, it was confirmed that home visits were arranged. • Positive impact of home visits were emphasised and continued support shared. • Areas of improvement were highlighted and life changing impact of receiving CAMHS support was noted.

2.2	Formal thanks for sharing the story was provided and MW queried support offered as a parent/carer. It was confirmed that an individual session with a counsellor/therapist was provided.
2.3	VA asked where improvements could have been made and SF suggested earlier intervention, particularly in relation to medication discussions. AA queried potential need for earlier intervention from the Closer to Home team and SF suggested usefulness of input following hospital discharge.
2.4	SE provided thanks for honest and open story shared and asked if there were any measures/support that could have been provided, in order to avoid the hospital stay. Usefulness of medication was emphasised and potential earlier intervention in this area was suggested. DK reflected on the importance of early intervention as an NHS/Board and the need to hear effects on people at this level of the Trust.
2.5	DJ commented on strong advocacy and queried proactive communications from the Trust. Communication issues were discussed and DJ suggested involvement in youth board activities to ensure that services were shaped from a lived-experience perspective.
2.6	MW asked about any internal learning from similar cases and AA confirmed ongoing work, particularly in relation to prescribing, to improve position. Issues regarding skills/competence were highlighted and importance of learning and joined up work as a system was emphasised. The Board thanked MF and SF for sharing their story. *SF, MF and SH left the meeting.*
3	**Staff Story- Occupational Health**
3.1	AR joined the meeting and provided an overview of his story and experiences. • AR explained incident with a volatile patient leading to self and management referral to the Occupational Health Service. • The Board were briefed on support and guidance received, including techniques for coping mechanisms and therapy sessions. • AR shared benefits of support received and help to ensure robust and resilient mindset since returning to work. AR also commented on further support for staff from a management perspective.
3.2	NB thanked AR for his candour when discussing mental health and coping mechanisms. Ongoing work for designing services within the new organisation was highlighted, including consideration of delivery models within occupational health and associated benefits. The Board discussed strong wellbeing offers and AR recommended the employee assistance programme as an independent support service.
3.3	MW queried support/security available at the time of the incident with the patient. AR confirmed that security was called and further commented on challenging area of work, particularly in consideration of staff pressures. AA asked about potential further preventative work to support staff under pressure and provide effective stress management. AR emphasised the importance of coping mechanisms to pre-emptively build resilience, as well as ensuring effective management support in place to enable staff to be able to access occupational health support during work hours.
3.4	DJ reflected on the importance of ensuring that panic buttons were available within all public facing environments and suggested usefulness of audit to review security measures in place and ensure consistency. MW agreed and commented on importance of ensuring staff feel confident and safe at work.

	AR noted potential improvements required, including security presence on sites and shared risk assessments and training in place.
3.5	AS queried timescales for self-referral and management referral. AR confirmed that first contact from occupational health was within 1 week, with 2 months until the first session. The Board thanked AR for attending and providing his story. *AR left the meeting.*
4	**Reflection on Patient and Staff Stories**
4.1	AS reflected on the patient story and importance of the provider collaborative to support community services, with strong impact of home visits highlighted. SE emphasised challenges regarding lack of integration and VA commented on usefulness as a case study for the Project Fusion strategy. The Board discussed issues in relation to co-ordination and focused approach required. Use of Harm Tool going forward was shared.
4.2	Regarding the patient story, DJ commented on strong advocacy undertaken for the patient and the need to ensure proactive care for those who do not have an advocate. NB agreed and reflected on the health and inequalities gap across the system.
4.3	MW asked about strong root cause analysis used and AA briefed on structured tool for serious incidents. MW emphasised importance of an end-to-end process across organisations and AA explained improvements and continued collaborative working.
4.4	AS commented on significant impact of the staff story and suggested feedback to NHS Property Services security teams. GK asked how the Board receives reports and assurance of detail relating to physical security. NB confirmed review of security papers within the Health and Safety Group and agreed to further consider how to include within Health and Safety reports to Board, to ensure appropriate oversight and assurance in relation to physical/site security. **Action- NB.**
4.5	Regarding the staff story, SE asked about conflict resolution training provided to staff. It was confirmed that live training was provided and NB informed of specialist practice with commissioned service for volatile patients. It was confirmed that incidents of violence and aggression were shared through quarterly health and safety reports.
4.6	GK reflected on powerful and multidimensional staff story presented. The importance of ensuring accessibility of all elements of staff support, tailored to each staff member, was highlighted.
5.	**Staff and Patient Story Proposal**
5.1	AA explained the background and purpose of the proposal, with focus on improving process, governance and assurance of actions taken. Recommendations and feedback was presented, including potential use of a roving model for future Board meetings. Importance of ensuring communication with services during the selection of stories and after they have been heard by the Board, to ensure appropriate sharing of learning, was highlighted and AA explained triumvirate leadership model suggested.
5.2	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.

	The Board discussed the importance of ensuring visibility in staff/patient environments and usefulness of alignment to Board to Floor visits was agreed.
5.3	MW queried consideration of actions following previous stories held and AA highlighted review held with summary report presented at the April Board meeting. DK emphasised the importance of building on this work within the new organisation. **The Board agreed the patient and staff story proposal presented.**
6	**Previous minutes, matters arising and action tracker**
6.1	The minutes of the last meeting were agreed as an accurate record. There were no matters arising to share.
6.2	There were no actions to review. DK reflected on the term 'to note' used throughout reports/minutes and suggested amending language to ensure clarity of requirements and recommendations.
7	**Safety and Quality**
7.1	<u>Board to Floor 6 monthly update report Quarters 3 and 4 2022/23</u> AA informed of ongoing work to strengthen link between Board to Floor and other quality areas. Use of triangulated data to consider processes, together with fresh eyes visits, was confirmed. AS reflected on greater commentary expected regarding demand and capacity pressures. AA confirmed that Fresh Eyes visits had reviewed cultural elements, as opposed to inclusion within this report. MW asked about cascade of feedback to services and AA confirmed that all reports were shared, with ongoing work in relation to the 'you said we did' feedback.
7.2	There were no Freedom to Speak Up escalations to share.
8	**Patient Safety Annual Report including Learning from Deaths, Serious Incidents and Complaints**
8.1	An overview of the report was provided. • Implementation of the Patient Safety Strategy and continuing workstreams were highlighted. Close working with Southern Health and Isle of Wight NHS Trusts regarding strategy implementation was reported. • Increase in the number of incidents was confirmed, however the Board were assured that incidents were not translating to patient harm. • Full Deep Dive into Falls was shared, including proactive assurance work taking place. • AA informed that Pauline Jeffery had been shortlisted for the national Patient Safety Awards, following creation of the RIPPLE Model.
8.2	VA reported full review at the Quality Assurance Committee and positive work in relation to Falls, with outcome and improvements identified.
8.3	SE queried significant increases in relation to ICT and Digital Information systems. AA confirmed spike following change in IT contract providers however assured of reduction identified in the first quarter of the year. SE also asked about increase in HR/staffing issues reported. AA assured of continued monitoring and emphasised that the increase was not translating to level of harm.

8.4	Increase in unexpected deaths was queried and AA informed of deep dive undertaken in mental health services, with no trend/correlation identified.
8.5	MW asked about Project Fusion alignment of approach to the Patient Safety Incident Response Framework and the Patient Safety Strategy. AA shared planning to combine oversight group and establish a single plan, with learning and escalations reported as required.
8.6	MW commented on incident increase linked to strong reporting culture, however queried considerations of potential precursors to harm. AS emphasised strong assurances provided and triangulation across multiple areas, such as the Staff Survey. **The Board received assurance from the Patient Safety Report.**
9	**Clinical Professional Engagement and Leadership Report (inc. professional strategic framework and nurse revalidation)**
9.1	AA provided an overview of key items from the report. • The Board were informed of reinstated Matrons Forum and AA explained strong support to the quality agenda. • Continued positive work with international recruits and award of the Pastoral Care Quality Mark was highlighted. **The Board received assurance from the Clinical Professional Engagement and Leadership Report.**
10	**Chief Executive Report**
10.1	AS presented the report and key areas of note. • Areas of celebration were highlighted, including NHS 75 activity. • An overview of awards received for staff across the Trust was shared. • AS provided an updated regarding changes to the Trust Board. • Continued building work for the new Western Community Hospital site was highlighted, with expected completion in June 2024.
10.2	AS reported challenges in relation to Integrated Care Board (ICB) decision making, processes and level of scrutiny/assurance and confirmed full discussions to be held within Confidential Board. **The Board received assurance from the CEO Report.**
11	**Annual Review of Strategic Objectives**
11.1	DJ shared the latest position of each delivery commitment since the launch of the Solent Strategy in 2021, including progress, status and next steps. It was confirmed that from 2023/24, the Trust would revert to monitoring a single set of business objective metrics, mapped to Strategic Priorities. **The Board agreed closure of delivery commitments and further monitoring through business objective progress reporting in 2023/24.**
12	**NHS England Oversight Framework / Recovery Support Programme**
12.1	An overview of the purpose of the report was shared and an outline of key next steps presented. Ongoing debate of controls was explained and expected 12-month recovery programme highlighted. **The Board supported the recommendations outlined**.
13	**Estates Strategic Plan**

13.1	NB explained the Strategic Plan and changes aligned to Project Fusion in relation to the strategic function within the new organisation. Planning to address items such as workforce issues and key ratios were highlighted. Further considerations in terms of system and capital for community settings was acknowledged and it was confirmed that key elements were being reviewed. Estates inclusion within recovery plans was noted.
13.2	DK queried requirements for the strategic plan as well as an estates strategy. AS confirmed development in conjunction with service lines and Southern Health, in order to provide fit for purpose premises at cost efficient basis. DJ commented on need for the plan to enable clear vision and direction for enabling delivery. NB emphasised the estates team as a key asset within the Trust and commented on influence across the system and nationally. It was confirmed that ongoing discussions to shape the Integrated Care System strategy was taking place, with the strategic plan supporting areas of the framework. Strong system and partner working was emphasised and planning for Project Fusion commended. **The Board approved the Estates Strategic Plan.**
14	**Integrated Performance Report**
14.1	<u>Safe</u> • Review of VTE related assessments was confirmed, with increased performance expected. MW asked about effects in practice and AA explained reliance on medical staff to complete assessments. Training to ensure a consistent approach was shared. • ASn reported increased number of incidents, particularly on Jubilee Ward, and ongoing monitoring being held. • VA queried open incidents and review undertaken to manage these. AA informed of initial work undertaken to close incidents up to 2019 and confirmed additional actions being reviewed by the Quality Improvement and Risk Group.
14.2	<u>Effective</u> • Increased length of stay associated with acuity of patients was reported and the Board were assured of continued monitoring. • Regarding urgent community response data issues, it was confirmed that ongoing work was taking place in terms of recording for national data sets. • The Board were informed of system conversations regarding investment in virtual wards. Decision to maintain levels was highlighted. • Prudent assessments regarding elective recovery funds were shared. • It was confirmed that junior doctor and union strike activity was on target. • MW queried level of assurance, particularly in terms of virtual wards. AS commented on planning/guidance received and ICB decision made regarding allocation. Implications were shared, particularly in relation to winter planning and surge capacity.

14.3	<u>Responsive</u> • Increased waiting lists were reported and AS assured of review taking place to consider potential harm and recommendations in depth. • The Board were informed of increasing pressure on Solent's mental health inpatient wards, to provide additional bedded capacity to the wider ICS. It was confirmed that significant bed capacity had been provided to Southern Health patients and collaborative working in place. • Challenges regarding IT issues were discussed and ongoing work with IT teams highlighted. • MW queried timeline for the Primary Care Strategy. Ongoing review and joint considerations with Southern Health colleagues was confirmed. **It was agreed that AS review with DB and Mark Kelsy (Deputy Medical Director) regarding next steps. Action- AS.**
14.4	<u>People</u> • The Board were informed of increased sickness level, above expected benchmark. Triangulation with the People Committee was highlighted, with full discussions into factors reviewed.
14.5	<u>Finance</u> • NB provided an overview of the Trust financial position at month 3. It was confirmed that the Trust was off plan and a number of corrective actions were underway. NB explained associated factors, including the NHS pay award. • Actions taking place regarding delivery of cost improvement plans were shared. • It was confirmed that creditors were reviewing areas of accounts and a new contract manager with SBS had been appointed. • NB confirmed full programme regarding capital expenditure and assured that the Trust was on track for delivery. • SE asked about the impact of the NHS pay award. NB explained differing levels of impact and completion based on tariff of income. Challenges managing locally was acknowledged and escalation regarding need to reforecast was highlighted. **The Board received assurance from the Integrated Care Report.**
15	**People Committee**
15.1	MW provided an update from the meeting. • It was confirmed that the People Strategy sign off had been deferred on this occasion. • The Board were informed of approval of the Carers Passport, with recognition of support required. • MW shared review of the Workforce Intelligence Report, and subsequent cascade to services. • Ongoing work in relation to turnover was reported.
16	**Mental Health Act Scrutiny Committee**
16.1	There was no meeting held to report.
17	**Audit & Risk Committee**

17.1	DK informed the Board of session held with external auditors, Ernst & Young, regarding reflections on year end and proposals for the year ahead. The need for proactive work was agreed and robust discussions were highlighted. DK provided an update in relation to internal audit and considerations aligned to Project Fusion, similarly for Counter Fraud.
18	**Quality Assurance Committee**
18.1	VA explained format of the meeting held, due to not being quorate on this occasion. • Deep Dive into Falls was explained and positive work and significant assurance shared. • High quality of reports was confirmed and formal thanks to report authors noted.
19	**Non-Confidential update from Finance & Infrastructure Committee**
19.1	There were no in public escalations to share.
20	**Charitable Funds Committee**
20.1	There was no meeting held to report.
21	**Remuneration and Nominations Committee**
21.1	Updates from the meeting were provided, including welcoming DF as Governance Lead.
Any other business	
22	**Any other business and reflections including:** • ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***
22.1	AS reflected on considerations following the patient and staff stories and emphasised strong quality of reports submitted. MW agreed and commented on the importance of being mindful of recommendations and assurance received.
22.2	Regarding patient and staff stories, NB highlighted the importance of systematic root cause analysis and balance of commitments to ensure formal agreement of action closure/outcomes and be able to demonstrate this in public. MW agreed usefulness of live feedback loop with systematic cascade. DJ queried the potential use of the Clinical Executive Group to review issues and discuss actions. Further considerations of process/governance was discussed.
22.3	DF provided reflections of his first In Public Board meeting. • Positivity of time allocated to review patient and staff stories publicly was emphasised. Importance of direct voices, particularly during period of organisational change, was highlighted. • Usefulness of a roving Board model to encourage public attendance was agreed and DF commented on useful dynamic of a public audience. • DF reflected on discussions regarding 'noting' of reports. The need to ensure clear and explicit recommendations within the executive summary papers was emphasised.

	• Positive level of challenge was discussed and MW commented on usefulness of fresh perspective.
22.4	No other business was discussed and the meeting was closed.
23	**Close and move to Confidential meeting**

Action Tracker

Overall Status	Source Of Action	Date Action Generated	Minute Reference/ Additional URN	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
On Target	Board meeting - In Public	07/08/2023	4.4	Reflection on Patient and Staff Stories	GK asked how the Board receives reports and assurance of detail relating to physical security. NB confirmed review of security papers within the Health and Safety Group and agreed to further consider how to include within reports to Board to ensure appropriate oversight and assurance in relation to physical/site security. **Action- NB.**	Nikki Burnett	**September 2023 update-** The annual Health and Safety report (to be tabled at Board) includes matters around site security. Routine escalation reporting mechanism into Board sub committee to be established to feed up more frequent escalations into the Board.
On Target	Board meeting - In Public	07/08/2023	14.3	Integrated Performance Report- Responsive	MW queried timeline for the Primary Care Strategy. Ongoing review and joint considerations with Southern Health colleagues was confirmed. It was agreed that AS review with DB and Mark Kelsy (Deputy Medical Director) regarding next steps. **Action- AS.**	Andrew Strevens	

Board and Committee Summary Report

Item 9

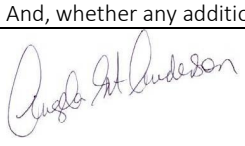
NHS Solent NHS Trust

Title of Paper	Briefing on Response to Lucy Letby conviction				
Date of paper	14 September 2023				
Presentation to	In Public Board				
Item No.	9				
Author(s)	Angela Anderson, Chief of Nursing & AHPs				
Executive Sponsor	Angela Anderson & Dan Baylis				
Executive Summary	• Following a review of the case and of the Trust approach to receiving and responding to concerns raised we have identified a number of mechanisms to support staff and people who use our services. We are assured that responses and actions are timely and proportionate but also recognise that the experience of staff may not be universal across our organisation. A number of actions are in place to address this and these will be continuously reviewed and adapted to ensure continued improvement				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The In Public Board is asked to: • Note the initial response taken in light of the conviction • Note the ongoing work needed to ensure we continue to hear and respond to concerns raised by colleagues at all levels across the organisation				
Statement on impact on inequalities	Positive impact (inc. details below)	X	Negative Impact (inc. details below)		No impact (neutral)
Positive / negative inequalities	The purpose of the actions taken in response to the factors identified in the Lucy Letby case are aimed at ensuring all of our people and our patients, carers and families have a voice, are listened to, heard and all concerns acted on regardless of any protected characteristics or other factors				
Previously considered at	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	x	13. A greener NHS	
3. Outcomes that matter		10. New ways of working		14. Supportive Environments	x
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	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 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								

Briefing on Response to Lucy Letby Conviction

1. Purpose

The purpose of this paper is to provide a summary of the reflections and actions taken in response to the conviction of Lucy Letby in August 2023. It is to provide assurance to the Board that we have considered the case in the context of our organisation and that we will continue to respond to concerns raised in a proportionate, just and compassionate way regardless of the origin or nature of the concern being raised.

2. Situation, Background and Actions to date

In August 2023 Lucy Letby was convicted of the murders of seven babies and the attempted murder of seven other babies at the Countess of Chester Hospital between June 2015 and June 2016. Concerns were raised in August 2015 but at this stage no trends or red flags were identified. In October 2015 concerns were raised by paediatricians working in the neonatal unit and despite ongoing concerns being raised with senior colleagues and Executives in the Trust it was not considered a matter to report to the police and internal investigations did not find any cause to take action in respect of Lucy Letby. Concerns were raised by the Child Death Overview panel (an external panel to the Trust) to the police in March 2017 that was the trigger for the Police to commence formal investigations in May 2017.

3. Assessment - Risks and Issues

In considering this case it is important to recognise that much of the information available currently in the public domain is what has been reported via the media and does not represent the full facts of the case. It is also noted at the time of writing that a public enquiry is to take place as a result of which there will be further learning for Trusts to consider in relation to how they respond to concerns raised and Whistleblowing.

In considering Solent NHS Trusts position we reviewed the current systems and process to respond to both unexpected deaths and also our response to allegations raised regarding the performance and behaviours of staff. We also reviewed the Board Assurance requirements set out in the letter from the Chief executive (CEO) Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) for England. A summary of our assessment is set out in the tables below:

Table 1: Board Assurance Requirements

	Requirement	Current Solent Position
1	All staff have easy access to information on how to speak up	Regular communication to staff through different route for speaking up. Lead Guardian attends team meetings, away days and facilitates safety chats alongside the Head of Patient Safety. Champions network established and support with raising awareness
2	Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme	The Lead Guardian is aware of the scheme and works closely with HR colleagues To date one person has been signposted to the scheme

3	Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place	The Lead Guardian has a regular slot on International nurse induction, they are also linked in with staff networks. In addition ot clinical services there are Champions in estates and facilities. Anonymous reporting is available for those who face barriers to speaking up, although this could be strengthened by procuring a tailored system for anonymous reporting which allows two way conversation (business case currently being finalised in collaboration with the Head of Digital solutions) The Chief of Nursing & AHPs has held a 2 engagement events with nurses who have joined us from abroad and plans to hold them every 6 months
4	Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well	The Trust operates within a 'Just Culture' framework which supports and encourages staff to raise concerns either through our normal incident reporting systems, through their line manager or through the Freedom to Speak Up avenue. The Board received quarterly FTSU Oversight reports
5	Boards are regularly reporting, reviewing and acting upon available data.	The Board received regular reports on matters relating to patient safety and Freedom 2 Speak Up. They are briefed on contemporary issues and the actions being taken in response to any concerns raised

Table 2: Internal Assurance

Incident Reporting System	The Trust has a positive reporting culture and reviews incidents and trends and where indicated will undertake deep dives, e.g review of excessive deaths by suicide in September 2022 in our community mental health services
Safeguarding Adults Management of Allegations (SAMA) Framework	The Trust uses the SAMA framework when concerns or allegations are made in relation to the actions or behaviours of staff either toward patients or colleagues. The needs of the person or persons who have raised the concern and those of the person the concerns relate to are taken into consideration and based on this the person will either be transferred to other duties or suspended pending investigation, e.g. an allegation of assault was made by a patient against a member of staff & in order to protect all involved the police were immediately called and the staff member suspended pending investigation
RIPPLE – Safety Chats	The introduction of safety chats in response to an incident provides people with an opportunity to discuss in a safe space any concerns they have and ensures these can be escalated where this is identified as a need.
Schwartz Rounds	There is a direct correlation between patient safety and the use of Schwartz rounds. These have been in place across the Trust for a number of years and we are in the process of providing the opportunity for individual teams/service liens to have trained facilitators who can run rounds at a more local level
Staff Networks	There are a number of staff networks in the Trust and these provide a safe space for people with protected characteristics to discuss their concerns where they may otherwise not feel safe to do so.
Quality Assurance Visits/Fresh Eyes	Through our programme of quality assurance visits and regulatory reviews there is an opportunity for staff either to discuss on a one to one or through focus groups how it is to be working in their environment and any concerns they may have
Board to Floor	The Non Executive Directors have an opportunity to review areas across the Trust and have the opportunity to speak directly with staff and patients as well as reviewing data in relation to the area being visited
Matron Walk Arounds	The matron's undertake regular walk arounds of their clinical areas and our inpatient matrons have commenced a programme of peer visits. This provides an opportunity for matron's to identify any areas of concern and to engage directly with colleagues
Clinical Visits by Executives & Senior Leaders	The executives and senior leads within the Chief of Nursing & AHP team undertake regular visits to clinical teams, e.g. the CNO&AHP has spent time in the Transfer of Care Hub and in the acute Mental Health wards in August 2023 and has a schedule of visits planned over the Autumn
Complaints Procedure	We have a robust approach to responding to concerns and complaints raised by patients, service users, carers and families. We seek to find local resolution and all service concerns and formal complaints receive a written response. All formal complaints and their responses are reviewed by the Chief of nursing & AHPs and signed off by the Chief executive Officer

4. Next steps and actions

Although Solent NHS Trust has a positive culture of reporting and has mechanisms in place to support people to raise concerns and for these to be responded to it is essential that we are not complacent and that we continue to challenge ourselves to learn and improve. It is also important that staff at all levels experience the same supportive and robust response to concerns they raise and in a timely manner. Since the conviction we have undertaken additional actions to the ones outlined above which are:

- In the weekly Friday Focus from the CNO & CMO we have discussed the case and reiterated the need for us all to feel safe to raise concerns and identified the options available to staff
- The CNO has discussed the case at professional meetings: Head's of Quality & Professionals check in; Professional Advisory Group; Clinical Executive Group; requesting all to undertake reflective discussions within teams and to also have reflective discussions as tabled agenda items at these formal forums over Q2/3
- The CNO and the Lead Freedom to Speak Up Guardian has held an all staff Zoom call to give people across the organisation an opportunity to discuss their concerns or experiences and an All Managers Zoom is planned for w/c 18 September
- The CNO & CMO will consider specifically the needs of medical colleagues and any additional actions or support which may be required given the paediatricians in this case were the professional group raising concerns

5. Recommendations

This is an extremely difficult case for professionals and members of the public to comprehend and will cause distress in many different ways for individuals and it is important we recognise this and support colleagues. The executive and Board in Solent are committed to continuing to build a culture of openness and transparency and to ensure staff and people who use are services are heard and actions are timely. The recommendations to the Quality Assurance Committee are:

- To recognise and note the current assurances available in relation to how we support colleagues and service users to raise concerns
- To support the ongoing work to ensure we receive and respond to concerns within the 'Just Culture' framework.

Item 10

CEO Report – In Public Board

Date: 25 September 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

National awards

Solent's commitment and innovation in recruiting international nurses was nationally recognised after receiving the Pastoral Care Quality Award.
The award acknowledges the great lengths Solent goes to in order to welcome international colleagues to ensure they settle in, feel welcome and to ensure their needs are all met.
This includes supporting with flights and accommodation as well as signposting to support networks.

A team of Allied Health Professionals at the Trust was also nominated for an award at the prestigious national CAHPO (Chief Allied Healthcare Professionals Officer) Awards, for their work on transforming Solent's Allied Health Professional (AHP) and nursing workforce through the development of advanced and consultant clinical practitioner roles. The team took up the challenge of radically redesigning the workforce, as set out in the NHS Long-term Plan, which argues for a broader, multi-disciplinary workforce to tackle the rising complex needs of our communities.

Western Community Hospital 'topping out' ceremony

A topping out ceremony took place to mark the end of the second phase in the construction project to build a new rehabilitation unit at the Western Community Hospital in Southampton.

As part of the ceremony, Solent NHS Trust Chief Executive Andrew Strevens laid the last shovel of concrete, and all attendees were invited to sign a column as a symbol of good luck for the building.

The £21m project will bring 50 beds to the hospital, bringing together staff from two existing wards at the Royal South Hants Hospital into a unit where teams can provide specialist rehabilitation care in a high-quality therapeutic environment. The new unit is due to open in summer 2024.

Solent AGM

We hosted our AGM on Monday 11 September, which was both online and in-person. Around 100 people attended – around 20 in person in the room at the Mountbatten Centre in Portsmouth and nearly 80 on the livestream. The Trust received positive feedback about the event and Review of the Year film from colleagues and from patients and partners involved in the video.

Our campaigns

A campaign is underway to recruit dentists to the trust. This has included a social media campaign, recruitment events and the creation of a promotional video for the service.

We continue to support our staff who are also carers through our Carers Staff Network. The network recently developed a Carers' Passport, which now officially forms part of our formal support for colleagues who have unpaid responsibilities outside of work. This passport gives managers guidelines on how to balance requests by staff who are also carers with demands of the workplace.

Alongside health and care colleagues at Portsmouth City Council, we celebrated the rollout of our family hubs in Portsmouth, with two events in the city. We also promoted our virtual hub – Family Assist.

The online offer is an innovative new way of ensuring that parents and their friends and families have access to a wide range of information and resources, both local and national, at their fingertips.

Solent's Veterans Network is being relaunched as the Armed Forces Network, to ensure we are reaching not only our veterans, but colleagues that are currently serving in the Armed Forces, and the families or support network of both. The Armed Forces Network provides a supportive space for staff to share their lived experience, recognising and honouring the valuable contribution and unique skillset they bring to our service. A calendar of events is being scheduled, to tie in with Solent's recent Veterans Aware Accreditation.

Two hospital chefs in national finals

Two of our catering team stormed their way into the finals of NHS Chef 2023.

Jim Richardson and Naz Ahmed romped to victory in their regional heat at the University of West London in Ealing, London.

The pair were declared winners after the latest round of the national competition, in which Jim came third last year with colleague Joe Hennigan.
After winning their heat, Jim and Naz will next compete in the gruelling six-day final to be held at Lainston House Hotel in Winchester at the end of October.

The Finance Team have also won the Training & Development Award at the 2023 South Central HFMA Conference, recognising the dedication of the Trust into supporting the development of our finance team and budget holders to provide the best possible service to the organisation.

Section 2 – Internal matters (not reported elsewhere)

Veterans Network

Armed Forces Covenant
Proudly supporting those who serve

The Trust has recently relaunched its Armed Forces Network with an afternoon tea, hosted at St Mary's Hospital. A programme of events has been diarised to create a space for veterans and armed forces family within our workforce, including local serving personnel and volunteers.

The relaunch coincided with the trust receiving a Veteran Aware Trust accreditation. The awarding panel noted they were particularly impressed by the dedication of the Trust in achieving the principles of the Armed Forces Covenant Duty, and the standards set by the VCHA. Solent NHS Trust provides healthcare services to the highest density of Armed Forces community individuals in the country.

This accreditation is public recognition that you understand and are cognisant of the unique challenges faced by patients, staff, and the wider community.

Great Care

Safety matters

SolWe are seeing an upsurge in cases of Covid across our communities and in turn within our workforce. This alongside the pressures across our system and with the flu season also coming in, is a cause of concern and a situation we will be monitoring closely. We are actively encouraging staff to access flu and Covid vaccinations and our Occupational Health Team have commenced their flu campaign.

Great Place to Work

Workforce matters

Staff Survey

Solent staff took part in the NHS Quarterly Staff Survey in Q2 and we are pleased to have received excellent results. Our indicators for engagement, involvement and motivation were in the top quartile of 180 providers. We will continue to encourage participation in this quarterly survey as well as the annual national staff survey which will be open from 2 October. Opportunities for our staff to provide feedback and raise concerns is something we take very seriously.

Industrial Action

Our operational team continue to plan for ongoing industrial action, seeing junior doctors strike action on a monthly basis, now joined by consultants organised at the same times by the BMA. Services have fortunately seen limited impact thus far, but the continual pressure of managing this is causing fatigue.

Change Engagement Programme

We are pleased to be launching our change engagement programme for all staff with respect to Project Fusion. The collaborative work has been designed between our Communication and People teams. There are multiple events that have been organised with supporting, accessible information available for all.

Our key risks

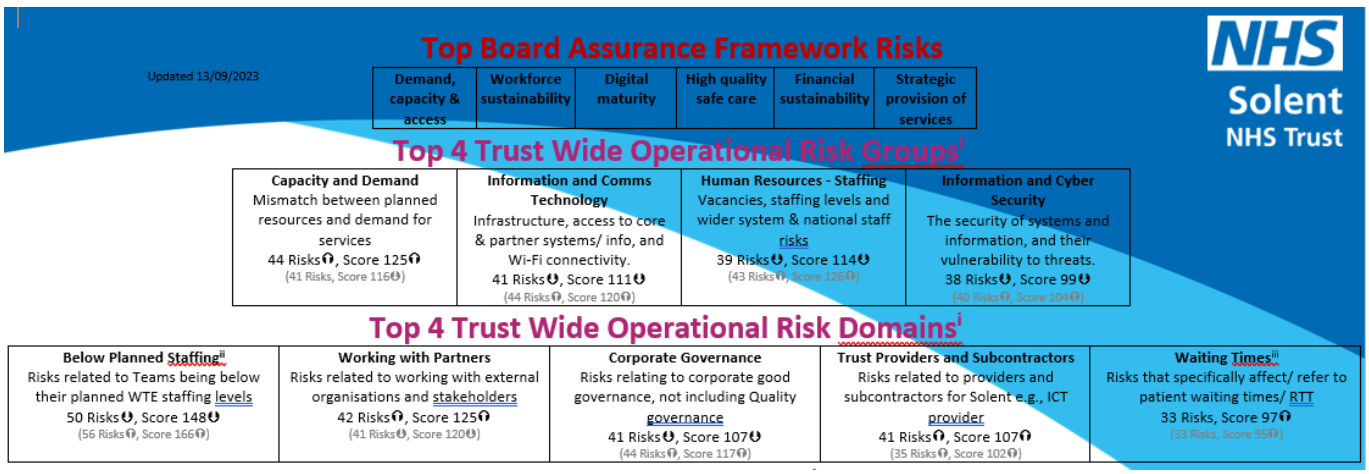
Operational Risk Register

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

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

Our top Risk Domains are:

1. Below Planned Staffing
2. Working with Partners
3. Corporate Governance
4. Trust Providers and Subcontractors
5. Waiting Lists



Board Assurance Framework (BAF)

During August and September 2023, executive leads reviewed the detail within their respective BAF entries and provided relevant updates. The Committees of the Board will reflect on the BAF entries as part of their assurance process of managing associated risks. The BAF is summarised as below.

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

Section 3 –System and partnership working

Project Fusion

The Project Fusion full business case, patient benefits case and post-transaction integration plan are scheduled for approval at a 'Boards in common' meeting of each of the Project Fusion partner organisations on 23 October 2023. This will be an in-public meeting, held at the Kings Community Church Conference Centre, Upper Northam Road, Hedge End, Southampton, SO30 4BZ.

Following approval by Boards, NHS England will begin their review of our proposals and plans. The current scheduled date for establishment of the new community and mental health provider for Hampshire and Isle of Wight remains 01 April 2024.

HIOW ICS

Work is ongoing in relation to the System Recover Programme, with metrics being applied to the five transformation projects. These will be discussed in the forthcoming meeting with national colleagues.

Item 11

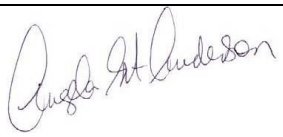
Board and Committee Summary Report

Title of Paper	Solent NHS Trust Self Declaration on Same Sex Accommodation – September 2023				
Date of paper	September 2023				
Presentation to	Trust In Public Board				
Item No.	11				
Author(s)	Sarah Balchin - Director Community Engagement and Experience Anastasia Lungu Mulenga - Head of Community Engagement and Experience				
Executive Sponsor	Angela Anderson – Chief Nurse				
Executive Summary	This paper presents to the Board the annual statement of compliance against the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest or reflects their personal choice.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	In Public Board is asked to: • Review the declaration within and approve the outlined declaration for assurance.				
Statement on impact on inequalities	Positive impact (inc. details below)	X	Negative Impact (inc. details below)		No impact (neutral)
Positive / negative inequalities	Solent is committed to providing accommodation that complies with the delivering same sex accommodation standards and considers these to be a key factor in maximising patient privacy, dignity and respect.				
Previously considered at	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		12.Digital transformation	
2. Alongside Communities		9.Belonging to the NHS		13. A greener NHS	
3. Outcomes that matter		10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	Significant		Sufficient	X	Limited		None	
Assurance Level	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								

Solent NHS Trust Self Declaration on Same Sex Accommodation – September 2023

All providers of NHS-funded care are expected to prioritise the safety, privacy and dignity of all patients. In April 2011, reporting of breaches to same-sex accommodation guidance became mandatory. Since then, trusts have continued to report on a monthly basis and there have been huge improvements in privacy and dignity.

All our patients and the public wish their privacy and dignity to be respected at all times whilst using our services. The physical environment and the provision of single sex accommodation is considered to be a key factor in maximising patient dignity at each stage of patient care and treatment.

The guidance refers to all patients who have been admitted to hospital and sets out the following:

- Sleeping Accommodation- Patients should not normally have to share sleeping accommodation with members of the opposite sex.
- Bathroom and Toilet Facilities- Patients should not share toilet/washing facilities but may have to access ones used by male and female patients if not enough are available. Patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms, this excludes corridors.
- On the rare occasion that mixing does occur, every effort should be made to rectify the situation as soon as possible. Until that time, employees must take extra care to safeguard privacy, particularly in areas where patients are admitted and cared for on beds or trolleys even where they do not stay overnight. It does not include areas where patients have not been admitted. In every instance the patient, their relatives and carers should be informed of the reasons why mixing has occurred, what is being done to address it and some indication as to when it may be resolved.

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

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

- ✓ There are no exemptions from the need to provide high standards of privacy and dignity

- ✓ Patients should not have to sleep in the same room, unless sharing can be justified by the need for treatment or by patient choice. Decisions should be based on the needs of each individual not the constraints of the environment, nor the convenience of staff.

- ✓ Patients should not have to share toilet and washing facilities with the opposite sex, unless they need specialised equipment such as hoists or specialist baths.

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

What does this mean for our patients?

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

- The room where they sleep will only have patients of the same sex as them.

- Transgender and non-binary patients should be accommodated in line with their stated gender identity.

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

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

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

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

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

Board and Committee Summary Report

Item 12.1

NHS Solent NHS Trust

Title of Paper	ANNUAL REPORT FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE 2023
Date of paper	18th September 2023
Presentation to	Trust Board
Item No.	12.1
Author(s)	Lee Havey
Executive Sponsor	Alasdair Snell
Executive Summary	The industrial action taken so far in 2022 and 2023 has been unprecedented. Risk assessments on most of our previous BCP's noted the risk of industrial action as non-applicable. This has changed with the new BCP's which now include this as a risk with mitigations in place. In 2022, the Trust achieved substantial compliance against the NHS England EPRR assurance framework, and our work plan set out what we needed to achieve for this year. Lockdown exercises have been conducted and in one instance actioned for real, we have improved our record keeping of training delivered and produced new training material and reviewed and tested our BCP's. The evacuation and shelter exercise the Deputy COO attended in June produced lots of questions and issues and we await the learnings paper from the exercise.

Action Required	For decision?	(N)	For assurance?	Yes
Summary of Recommendations	The Trust Board is asked to: • Note this report and the assurance provided regarding EPRR activities for Solent NHS Trust • Support onward assurance provision to the Board, and escalation of issues for Board information and support as appropriate			

Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	x
Positive / negative inequalities	This report is not considered to have a specific impact on inequalities and is therefore neutral					
Previously considered at	*EPRR Group*					

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		10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: sufficient assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature	A. Snell							

Item 12.2

ANNUAL REPORT FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE 2023

Contents

1. Introduction

As all NHS-funded organisations are expected to meet the requirements of the Civil Contingencies Act (2004), the Health and Care Act (2022), the NHS Standard Contract 2022/23, and the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR). This report identifies work undertaken to ensure that Solent NHS Community Trust (henceforth known as Solent) is compliant with these statutory requirements. The report therefore outlines the current position of emergency preparedness, resilience and response through the key activities that have taken place during the last year 2022-2023.

2. Requirements and Principles of EPRR

The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level. Solent NHS Trust sit under the auspices of the ICB, who are category 1 responders, and are obliged to comply with the full set of civil protection duties.

Acting as a category one responder, Solent is subject to the following civil protection duties:

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

3. Assessment of Risk

Solent NHS Trust has clear and effective risk processes in place and contributes to the review and updating of not only our own, but also the Hampshire and Isle of Wight Local Resilience Forum (HIOW LRF) community risk register, as part of the work undertaken by the Local Health Resilience Partnership (LHRP).

In accordance with the national and local risk assessments, the highest risks and any subsequent plans are reviewed regularly. Local potential business continuity risks are also included in Solent's risk register.

Solent NHS Trust Risks	
Risk	Risk Number
Pandemic / capacity & demand	1197 & 1212
Adverse weather	1207 & 1194
Widespread electricity failure	1206
Fuel shortages	1210
IT outage	1211

The picture below demonstrates the risks attributed to 'health' and UKHSA in the Hampshire and Isle of Wight Community Risk Register (HIOW CRR.) The inclusion of volcanos may seem odd, but it was as a result of the 2010 eruption of the Eyjafjallajökull volcano in Iceland. The subsequent flight cancellations left hundreds of NHS staff stranded abroad.

R072	Accidents & System Failures	Insolvency of supplier(s) of critical services to the public sector	**High**	Medium	Moderate	Health
0	Accidents & System Failures	Radiation release from overseas nuclear site	Low	Low	Limited	UKHSA
R070	Accidents & System Failures	Radiation exposure from transported, stolen or lost goods	**Medium**	Low	Moderate	UKHSA
R062	Accidents & System Failures	Accidental work-related (laboratory) release of a hazardous pathogen	**High**	Low	Catastrophic	UKHSA
R069	Accidents & System Failures	Food Supply Contamination	**Very High**	Medium High	Moderate	UKHSA
R087	Natural Hazards	Volcanic Eruption	**High**	Medium High	Moderate	Health
R090	Natural Hazards	High temperatures and heatwaves	**Very High**	Medium	Catastrophic	Health
R095	Human & Animal Disease	Pandemic	**Very High**	Medium	Catastrophic	Health
R097	Human & Animal Disease	Outbreak of an emerging infectious disease	**Very High**	Medium High	Catastrophic	UKHSA
RL09	Accidents & System Failures	Radioactive release by a visiting nuclear powered vessel to Portsmouth & Southampton Ports	**High**	Low	Catastrophic	UKHSA
R063	Accidents & System Failures	Accidental Release of a Biological Substance	**High**	Medium High	Moderate	UKHSA

The full community risk register can be found here. [HIOW CRR (resilience.gov.uk)]

The 2023 national risk register was released on the 4th of August which notes the ever-changing and growing risks facing the UK today. From the invasion of Ukraine, the long-lasting effects of Covid-19 pandemic, climate change and the opportunities and challenges of technologies such as artificial intelligence. The full document can be found via the link below.
https://www.gov.uk/government/publications/national-risk-register-2023

4. Emergency Preparedness Plans

The EPRR team continues to write, review and update plans. We are working more closely with our EPRR colleagues from Southern Health and have begun to align documents in the run up to Fusion. The Fuel plan, written by Solent, is now a joint plan; as is the Adverse

Weather plan, written by Southern. There are subtle differences but for all intents and purposes, they are the same document.

Areas reviewed this year include:

- Business Continuity Framework
- On Call O-SOP for Directors and Managers
- Incident Response Plan (Previously Incident Response Arrangements)
- Fuel plan
- Adverse weather plan
- All BCP's and guidance cards

5. Business Continuity Management

As we as working more closely with SHFT's EPRR team, we also work with the acute trusts and the ICB. We provide a response to the expected challenges but also unexpected challenges such as Industrial Action (IA) and water outages etc.

BCP's have undergone a fundamental update and review this year which has been enabled by employing an EPRR facilitator. The BCP template has been re-written making it easier to follow and complete. They have worked tirelessly with service lines to get the BCP's even more robust than before and feedback from service lines has been universally positive.

6. Incidents and planning

6.1 Industrial Action

This year has seen unprecedented levels of Industrial Action (IA) and this looks set to continue. IA has taken up a lot of time and energy within the EPRR team. Data collation and submissions are time consuming and require lots of collaboration with different teams. The industrial action team helped EPRR enormously with data collation and information making our job much easier.

NHS England South-East declared level 3 incidents in response to IA in June, July and August. As of the 22nd of September there have been 54 days of IA with 4 more days announced for October.

The embedded excel documents are snapshots of the returns Solent submitted to the ICB with the performance team submitting returns via SDCS. The word document shows the timeline of industrial action taken to date.


RTN-0455 ICB return for JD and Con IA July


Solent 2nd return SEROC-RTN-0404 20


BMA IA 13th - 18th July 2023 Returns.xls


Com_MHLD - IA sitrepWC_12-06-23 V


IA timeline.docx

As well as having a direct impact on Solent services IA has also had an indirect effect. Teaching and transport unions have meant BCP's were again looked at in planning for staff absences due to childcare or unable to get to work either on time or at all.

6.2 Water Supplies

On the 26th of May there was a water main burst at the entrance to St Mary's Community campus, the second in eight months. Mains water to the site was shut off whilst work was carried out but the contingencies we have in place ensured there was water to the site at all times. All works were carried out by the estates team and a civils contractor and water restored later the same day.

Work has been programmed in to replace the water main as it is in poor condition, and this is scheduled to be complete this financial year.

We are also in discussion with the Estates team and Portsmouth Water to further increase our water resilience and a new water main supply to the St James's site is also underway.

6.3 Water Disruption (Southern Water)

In late December 2022 a sharp frost and rapid thaw led to a large number of burst pipes. This was followed by excessive rainfall and a subsequent reduction in water production (excessive rain puts more debris into water courses leading to more filtration requirements). These and other engineering works led to the loss of supply to some 23,000 properties in the Southampton area. Several Partner Activated Teleconferences (PAT) were called to ensure all stakeholders were kept informed. Once specific postcode areas had been identified it was clear none of Solent's buildings were affected.

As part of our resilience, service lines keep lists of their vulnerable patients, who are encouraged to sign up to utility companies' priority registers. If required, we can send up to date lists to the water companies meaning bottled water can be delivered direct to their homes.

6.4 Incident at RSH

There was an incident in April involving three men at the RSH where the hospital was partially locked down. Solent services where not informed of the incident by the RSH security team; however, Solent staff used their initiative and locked down parts of the building to keep both staff and patients safe.

A report from members of staff involved in the incident can be found on Ulysses. Incident number 194094.

6.5 Oxygen

In early January supply issues with Oxygen cylinders led to shortages in several trusts and South Central Ambulance Service (SCAS). An urgent request for cylinders was made by St Mary's hospital on the Isle of Wight as they had less than 24 hours of bottled oxygen left of the island. Solents Chief pharmacist and the EPRR team collated the information regarding our own supplies, expected deliveries and any spare capacity. Due to Solent's own careful planning and using oxygen wisely we had no issues with our supplies.

6.6 Reinforced Autoclaved Aerated Concrete (RAAC)

A desktop review of Solent buildings identified RACC in Block A of the St Mary's community Hospital in Portsmouth. The estates team are aware of the industry advisories and have been working on this subject since the tail-end of 2022 liaising closely with NHSE and completing all the required returns. Estates confirmed that RAAC is present on the fourth and fifth floors of SMH Block A (constructed circa 1966) where we have temporary props in situ in the event of end bearing failure with further longitudinal support beams being installed shortly.

The NHS RAAC Taskforce visited the site in July and the EPRR team continues to liaise with Solent's estate team and the ICB on this matter.

7. Learning (EPRR)

A cyber exercise was held on the 17th of April with a member of NHS England as part of Solent's commitment to preparing and responding to a cyber security incident. (This also a mandatory requirement of the Data Security and Protection Toolkit, to undertake an annual security exercise.)

The report from the Data Protection Officer below has details of the exercise and learning gained from it. The EPRR team now has a specific page within the BCP's regarding ICT. If service lines are unsure of any IT workarounds, they can contact the EPRR team in the first instance or digital services if there is a more complex issue.

20220525_CyberInci
dentExercise_Debrief&

8. Arrangements to Warn and Inform the Public

Solent NHS Trust has continued to work in partnership with other health providers and commissioners to provide information to both staff and the public. During periods of IA, teams contacted patients as soon as possible to cancel or re-arrange appointments.

Throughout the year information is placed on the staff website when required, this ranges from information about weather events such as flooding or excess temperatures through to clinical updates such as Covid-19.

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

9. Co-operate with Other Providers

Co-operation is fundamental to robust emergency preparedness. As a member of the Hampshire and Isle of Wight Local Health Resilience Partnership (LHRP) Exec group, Solent's Chief Operating Officer attends the LHRP Exec meetings which are held three times a year. Attendance at these meetings is mandatory as it forms part of the annual assurance process.

As the Emergency Planning Lead, I attend local health resilience meetings and feedback relevant information to the emergency planning group. I also work in partnership with Southern Health Foundation Trust and the acute trusts to ensure all work undertaken is consistent across the region. Working together in this way supports the requirements of the Civil Contingencies Act and allows for joint learning and the sharing of EPRR documents and work plans. All the trusts, both acute and community and mental health send documents to each other's organisation for comment which is proving to be beneficial to all EPRR teams.

10. Training and Exercising

10.1 Exercise Arctic Willow

In November 2022 exercise **Arctic Willow** took place to test the EPRR arrangement at ICB's with all HIOW trusts taking part. The exercise highlighted the robustness of the systems in place with only two areas for improvement across the ICB: sitrep reporting and planned power outages. Sitrep reporting has become more streamlined in Solent with most requests now coming via EPRR. The full debrief can be found in the document below.

Exercise Arctic Willow Handbook - Full Debri

10.2 Exercise Hiertan

Exercise **Hiertan** took place at Charlton Athletic Football Club in London on the 29th of June 2023. The aim was to explore the challenges of a hospital evacuation and further develop the regional Plan to Support a Hospital Evacuation in the NHS South-East Region. Solent's Deputy COO attended on behalf of the Solent. We are still waiting for the learnings paper to be published and we will use this to help us with our own evacuation and shelter planning and exercising going forwards.

10.3 Training Packages

Director and Manager on-call training sessions have taken place throughout the year for those new to the on-call roster and as a refresher for those already on call.

A new training package is currently being reviewed by the COO and Deputy COO before being sent to on call staff. The training is in two parts, the first a self-led online Power Point presentation with the second part a face-to-face scenario-based session. This is specifically aimed at a rapid onset major incident with more scenario-based elements to be included.

'**Guidance for the initial management of self-presenters from incidents involving hazardous materials'**. A new training package has been developed to include updates to the Initial Operational Response. A link to a booking page will allow reception staff to book onto a session of their choosing. Sessions will be scheduled to take place on different days of the week and will include evening sessions to cater for shift and part time working. We will also run weekend sessions if required to ensure all staff have the opportunity for training.

11. Assurance

Solent achieved substantial compliance in 2022 under the NHSE Assurance regime with this year's annual assurance process now underway. The EPRR team must provide evidence to show our compliance with 86 core standards and a further 12 standards which are part of a 'deep dive'. A peer review of our current assurance state is taking place on September the 18th by our EPRR colleagues from Southern Health and a member of the ICB which will highlight any shortcomings we may have; we are on track to be substantially compliant this year.

The deep dive this year is aimed at training and exercising.

12. Work plan

- Next year's work plan will be focused on Fusion and ensuring we comply will all the requirements of the Civil Contingencies Act 2004.
- Continuous development of training packages for staff and to place training materials on the new ICT platform post April 1st, 2024.

13. EPRR Team

The EPRR team doubled in size in October 2022 when we employed an EPRR facilitator who came from a role with Thames Valley police and their Local Resilience Forum. Earlier this year she was awarded a Distinction in her master's degree in Crisis and Disaster Management. We now also have a volunteer working for the team, having retired as a Lieutenant Colonel in the Royal Marines Hugh worked with the vaccination programme and was introduced to EPRR by the volunteer's management team. Post Fusion we will join our Southern Health colleagues who also have different backgrounds which makes for a dynamic team going forward.

14. Summary

The industrial action taken so far in 2022 and 2023 has been unprecedented. Risk assessments on most of our previous BCP's noted the risk of industrial action as non-applicable. This has obviously changed with the new BCP's, and all service lines now include this as a risk. As an organisation we have always taken the approach of planning for the worst and working hard towards mitigating any risks. The industrial action has impacted the trust, but we have been extremely resilient and at no time was patient or staff safety compromised. Whether taking part in IA or not all staff were supported by the Trust. Picket lines were visited by senior managers as were the wards and departments in equal measure.

As the Board are aware, last year the Trust achieved substantial compliance against the NHS England EPRR assurance framework, and our work plan set out what we needed to achieve for this year. Lockdown exercises have been conducted and in one instance actioned for real, we have improved our record keeping of training delivered and produced new training material and reviewed and tested our BCP's.

The evacuation and shelter exercise the Deputy COO attended in June produced lots of questions and issues and as previously mentioned we await the learnings paper from the exercise.

Clearly, no plan ever really covers all the bases, but we are in a good place with our plans, processes and procedures and we continue to learn and adapt. Fusion will bring new challenges but the EPRR teams for both Solent and Southern are working to ensure as smooth a transition as possible to a single organisation.

Item 13

Title of Paper	Winter Resilience & Cold Weather Planning 2023/2023				
Date of paper	23rd September 2023				
Presentation to	Solent NHS Trust In-Public Board				
Item No.	13				
Author(s)	Lee Havey – Deputy EPPR Lead, Jo Pinhorne, Deputy Chief Operating Officer				
Executive Sponsor	Alasdair Snell – Chief Operating Officer				
Executive Summary	The purpose of the document is to describe the planning arrangements put in place by Solent NHS Trust to support the delivery of care throughout the winter period 2023 – 2024.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The Board is asked to receive assurances regarding the preparation for winter resilience				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) x
Previously considered at					

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		10. New ways of working		14. Supportive Environments	
4. Life-course approach		11. Growing for the future		15. Partnership and added value	x
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 Solent NHS 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	 Alasdair Snell, Chief Operating Officer							

Winter Resilience and Cold Weather Planning 2023/2024

Contents Page

1.0 Introduction

The purpose of this document is to describe the planning arrangements put in place by Solent NHS Trust to support the delivery of care throughout the winter period 2023/2024.

Solent NHS Trust plans to maintain organisational readiness and resilience, to respond appropriately to operational pressures and challenges to enable services to continue throughout the winter period. It is recognised that we are expecting the winter of 2023-2024 to be demanding when there is already a need for an additional focus is during this period, demand for some services is likely to be at its highest level especially with the possibility of a resurgence of the Covid-19 virus. It is therefore essential to maintain a co-ordinated approach to ensure that preparation is robust and that processes are in place that can adapt to the different pressures as and when they arise.

To ensure the organisation can respond to significant peaks in demand Solent NHS Trust has Incident Response Arrangements which are supported by associated plans and action cards.
These documents are underpinned by the individual service's Business Continuity Plans which detail how capability and capacity is maintained at peak times. Lessons learnt from the Covid-19 pandemic and routine testing and review ensure plans are fit for purpose.

The trust engages with system partners in both cities to effectively contribute to system plans throughout the winter period. Close collaboration with Hampshire and Isle of Wight Local Resilience Forum (HIOW LRF) has also shown our effectiveness when working with external partners. This paper addresses the trust's internal preparedness for winter pressures, although the responsibility for governance of system resilience is currently with the Integrated Care Board (ICB).

1.2 Key Purpose

This document sets out:

- Key pressures and risks
- Escalation framework and protocols
- Capacity and Demand Monitoring and reporting arrangements.
- Situation Reporting Influenza and infectious diseases.
- Service level planning and continuous learning from Covid-19,
- Governance
- Communications

2. Key Pressures and Risks

2.1 There are several key pressures which are likely to occur during the winter period:

- Increased demand on the health and care system as a whole due to the direct effects of cold weather, and this could be exacerbated by the cost of living challenges.
- Reduction in community capacity due to reduced funding
- System wide delays in transfer and system operational pressures.

- Workforce; fatigue and recruitment challenges
- Further industrial action
- Impacts as a result of extreme weather affecting transport including:
    - Staffing issues caused by transport disruption.
    - supply chain issues
- Direct and indirect effects of Covid-19, Strep-A and other infectious diseases

2.2 Influenza

A specific weekly report will be published by UK Health Security Agency (UKHSA) which will include a range of indicators on flu including:

- the amount of Influenza-like illness (ILI) in the community
- the prevalent strain(s) of flu circulating.
- the proportions of clinical samples that are positive for flu or other specified viruses.
- the number of flu-related hospital admissions, the relative impact of flu on different groups of people, by age and by clinical condition (including data on deaths where flu is the confirmed cause) based on data from intensive care units.
- excess mortality monitoring
- the international situation

For the last 2 years during the coronavirus (COVID-19) pandemic we have had the largest NHS influenza vaccination programmes ever. We have also seen some of the best influenza vaccine uptake levels ever achieved in many of the cohorts, with more people vaccinated than ever before.

As a result of non-pharmaceutical interventions in place for COVID-19, influenza activity levels were extremely low globally in 2020 to 2021 and at present continue to be low, however, a late increase in activity cannot be ruled out this season.

Last year we ranked 6th in the country for our staff flu vaccination uptake and the trust is doing everything we can to help keep care services running and reduce the burden on the wider NHS during the winter. Our Flu Programme for this year is now underway and updates to Executives, the Board, the ICB, Region and NHSE will be provided as required throughout the Programme.

The way staff can receive a flu jab has changed; appointments will no longer be needed as walk in clinics will be taking place across Solent sites in the coming months. Vaccinations started mid-September across 13 sites and all details can be found on the occupational health pages of Solent. http://intranet.solent.nhs.uk/TeamCentre/PeopleServices/occupationalhealth/flu/Pages/Home.aspx

2.3 Infectious disease outbreaks

Close links are in place with UKHSA and surveillance information on infectious illness areas are e-mailed directly both to the EPRR and Infection Prevention and Control team (IPC) within Solent.

2.4 Covid-19

Solent NHS Trust recognises that it has a crucial role to play in the identification and management of infection, therefore they will continue to work in close partnership with multi-agency organisations across the Hampshire and Isle of Wight.

At the outset of the Covid-19 crises in March 2020, we made arrangements and re-configured our services to ensure we had the capability to deal with it. Having demonstrated our ability to surge to this posture more than once, we remain confident in our ability to make proportionate adjustments to face further waves not only of Covid-19 but other emerging infectious diseases.

It is recognised that staff continue to endure the prolonged period of working differently such as working from home and adapting to the constantly changing work environments and guidance. We pro-actively encourage our people to ensure they take a break and some leave to look after their own resilience and wellbeing.

2.5 Cold Weather and Alerts

Solent NHS Trust follows the national Met Office Cold Weather Alerts and informs staff of the alerts using the internal intranet (Solnet). These alerts are also cascaded by the Trust Communications team to all staff, together with the appropriate actions to take at that level and any advice for the patients and service users. Social media is also used to notify staff of any issues such as adverse weather and traffic issues.

Cold weather alerts are classified into four categories from November 1 to March 31

Level 0	Long-Term Planning - *All year*
Level 1	Winter Preparedness Programme *1 November to 31 March*
Level 2	Severe Winter Weather is Forecast – Alert and Readiness *Mean temperature of 2°C and/or widespread ice and heavy snow are predicted within 48 hours, with 60% confidence*
Level 3	Response to Severe Winter Weather – Severe Weather Action *Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow*
Level 4	Major Incident – Emergency Response *Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health.*

:

The Trust's communications plan includes arrangements in place for communicating with staff during severe weather conditions for example, to advise staff how best to get to work or to advise staff on mobile/home working.

The EPRR team attended the UKHSA cold weather preparation webinar on the 7th of September, Information gained from the webinar will be included in the next EPRR quarterly report. The forecast predicts autumn is likely to be warmer, wetter and less windy than mean averages.

The webinar provided information on:

- The latest weather forecast for winter 2023/24

- Reflections on winter 2022/23, including observed public health impacts of cold weather

- UKHSA/Met Office Cold Weather Alerting Service and the Met Office National Severe Weather Warning Service

- The role of the local and national authorities in the implementation of the Cold Weather Plan

- The role of social care services and community and voluntary services

3. Escalation framework & Protocols

3.1 Leads

The Deputy Chief Operating Officer (DCOO) is the Trust lead for systems resilience and winter planning and the Chief Nurse has the lead responsibility for flu planning. The DCOO and the Chief Nurse are supported by the relevant operational directors and duty managers.

3.2 System Networks

The Trust participates in local networks which support the development and coordination of day-to-day systems management and escalation. Key stakeholders involved within the networks include ICB, neighboring Trusts, Ambulance Trusts, Out of Hours providers, 111, Social Services, and other Local Authority Departments.

The escalation policies and frameworks for the Trust are rooted in System-wide management methodology at both national and regional level using the Operational Pressures Escalation Levels framework (OPEL) across the whole system.

3.3 Daily Escalation Reporting – System Priority Services

The Trust participates in routine daily reporting of the capacity and escalation status of key service areas that are critical to the effective management of demand, capacity, and patient flow through the system.

Each of the services has clearly defined triggers built around agreed early warning signs of escalating pressure, which allow the service to match themselves against the levels of alert. This traffic light system enables the services to communicate, early each day, any mismatch between capacity and demand. These triggers combine to form a Trust escalation framework which determines the alert status of the Trust overall. Throughout the year via daily status reports the alert status of each of the services and the overall Trust status are shared with the Acute Trusts and relevant stakeholders within the Southampton and Portsmouth systems. This includes submission to a system-wide depository to enable a systems dashboard to be distributed by the ICB, and a system wide escalation plan (SHREWD).

The escalation framework described above can be expanded to include other services where capacity pressures arise. Managers on call out of hours are provided with a daily capacity update when the system is under pressure and can request more frequent reports if necessary.

Each of the services has a capacity and escalation plan in place, which outlines their escalation triggers, actions, and responsibilities. These plans are supplemented by business continuity plans when pressures occur which extend beyond business as usual. Both sets of plans are held centrally within the Trust.

Workforce Planning: There are thresholds already in place for the numbers of staff that can have planned leave at any one time, however as part of our Winter Plan we are focussing on the robustness of business continuity plans and this will include more work on contingency planning.

3.4 OPEL Escalation Levels

OPEL Escalation Levels	
OPEL 1	Four-hour performance is being delivered. The local Health and Social Care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources. The Local Emergency Departments (ED) / Urgent and Emergency (U&E) Care Delivery Boards area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	four-hour performance is at risk. The local Health and Social Care System is starting to show signs of pressure. The Local EDA&E / U&E Care Delivery Boards will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep colleagues at regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	Four-hour performance is being significantly compromised. The local Health and Social Care System are experiencing major pressures compromising patient flow, and these continue to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all ED / U&E Care Delivery Boards Partners and increased external support may be required. The NHS E/I SE Regional Team including the SE Regional Director will be made aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. Decisions to move to system level OPEL 4 will be discussed between the Trust CEO, the ICB AO or Managing Director, and System leadership (This should also be agreed with the SE Regional Director, or their nominated Deputy. The National Urgent Emergency Care (UEC) Operations Team will be immediately informed by the SE Regional UEC Operational Leads through internal reporting mechanisms.
OPEL 4	Four-hour performance is not being delivered and patients are being cared for in overcrowded and congested department(s). Pressure in the local Health and Care System continues and there is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local ED / U&E Care Delivery Boards to recover capacity and ensure patient safety. If pressure continues for more than 3 days an extraordinary AEDB / U&ECDB meeting should be considered. All available local escalation actions taken, external extensive support and intervention required. The NHS E/I SE Regional Team will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in

	conversations with the system. The SE Regional UEC Operations Leads will have an ongoing dialogue with the National UEC Ops Room providing assurance of whole system action and progress towards recovery. The key question to be answered is how the safety of the patients in corridors is being addressed, and actions are being taken to enable flow to reduce overcrowding. The expectation is that the situation within the hospital will be being managed by the hospital CEO or appropriate Board Director, and they will be on site. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered

4.0 Capacity and Demand

4.1 Planning

System wide meetings enable sharing of information which can then act as a predictor of the peaks in demand such. Business Intelligence (BI) tools and SHREWD can also assist with capacity planning.

All service's Business Continuity Plans (BCPs) detail how capacity and quality is maintained at peak times and when there is a loss of critical services or resources. All service BCP's are subject to annual review and validation to ensure they are effective when in use.

4.2 Surge and Escalation

On receipt of the alert status reports from external providers or system-wide dashboards there is a system in place for the forward dissemination of this information within Solent NHS Trust.

Each of the key services has agreed actions within their capacity and escalation plans on how it will respond to capacity pressures internally or within the local health and social care system. The chart below summarizes these actions. Where surges in any part of the system arise, the ICB and Solent will use the OPEL Escalation Framework to determine the actions required.

National Escalation Status Triggers		
Escalation level	**Community care**	**Primary care services**
OPEL 1	Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand
OPEL 2	Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds	• GP attendances higher than expected levels • OOH service demand is above expected levels • Some unexpected, reduced staffing

	• Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services	numbers (due to e.g., sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services
OPEL 3	Limited Community capacity • Significant unexpected, reduced staffing numbers (due to e.g., sickness, weather conditions) in areas where this causes increased pressure on patient flow	Pressure on OOH/GP services resulting in pressure on acute sector • Significant, unexpected, reduced staffing numbers (due to e.g., sickness, weather conditions) in areas where this causes increased pressure on patient flow
OPEL 4	No capacity in community services • Unexpected, reduced staffing numbers (due to e.g., sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	Acute Trust unable to admit GP referrals • Inability to see all OOH/GP urgent patients GP Streaming not alleviating ED pressures • Unexpected, reduced staffing numbers (due to e.g., sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety

4.3 OPEL level 4 (OPEL Framework)

Provider organisations should request a full system conference call if they feel that they are reaching OPEL level 4 to ensure that all actions have been completed to avoid escalation.

Should escalation to OPEL 4 be reached, de-escalation will take place once the ICB is satisfied that there is no requirement for further escalation or intervention. This will be via verbal and written notification to the system providers and the ICB will then restate the overall system escalation status. Actions relevant to the lowered status will continue.

At times of increased pressure and demand, it may be appropriate to hold an extra-ordinary system-wide teleconference. Regular calls will take place during the winter months to ensure that weekend and out of hours systems are in place to cope with pressures. These will be individual to each system.

5. Situation Reporting

5.1 Solent NHS trust staff will continue to monitor and report daily bed and staff statistics. These reports will be available to contribute to the whole system groups and conference calls utilising Power BI and SHREWD. Solent NHS Trust also recognises the need to have availability of a bed state and staffing data daily throughout the winter period to inform the daily metrics that may be requested detailed in the table below. The information is updated on SHREWD by all organisations.

Data Item	Period for Reporting	Source	Lead	How these metrics will be shared
ED performance and admission conversion rates and acuity	Past 24 hours	ED data (4 hour waits and conversion to admissions %)	Acute representative	Conference call
Additional flex/extra beds open	Current as at time of conference call	Hospital bed status report (Ops report)	Acute representative	Conference call Escalation report
Bed capacity in acute and community services	past 24 and forward 24-48 hours	Rates of daily discharges and planned / predicted admissions Number of patients on Discharge Ready list & discharge issues	All bed-based service providers duty managers	Conference call. Escalation report
Ward closures	past 24 and forward 24-48 hours	Details of any occurring and predicted to occur	All bed-based service providers	Conference call Escalation report
Adult Social Services workload capacity	Past 24 and forward 24-48 hours	Details of service capacity	Duty managers HCC and SCC	Conference call Escalation report
Community caseload demand / capacity to receive patients	past 24 and forward 24-48 hours	Details of service capacity	Duty managers Solent, SHFT	Conference call Escalation report
OOH GP surgery predicted demand and capacity.	past 24 and forward 24-48 hours	Details of OOH GP surgery	Care UK NHUC	Conference call Escalation report
OOH GP surgery	Number of non-triaged calls outstanding as at the conference	Metrics of non-triaged calls	Care UK NHUC	Conference call Escalation report

	call			
Ambulance delays	Past 24 hours and current position as at the conference call	Ambulance handover reports	SCAS duty manager	As above plus emailed on regular distribution list each day.
111 issues	As above	Details of service capacity	111 lead	Conference call. Escalation report

6.0 Service level planning and learning

Common winter themes:

- Staffing – working differently, ensuring staff resilience & wellbeing
- Weather – mitigations in BCP and LRF
- Flow –whole pathway flow, acute & community
- Finance – funding constraints impacting ability to flex capacity as pressure grows
- IPC and influenza jab – to reduce infections and sickness.
- Communication – with the Acutes, local authorities and staff
- Prioritisation – risk assessed against greatest care need.
- BCP's – instigated when required.

6.1. Trust wide winter lessons learnt.

The Winter period 2022-2023 saw extreme pressures within the death management system with body storage in hospital mortuaries critical. Several Partner Activated Teleconference's (PAT) were called with plans made to ease pressures. Nationally the mortuary space data returns moved from weekly to daily showing the level of pressure the national system was also under.

Storm Eunice although short in duration saw PAT's called once again due to the potential loss of life and structural damage forecast by the met office. Directors and managers on-call were kept informed by the EPRR team enabling services to ensure priority patients where still seen with plans made to ensure visits took place when wind speeds were forecast to be lower and with the knowledge of when the M275 would be open.

7.0 Governance

The main group through which the delivery of the winter plan is monitored is the Trust's Emergency Planning Group, and ICB/local systems resilience meetings. Each Service Line is represented on the Emergency Planning Group.

7.1 Out of Hours Arrangements

The Trust operates a 24-hour 7 day a week on call Rota system. This includes, ICT, Estates, Service line Managers, and Directors. A communications team Rota is set up when required. Managers on

call out of hours are provided with a daily capacity update when the system is under pressure and can request more frequent reports if necessary.

8.0 Communication

Trust communications are formulated and distributed in a variety of ways as detailed below.

Date	Audience	Activity	Responsibility
November 1st	Staff	Add cold / adverse weather plans to intranet and circulate via Staff News	EPRR Team/ *Solent Comms
Mid September	Staff	Implement campaign to encourage staff to receive flu vaccine	Occ Health/ Solent Comms
Commencing November 1st	Staff	Inform staff of any met office adverse weather alerts via Staff News/ Intranet and global email (if required)	EPRR Team/Solent Comms
At first signs of severe weather	Staff	Remind staff of adverse weather plan via Staff News/ global email and social media	EPRR Team/Solent Comms
If adverse weather affects services	Public	Add latest clinic closures/ service opening times to Service Directory on solent.nhs.uk and include a banner on front page linked to pages with latest information.	Solent Comms
	Staff	Consider using media to cascade messages. Include links to latest information on all social media platforms with an obvious hashtag. Include information regarding clinic closures/ service opening times on intranet and if required circulate via global email. Encourage staff to look at social media and solent.nhs.uk	Solent Comms
	Stake-holders	Circulate information regarding clinic closures/ service opening times to stakeholders and comms leads via email.	Solent Comms
	GPs	Circulate information regarding clinic closures/ service opening times to GPs via ICB comms leads.	Solent Comms
When required	Staff and public	Pharmacy opening times to be publicized via Staff News and on public website when available.	Solent Comms
Ongoing	Staff	Include regular updates in Staff News and circulate information via Managers' messages.	Solent Comms
Throughout period	Public	Support ICB winter comms plans to convey messages to the public.	Solent Comms

* Information given to the comms team

Board and Committee Summary Report

Item 14.1

NHS Solent NHS Trust

Title of Paper	NHS Impact: Briefing Paper				
Date of paper	25th September 2023				
Presentation to	Trust Board				
Item No.	14.1				
Author(s)	Sarah Williams, Director of Research & Improvement				
Executive Sponsor	Dan Baylis, Chief Medical Officer				
Executive Summary	NHS England has recently launched NHS Impact (Improving Patient Care Together). This gives a framework for NHS Provider organisations to move towards a systematic approach to continuous improvement. All organisations are required to undertake a self assessment by the end of October, and consider strategies to mature their approaches. This paper outlines the areas for consideration, and shares the framework (currently in Draft) against which we will need to assess ourselves.				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The Board is asked to: • Note the framework emerging from NHS Impact, and the requirement for baseline self assessment. • Consider implications for Solent NHS Trust and Fusion for organisational design, operating model and approach to continuous improvement.				
Statement on impact on inequalities	Positive impact (inc. details below)	x	Negative Impact (inc. details below)		No impact (neutral)
Positive / negative inequalities	Focus on communities, and co-production.				
Previously considered at	Exec. Briefing given				

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	
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		15. Partnership and added value	x
5. One health and care team					
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)*	Significant		Sufficient		Limited		None	
Assurance Level	Concerning the overall level of assurance the [DN: insert name of Board/Committee] 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	 Dan Baylis, Deputy CEO & Chief Medical Officer

A systematic approach to Continuous Improvement: update on NHS Impact

Solent NHS Trust has a well established and mature learning and improvement culture, with a thriving Academy leading on a quality improvement programme, linked to research, clinical effectiveness and innovation. As an organisation, we have been increasingly merging approaches to improvement with quality and performance systems, and with ensuring patient and public involvement and co-design.

There are differing levels of engagement across the organisation, however, and often a variety of approaches are adopted. There is also scope for better connectivity between projects, and shared learning across the Trust.

A strong and growing national and international evidence base that shows that coherent and widely recognised approaches to improvement are core to high performing health care organisations and systems. These approaches go beyond quality improvement programmes, and require a focus on quality underpinned by a recognised and rigorous management system.

In April 2023 NHS England issued guidance related to the recommendations and findings of the Delivery and Continuous improvement review, conducted by Anne Eden, Regional Director South East England that drew on this evidence and widescale engagement.

Three recommendations arose from this review:

1. Establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and system, will focus improvement and delivery work
2. Launch a single shared 'NHS Improvement Approach'
3. Co-design and establish a Leadership for Improvement programme, beginning with board and exec teams

Formation of NHS IMPACT

NHS IMPACT 'improving patient care together', is the new single shared NHS improvement approach (rec 2). Underpinning a systematic approach to continuous improvement, it draws on this evidence base and defines five core components of system and organisational improvement. When applied consistently and intentionally across all areas of organisations and systems, this creates the culture and conditions for continuous and meaningful improvements in performance and outcomes.

NHS England has set an expectation that all NHS providers and ICSs will embed an approach to continuous improvement aligned with this. This will inform ways of working across services at every level. Corresponding adjustments to regulatory and oversight frameworks will be developed during 2023 including CQC assessment framework and 'Well Led' and the future arrangements for performance management, oversight and assurance by NHS England.

This represents a fundamental shift, moving beyond QI projects and individual transformation programmes to encompassing all planning, delivery, assurance, leadership and improvement activities, forming the basis of an operating model at system, organisation and team level.

Fig 1: NHS Impact, April 2023

Baseline assessment process and next steps

A series of baseline exercises and self assessments are now being undertaken, related to the current state, capability, maturity and progress towards embedding each of the five components of NHS IMPACT. This self assessment is due by October 31 2023 (see attachment 1).

Solent is part of a regional NHS IMPACT group, co-ordinated by the ICS, and the self assessment is being undertaken with relevant teams in the Trust. There is also a co-ordinated piece of work to bring onward planning into the Fusion workstreams.

Outcomes from this exercise and emerging national developments of NHS IMPACT will be shared with the Executive Team and Board with recommendations for action related to immediate delivery, and longer term development and maturity of our culture and system of continuous improvement and learning.

NHS England

NHS Impact Baseline for Improvement

To be completed by 31st August 2023

NHS IMPACT
Improving Patient Care Together

Draft for discussion only – this is not a statement of policy

NHS Impact 'Regional' Baseline for Improvement - Questions

1. Does the Regional Team have an executive responsible for improvement at system level in their region?	Y / N
1a. If yes, what is their title?	Title
1b. Does the Regional Team have improvement specialists?	Y / N
2. Does the Regional Director receive regular reports on improvement activity ongoing within each ICB (not just assurance), that are used proactively (e.g., for shared learning / developing the components of NHS Impact / taking action etc)?	Y / N
3. What percentage of the Regional Executive SLT has had any improvement training?	%
4. Does the Region have an Improvement Strategy with a measurement framework monitored by the SLT?	Y / N
4a. Does the strategy align internal activity with the components of NHS Impact?	Y / N
4b. Does the strategy align external activity with the components of NHS Impact?	Y / N
5. Is an improvement method or set of improvement methods being used within the Directorate (this does not include PMO functions)?	Y / N
6a. If yes, what is it / are they? [name of method(s) / approach(es)]	Text
6. Does the Regional Executive SLT use time series/SPC methods in its improvement activity and reporting (meaning anything from time series data including Model Health System, up to statistical process control methods) ?	Y / N
7. Does the Regional Team co-produce improvement work with Local Authorities and/or external partners (e.g. with VCSE, AHSNs etc) on shared improvement challenges?	Y / N
8. Is the Regional Team considering engaging, or has already engaged, with an improvement partner (a third party where the relationship could be focused on improvement strategy/capability building/organisational strategy development etc)?	Y / N
8a. If yes, which partner organisation(s)?	Name(s)
9. Does the Regional team co-produce improvement work with people with lived experience?	Y / N
10. What % of the Regional Team have attended as a minimum a 'Fundamentals' / 'Introduction to improvement' level of training (if estimating percentage, select from: 0-25%; 26-50%; 51-75%; 76-100%; and list the total staff headcount number *(both from an 'as-is' position)*?	%, of total staff number
11. Do you include improvement training as part of your staff induction for the Regional Team?	Y / N

NHS Impact 'Regional' Baseline for Improvement - Questions

12. How do you recognise those in your Region with improvement capabilities ?	Free text
13. Are any of your staff members part of improvement communities? If so, please use the text box to include which groups	Free text
14. Do your staff interact with other improvement colleagues across the Region? (if so how do they come together?)	Free text
15. How do you deploy staff with improvement capability and capacity to respond and focus on a particular challenge ?	Free text
16. How do you pivot improvement skilled individuals or improvement teams if a sudden unexpected challenge arises?	Free text
17. If you would like to share their names with us, we would like to convene a learning session to hear more about what they find works well and what doesn't. This information will help to shape NHS Impact further, especially using existing learning and strengths to understand how NHSE can add value, rather than duplicate.	Free text
18. What, if any, support would you want/need around your improvement communities through NHS Impact?	Free text

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NHS England

NHS Impact Self-Assessment

To be completed by 31st October 2023

NHS IMPACT
Improving Patient Care Together

Building a Shared Purpose and Vision (C1-Trust)

What this looks like in practice:	Themes:
• 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. • Involve communities and people with lived experience as partners in the design of the vision and shared purpose. • Find ways to make the vision and shared purpose practical, so that they are lived everyday by its people and are underpinned by core values. • Ensure all 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 frontline staff are working, their challenges, their successes, and the improvement they'd like to see to guide this vision and shared purpose, for example through methods of co-design and collaboration like crowd sourcing platforms or engagement events. • Take account of the current Care Quality Commission 'Well-Led' scores 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.	• Board and executives setting the vision and shared purpose • Translating this into a compelling narrative for staff • Improvement work aligned to organisational vision, purpose and priorities • Co-design and collaborate - celebrate and share successes • Lived Experience driving this work

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Building a Shared Purpose & Vision (C1-Trust)

NHS England

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 metrICB (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 (C2-Trust)

What this looks like in practice:	Themes:
• Set the expectation (e.g. 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 systems and 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 NHS staff survey information, to support organisational development and learning.	• Pay attention to the culture of improvement • Respond to what matters to staff, people using services and unpaid carers • Enabling staff through a coaching style of leadership • Enabling staff to make improvements

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Investing in people and culture (C2-Trust)

NHS England

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 (C3-Trust)

What this looks like in practice:	Themes:
• 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 development sessions identifying strengths and gaps for each individual and as a team. • Create leadership stability and continuity of approach. • Support leaders and managers across the system to live and breathe the values and behaviours of the organisation and hold leaders and managers to account for behaviours, not just improvement outcomes. • 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 leadership and management behaviours are demonstrating organisational values, identifying strengths and gaps. • Engage with peer support networks to understand different approaches to the issues and leadership and management behaviours. • Empower teams delivering on the ground to carry out and test improvement projects.	• Leadership and management development strategy • Leadership and management values and behaviours • Leadership and management acting in partnership • Board development to empower collective improvement leadership • Go and see visits

Developing leadership behaviours (C3-Trust)

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 and Capacity(C4-Trust)

What this looks like in practice:	Themes:
• 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. • Leaders and managers attend teams daily huddle boards and work to unblock issues which teams are facing.	• Improvement capacity and capability building strategy • Clear improvement methodology training and support • Improvements measured with data & feedback • Co-production • Staff attend daily huddles

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Building improvement capability and capacity (C4-Trust)

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 daily huddles	Any huddles are only traditional shift change clinical handovers	There is a plan in place for team huddle to focus on continuous improvements in all clinical frontline areas with clinical and	All clinical frontline areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all	All operational/support/corporate areas have continuous improvement team huddles established.	There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a

Embedding into Management Systems and Processes (C5-Trust)

What this looks like in practice:	Themes:
• Develop an explicit management system that aligns with the strategy, vision and purpose of the organisation at board level and throughout all services and functions. • Put systems in place to identify and monitor early warning signs and quality risks with clear 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, quality, experience, and outcomes. • Building a management system which enables the organisation to respond to system and national priorities more easily and with greater agility as the organisation has a consistent and coherent set of management systems and processes. • A committed board and senior management 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.	• Aligned goals • Planning and understanding status • Responding to local, system and national priorities • Integrating improvement into everything we do

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Embedding into management systems and processes (C5-Trust)

NHS England

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

Classification: Official

Publication reference: PR1844

Item 15

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

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

   The Chief Medical Officer is Solent's Responsible officer. Solent also has a second Responsible officer which is the Deputy Medical Officer.

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

   Yes.

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

   Yes by the CMO Business Manager

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

   They, they are reviewed regularly and discussed at ROAG. Our Trust will be merging with local community trusts on the 1st April 2024. All relevant policies are being reviewed and when necessary rewritten to ensure that due process can continue after the merge.

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

No peer review within the current appraisal year but the appraisal lead has met with her counterpart within adjacent trust with a view to mutual review as part of the merger.

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

Yes. Doctors on long fixed term contracts are treated the same as permanent staff from an appraisal and revalidation point of view. The CMO team have a better understanding of the number of locum agency employee we have in the trust that last year. However, the CMO team is not yet assured that they are informed when an agency locum leaves.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

All Solent doctors have had an appraisal that meets these criteria. 3 employees appraisals were missed due to sickness and maternity leave. This was recorded as "approved/missed".

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

N/A.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

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

Yes. The Medical appraisal and revalidation policy was approved by Solent board in June 2022.

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

Yes. 21 appraisers and 97 doctors.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes, as managed by our Appraisal Lead and Deputy Medical Officer. 2 meetings held with appraisers to inform and educate. Feedback format welcomed, refined and greatly appreciated. Quality assurance has concentrated on quantitative data, this year the intention is to look for a tool to provide qualitative data.

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

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

The QA process has slipped since the introduction of computerized appraisal records. As described above appraisers get annual feedback comparing their performance to the whole group in terms of time to complete their reports and other key data. They receive the verbal feedback from their appraisees in a much more timely fashion than the previous system. However, our Appraisal Lead is working on meaningful feedback on content which would include QA of the appraisal.

Section 2b – Appraisal Data

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

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	**95**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**86**
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	**0**
Total number of agreed exceptions	**3**

Section 3 – Recommendations to the GMC

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

All revalidation submissions are reviewed at ROAG 3 months before due date where a recommendation is made. The CMO Business Manager then actions the recommendations via the GMC connect system.

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

Yes.

Section 4 – Medical governance

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

The trust is divided into eight service lines, each lead by a Clinical Director alongside and Operational Director and a Head of Quality and Professions. This gives a robust environment in which clinical governance thrives and doctors well embedded in the process.

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

Our Clinical Directors and their Clinical Leads are supported to ensure that everyone is performing to the best of their ability. Open and easy channels are in place for them to discuss concerns about doctors early in any situation.

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

Solent NHS Trust works to HR17 managing the performance of doctors and dentists. This policy is closely aligned with MHPS. The four policies representing each of the community trusts to merge are being compared and one joint document will be in place by 31/03/2024.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Records are kept of concerns both formal and informal. They are discussed at ROAG. The 2022/2023 data has not been looked at regarding protected characteristics, but the current year data includes this data and will be looked at in due course.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Job Planning has been implemented this year, which gives Solent NHS Trust a better grasp and knowledge of who is working where. The CMO team are working with their colleagues to implement a uniform approach to information across organisations.

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

Such issues are discussed at ROAG where there is always a senior people partner, the NED responsible for workforce and a lay advisor.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

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

Yes.

Section 6 – Summary of comments, and overall conclusion

We are confident that our connected doctors are subject to a thorough medical appraisal and that recommendations for revalidation are robust.

The anticipated merge with adjoining trusts gives opportunity to review and develop our processes.

Projects this year include improving quality assurance of the content of appraisals and ensuring that information about work in other organisations is always considered.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Solent NHS Trust

Name: Dr Dan Baylis Signed: 

Role: CMO

Date: 20/09/2023

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This publication can be made available in a number of other formats on request.

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Board and Committee Summary Report

Item 16.1

NHS Solent NHS Trust

Title of Paper	Equality Diversity Inclusion and Belonging (EDIB) Annual Report				
Date of paper	September 2023				
Presentation to	In Public Board – October 2023				
Item No.	16.1				
Author(s)	Anna Rowen – Associate Director Equality, Diversity, Inclusion and Belonging				
Executive Sponsor	Sorrelle Ford – Acting Chief People Officer				
Executive Summary	This Item is the 2023 Equality Diversity Inclusion and Belonging Annual Report and is being presented to the Board for assurance and approval. Suggested changes by the People Committee have been made to this report. Once the Board have approved this it is ready for publishing in line with our duty under the Public Sector Equality Duty Act. Any suggested changes will be made before publication.				
Action Required	For decision?	Y	For assurance?	Y	
Summary of Recommendations	The Board is asked to: • Confirm if they are approve the report and are assured by the contents of the report and for it to be published in line with our obligations under the Public Sector Equalities Duty Act and our moral and social responsibility as a health care provider, employer and anchor organisation.				
Statement on impact on inequalities	Positive impact (inc. details below)	X	Negative Impact (inc. details below)		No impact (neutral)
Positive / negative inequalities	This report outlines the activity over the past year and planned activity for the next year that aims to address inequalities and increase diversity and improve inclusion and belonging for the workforce in Solent.				
Previously considered at	People Committee August 2023.				

Strategic Priority this paper relates to

Great Care		Great Place to Work		Great Value for Money	
1. Safe effective services	x	8. Looking after our people	x	12.Digital transformation	
2. Alongside Communities	x	9.Belonging to the NHS	x	13. A greener NHS	
3. Outcomes that matter		10. New ways of working	x	14. Supportive Environments	
4. Life-course approach		11. Growing for the future	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		Limited		None	
Assurance Level	Concerning the overall level of assurance the [DN: insert name of Board/Committee] is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature	Sorrelle Ford, Acting Chief People Officer							

Item 16.2

NHS Solent NHS Trust

Equality Diversity, Inclusion and Belonging Annual Report 2023

Author
Anna Rowen
Associate Director Diversity, Inclusion and Belonging
June 2023

Contents

Delivering Actions to Improve Equality Diversity, Inclusion and Belonging at Solent NHS

Introduction

This paper provides an update on Equality, Diversity Inclusion and Belonging (EDIB) to the People Committee and Trust Board.

The Trust has a statutory obligation under the Equality Act 2010 to publish a range of monitoring information relating to patients and staff. This report is one of the ways in which the Trust fulfils itsobligations.

This report provides the People Committee and the board with an update and progress report in relation to the EDS3 (Equality Delivery System3, NHSE workforce standards, Gender Pay Gap and contributes to meeting our PSED [Public Sector Equality Duties]).

By publishing our annual data on the Trusts main functions in relation to dversity and inclusion we are adhering to our Public Sector Equality Duties (PSED) obligations and our moral and social responsibility as a health care provider, employer and anchor organisation.

People Strategy

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

In 2022 Solents' 'Great Place to Work' strategy was agreed and launched. It aims to create a highly motivated, engaged workforce that has a positive impact on patient care and outcomes.

Equality Diversity, Inclusion and Belonging (EDIB) within our People Strategy

Our EDIB strategy is embedded and integral to Solents People Strategy.

Solents People Strategy has 4 themes:

1. **Looking after our People:**
    - Strategic Objective: *We are committed to raising the health and wellbeing within the organisation – so that our people are supported to 'Be here, Be Happy and Be Healthy*
2. **Belonging in the NHS:**
    - Strategic Objective: *We want to enable every person working in Solent NHS Trust to bring their authentic self to work each day, ensuring we all feel visible, and our identity and contribution is validated and valued.*
3. **New Ways of working:**
    - Strategic Objective: *We will work closely with our services to support programmes of improvement, change and innovation in the way we manage our workforce. We will embed strategic workforce planning in everything we do so we can harness the talents of our people through effective talent management conversations.*
4. **Growing for the future:**
    - Strategic Objective: *We are committed to developing a sustainable workforce and will attract, develop, reward and retain diverse talent who want to be part of a great place to work & thrive.*

Whilst equality diversity, inclusion and belonging runs through all the strategic themes it is theme 2, ***Belonging in the NHS*** that is the primary strategic pillar that strategically drives our Equality Diversity Inclusion and Belonging (EDIB) Action Plan.

The People Strategy will drive us forward in our commitment to an inclusive culture acrossthe organisation to ensure that all members of our staff, patients, carers, volunteers, and visitors feel valued when they connect with our services.

- We want to make it easy for our diverse communities to access our services
- We want to recruit and retain staff from diverse communities
- We want all our staff and those who use our services to be valued and respected as individuals
- We want to offer and provide learning and development opportunities to our diverse workforce

Our Board and senior leadership team support this agenda by:

- modelling the behaviors from our HEART values to promote a positive inclusive culture in the organisation
- providing the resources required to deliver on Trust wide Diversity, Inclusion and Belonging programmes
- working in collaboration with our systems partners and communities
- having oversight to ensure that our PSED (Public Sector Equality Duties) are

being effectivelyimplemented

- actively sponsoring our staff networks and empowering staff voice

The Associate Director of Equality Diversity, Inclusion and Belonging has a key role in:

- helping to raise the profile of Diversity, Inclusion and Belonging internally and externally at Solent NHS Trust
- providing expertise and senior leadership to the Trust Board and Executives and other senior managers across the Trust
- supporting senior leaders to develop inclusive cultures within their service lines
- providing robust and accountable leadership to ensure that successful outcomes are delivered in line with those laid out within the Diversity, Inclusion and Belonging Plan
- ensuring robust performance, accountability and governance systems are in place
- modelling active allyship and inclusive leadershipThe Trust is committed to ensuring that the NHS England's workforce equality standards (WRES and WDES) are embedded into its People Strategy and Diversity, Inclusion and Belonging Action Plan.

It has, and continues to engage with third sector organisations, regional & national networks, to learn and share best practice. This strategy runs parallel with the Alongside Communities Strategy and the deliverables of both plans dovetail to further strengthen the outcomes of each.

Equality Diversity Inclusion and Belonging in Solent NHS

The EDIB action plans aims to ensure every person working in Solent NHS Trust is able bring their authentic self to work each day, ensuring we all feel visible, and our identity and contribution is validated and valued.

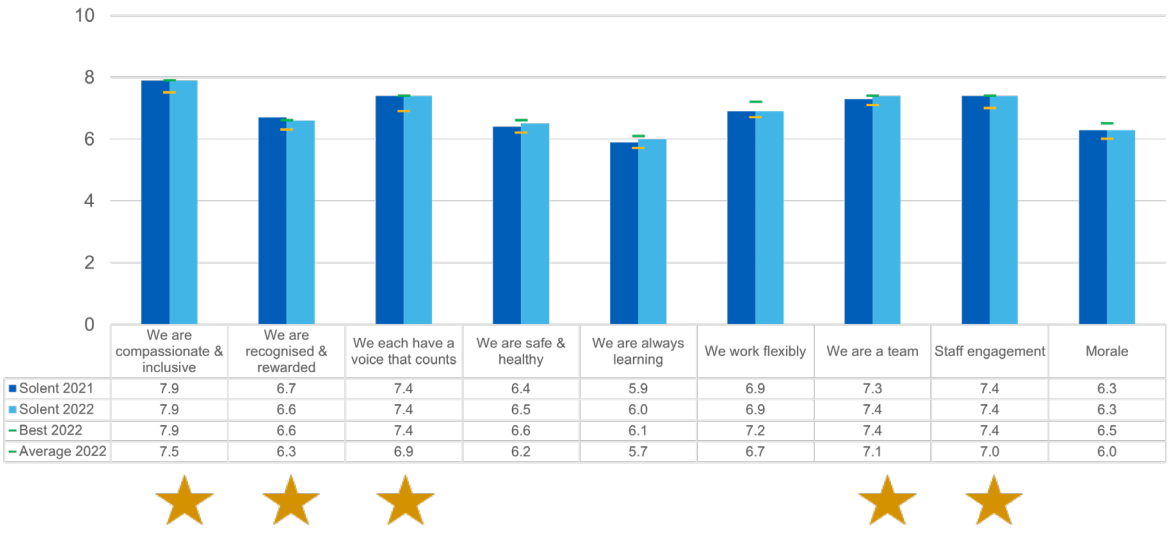
Solents Workforce

Solent NHS Trust has continued to make advances on building an inclusive and engaged culture and this was evidenced in this year's staff survey results where our engagement score rose again to our highest yet to 68.4% from 67.7% last year. By comparison benchmark trusts having an average response rate of 50%.

In 2021 Solent scored amongst the best performing trusts of our type in 3 out of 9 themes, those being:

- We are compassionate and inclusive
- We each have a voice that counts
- Staff Engagement

However, Solent this year has now ranked top for 5 of the 9 key metrics, an improvement from 3 last year.



	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Solent 2021	7.9	6.7	7.4	6.4	5.9	6.9	7.3	7.4	6.3
Solent 2022	7.9	6.6	7.4	6.5	6.0	6.9	7.4	7.4	6.3
Best 2022	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
Average 2022	7.5	6.3	6.9	6.2	5.7	6.7	7.1	7.0	6.0

Research shows that if we make improvements on race equality, we will make advances on all nine protected characteristics.

Therefore, we have used the Workforce Race Equality Standard (WRES) methodology at Solent with the aim of improving on the following as part of our commitment to the 10-year WRES plan:

- Increase our talent pool of BAME staff
- Ensure there is an equitable process for BAME staff in relation to Disciplinary and Grievance
- Improve our understanding on blind-spots in the recruitment process

We have also worked to use the Workforce Disability Equality Standard (WDES) with the view to ensuring our commitment to improving diversity, inclusion and belonging.

For the first time this year 2 new metric frameworks have been introduced.

1. **BANK Only Workers WRES**

- There are an estimated over 150,000 bank-only workers in NHS trusts.
- Bank WRES has been designed to support NHS England's strategic aim of improving the quality of bank provision as a flexible option for staff.
- The WRES team have developed a set of indicators for NHS bank only workers, designed to explore the experiences of this group, the indicators are aligned to the People Promise and People Plan.
- There are nine indicators for the bank-only workers WRES. The indicators will measure the following:
  - Representation by ethnicity and gender
  - Experience in the workplace, including disciplinaries, dismissals, bullying and harassment
  - Route of entry into the NHS.

to read more about the WRES indicators for the NHS bank only workforce click here

2. **Medical WRES**

- The Medical Workforce Race Equality Standard (MWRES) was launched in 2020 to analyse national race equality for medical and dental workforce.
- The Medical Workforce Race Equality Standard (MWRES): the first five sets out practical actions based on data and evidence to tackle existing inequalities in the medical workforce.
- It is jointly developed alongside royal medical colleges, regulators and key stakeholders.
- The 2020 MWRES report found that BME doctors are:
  - Underrepresented in Consultant posts
  - Underrepresented in academic and leadership positions
  - Less likely to progress through postgraduate exams and Annual Review of Competency Progression
  - More likely to experience discrimination, harassment, bullying and abuse from patients and other staff.
- MWRES compliments the work of WRES in evidencing NHS compliance with the Public Sector Equality Duty (EqA2010) to advance race equality for the dental and medical professional groups.
- MWRES data and analysis is used to inform actions to advance race equality and

develop targeted interventions to address structural and organisational disparities that result from race.

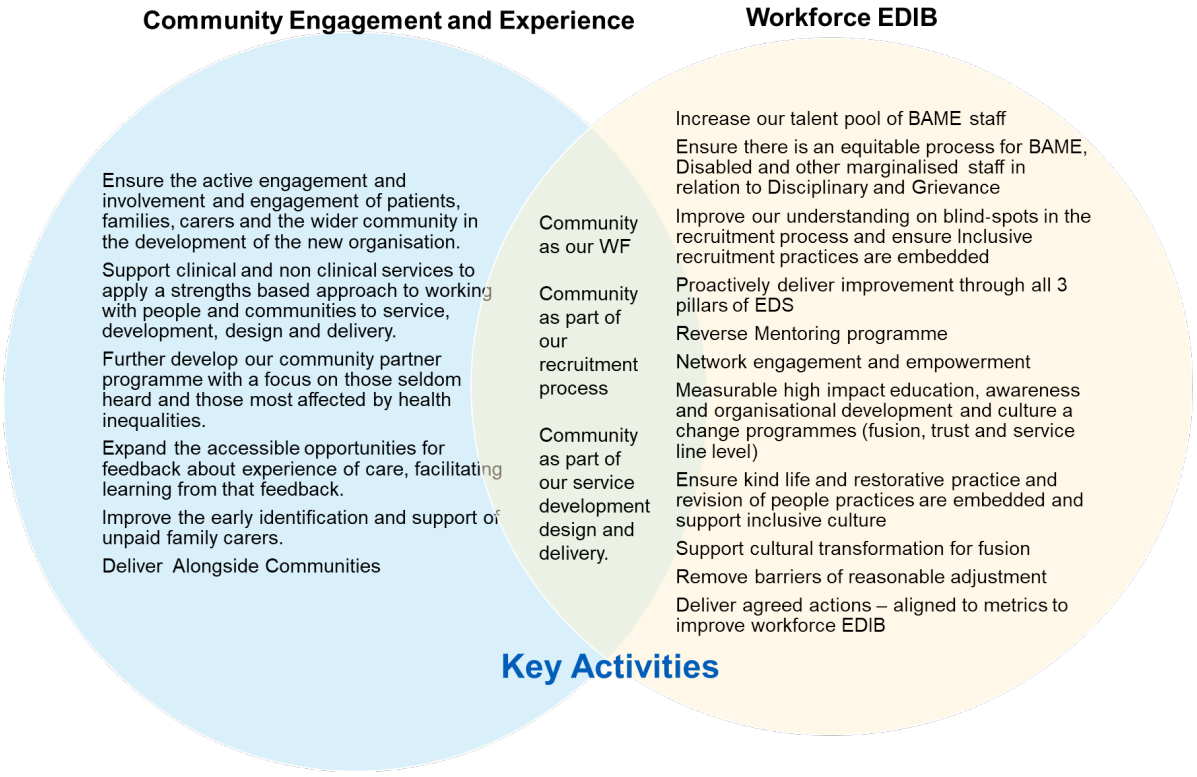
- MWRES data will help providers to develop tailored programmes for BME staff to break down barriers to advancement and improve experience in general. ***to read more about MWRES click here***

Solents Community

We aim to ensure that our community partners reflect our diverse communities in areas we work in andhave been involved in creating the Alongside Communities Strategy.

We intend to continue to improve our data collection by offering support through our learning and developmentteam with self-identification and refreshing data for our workforce and patients.

The Venn diagram below outlines the connection and collaboration of the Community engagement and experience and the EDIB Team in Solent.



See appendix for Solent Community Engagement Annual Report

Delivering on Standards for Equality Diversity, Inclusion and Belonging

NHS Standards - EDS3 Pilot Progress

Solent NHS Trust provides services across richly diverse communities, and this should influence how we provide our services as well as how we treat our staff, both current and future.

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

In order to maximise the opportunities that EDS can offer, organisations are encouraged to engage in active conversations with people who use services, patients, public, staff, staff networks, community groups and trade unions to review and develop their approach in addressing health inequalities.

The tool is split into three domains, all driven by data, evidence, engagement, and insight.

- **Domain 1: Commissioned or provided services**
- **Domain 2: Workforce health and well-being**
- **Domain 3: Inclusive leadership**

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

Each outcome is scored based on the evidence provided. Once each outcome has a score, they are added together to gain domain ratings. Domain scores are then added together to provide the overall score, or the EDS Organisation Rating. Solent NHS Trust working with staff and the people who use our services assess their position against the standards and use that to help set improvement aims for the future
The scoring system allows organisations to identify gaps and areas requiring action

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

Summary Conclusion – See appendix for full report and action plan

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

As a result of completing the EDS review an action plan for 23/24 with objectives was co-created and the following areas of improvement identified (for full detail see appendix)

- **Objectives for Domain 1: Commissioned or provided services**
  - To better understand the differing levels of access for different demographic groups and to ensure services are targeted on this basis to and promote inclusion and improve under representation.
  - Service line leads will carry out further stakeholder mapping and engagement activities with diverse communities to ensure health needs are understood and met through service design and provision.
  - To ensure that Co-production continues in a sustained way to support the development and delivery of services.
  - To improve the way we collect and use data to ensure that feedback is effectively collected, and that patient feedback is reviewed through an equality and diversity lens to ensure that underrepresented groups are being treated equitably.

- **Domain 2: Workforce health and well-being**
  - To understand the extent to which different groups of people access health offers, particularly where prevalence of certain health conditions is higher and to use this information to proactively address any inequalities identified.
  - To support staff who experience harassment and improve accessibility to appropriate specialist support and advice.
  - To improve the reach of access to mental health services for all staff groups
  - To continue to raise awareness of specialist support e.g., Musculoskeletal/physiotherapy access, menopause 1-1 support, Employee Disability and Neurodiversity Advice service (EDNA)

- **Domain 3: Inclusive leadership**
  - To further develop the role modelling and voice of senior leaders and increase activated allyship
  - To further develop the role modelling and voice of senior leaders and increase activated allyship
  - Further engagement and ownership EDIB Plan and People Strategy- so to ensure that actions are owned and acted on at service line level

NHSE Workforce Race Equality Standard (WRES)

Evidence shows that a motivated and inclusive workforce results in better patient care and increasedpatient satisfaction and safety. The Workforce Race Equality Standard (WRES) is a set of 9 indicators that are used to measure workforce race equality and has been mandated through the NHS standard contractsince 2015-16. The metrics for indicators 1 – 4 are taken from ESR data, 5 – 8 from the NHS staff survey results and metric 9 from Trust Board.

All workforce data has been taken from the ESR records dated 1st April 2021 to 31st March 2022. This data is then fed into the WRES report for 2020. The data covers staff categorised under the Agenda for Change.*Please note that the WRES team only ask for data on substantive staff.*

In 2023 there were 4,430 members of substantive staff, of which 12.8% (10.7% on 31/3/22) were from a Black Asian Minority Ethnic background. The 2021 Census data shows that there are 1,400,899 residents in total of which 186,090 are from BAME background – this equates to circa 13%, therefore illustrating good representation at board level.

Board Representation

WRES Category	Headcount	Headcount %	Board Headcount	Board Headcount %
BME	569	12.84%	3	23.08%
White	3810	86.00%	10	76.92%
Z Not Stated/Not Given	51	1.15%	0	0.00

As of reporting of 31st March 2023 - 23% of the board are from BAME backgrounds

		Headcount (%)		
Clinical / Non-Clinical	**WRES Banding**	BME	White	Z Not Stated/Not Given
Clinical	Band 2	18.3%	81.1%	0.6%
	Band 3	7.5%	91.8%	0.7%
	Band 4	10.8%	88.4%	0.8%
	Band 5	23.5%	74.3%	2.2%
	Band 6	10.5%	89.0%	0.5%
	Band 7	6.9%	92.8%	0.4%
	Band 8a	6.4%	91.3%	2.3%
	Band 8b	13.6%	86.4%	0.0%
	Band 8c	7.1%	92.9%	0.0%
	Band 8d	11.1%	88.9%	0.0%
	Band 9	0.0%	100.0%	0.0%
	Medical & Dental Consultant	36.4%	60.6%	3.0%
	Medical & Dental Non-Consultant Career Grade	34.0%	60.8%	5.2%
	Medical & Dental Trainee Grades	26.5%	64.7%	8.8%
Non Clinical	Band 2	23.5%	75.5%	1.0%
	Band 3	6.3%	93.7%	0.0%
	Band 4	3.2%	92.1%	4.8%
	Band 5	12.2%	86.6%	1.2%
	Band 6	3.6%	94.6%	1.8%
	Band 7	7.2%	92.8%	0.0%
	Band 8a	4.3%	91.5%	4.3%
	Band 8b	9.5%	90.5%	0.0%
	Band 8c	4.2%	95.8%	0.0%
	Band 8d	0.0%	100.0%	0.0%
	Band 9	0%	100%	0.0%
	Director	66.7%	33.3%	0.0%

Across our total workforce we are broadly representative of the population we serve, with 12.8% of colleagues from Black Asian minority ethnic backgrounds versus 13.00% of the Hampshire population.

Colleagues from Black Asian minority ethnic groups makeup 2/3 of our Board Level Directors. Our Diversity inclusion plan aims to address this inequality and under representation throughout all bandings.

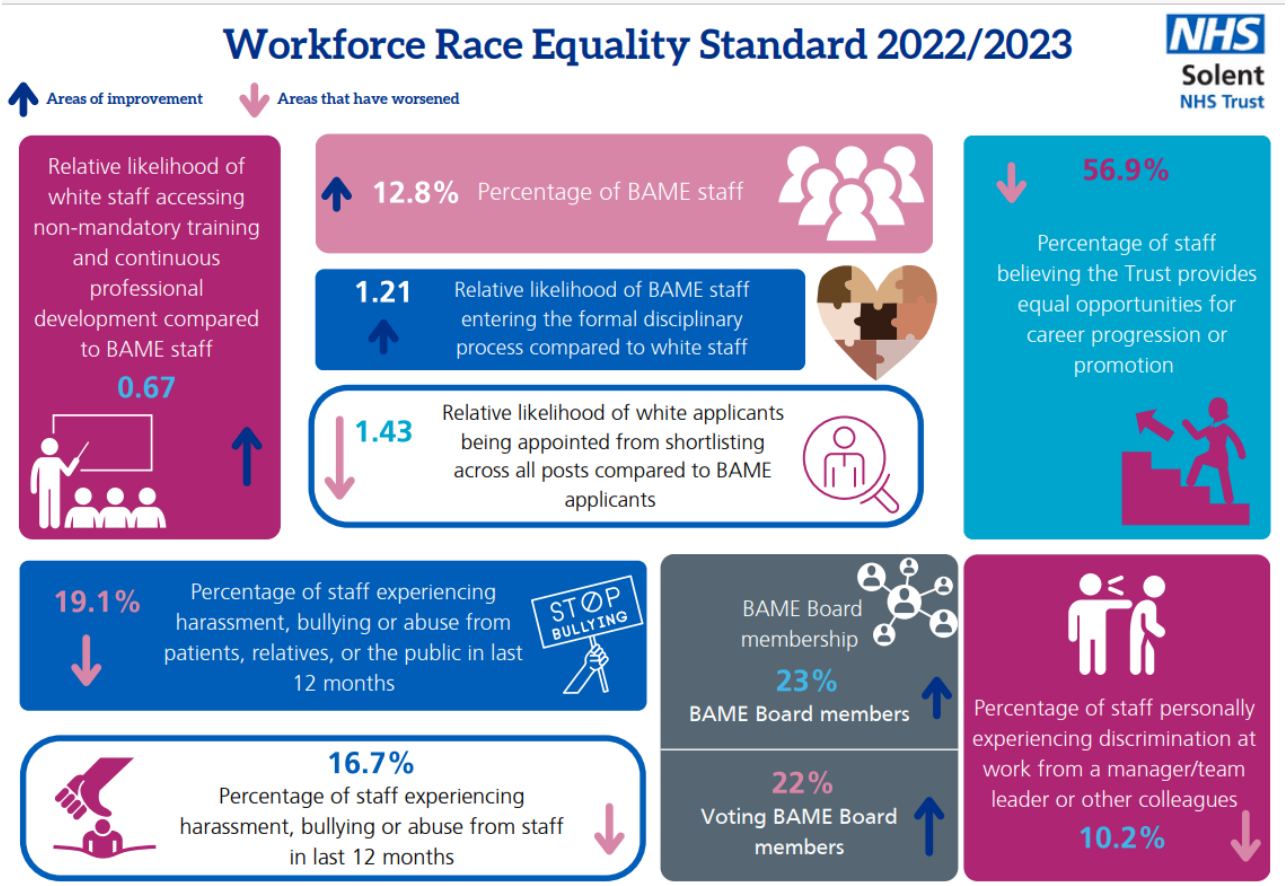
Over a 1/3 of the consultants and non-consultant are from BAME background and over a ¼ medical dental trainees.

There is however unrepresented in bands 3-9 (given latest census data shows approx. 13% BAME)

There is also an under-representation of colleagues in band 4 with only 3.2 % of colleagues in this band of Black Asian minority background. However, there was an increase in band 5 indicating internal promotion.

It is only grade band 2 where BAME are over-represented and in all medical and dental grades.

Table - Breakdown of staff banding and ethnicity



Work themes in place to address these issues include (please see full action plan for further detail):

- Reverse Mentorship for Inclusion Programme
- Sharing job opportunities with Community Partners
- Overhaul and debiasing of our attraction and recruitment practices
- Working with specific workstreams across HIOW ICS (Hampshire Isle of Wight Integrated CareSystem) focusing on recruitment, retention, and talent management and Leadership development
- Anti-Discrimination Taskforce and introduction of a 2steps hate crime reporting system
- Education, awareness and allyship programs
- Greater engagement with the networks in co creating new people policies and practices that are free from bias

Where we have seen improvement:

1	Percentage of BAME staff **Target: Increase by 2% (total 11.3%) by July 2022.**		**Revised target for Sept 23 In line with local census data**
2019/20 9.2%	2020/21 9.3%	2021/22 **10.7%**	**2022/23** **12.8%**

9.	BAME board membership - Percentage difference between the Board's voting membership and its overall workforce **Target: Increase diversity of board membership when vacancies arise.**		**Revised target for Sept 23 TBC**
2019/20 15.4% BAME Board members 18.2% Voting BAME Board members	2020/21 21.4% BAME Board members 18.2% Voting BAME Board members	2021/22 **16.7%** BAME Board members **20.0%** Voting BAME Board members	 **23%** **22%**

- The BAME network is a safe space for people to share their experiences and learn from others. Ongoing promotion of Freedom to Speak Up for BAME staff continues, which enable staff the opportunity to raise concerns in a confidential and safe environment.
- Board diversity is important to avoid group think, and it allows more nuanced discussions that will reflect the colleagues that work for Solent and the communities we serve.

From our staff survey results published in March 2022 we can see that staff satisfaction levels are comparable across both white and BAMA staff. Two exceptions are BAME staff rating the trust higher for both 'we are always learning' and 'staff engagement' – recognition for all the great work done by the trust over the last year.

	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
White 2022	8.0	6.6	7.4	6.5	6.0	6.9	7.4	7.4	6.3
BAME 2022	7.9	6.6	7.5	6.7	6.6	6.9	7.5	7.7	6.5

Where we need to improve

Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants **Target: decreased to 1.2 by July 2022**			**Revised target for Sept 23 1.2**
2019/20 1.40	2020/21 1.36	2021/22 1.41	**2022/23** **1.43**

- There is ongoing work to ensure our attraction and recruitment process are free from bias. It is worthwhile to note, that there is a better % better at Offer – at offer there is a ratio of 1.27.

- An action plan is underway and the following improvements are being made to ensure positive action and improvement is made to the recruitment process this includes, adding a new and stronger equality statement on the recruitment site and all job adverts, the design of a training package to develop a bank of recruitment allies that will include community partners as well as colleagues from across the workforce and that will be on all band 7 and above interview panels and a clear and transparent escalation route for recruitment allies to raise concerns, closer monitoring and follow up to ensure compliance of the two ticks and disability confident and armed forces covenant.

- However less BAME offers convert to appointments - 30% of those BAME offered do not become appointed, vs 22% White. This drop off is due to Right To Work checks being carried out after offer – also worth noting there was a large scale NHSE event that recruited and offered but high % did not translate into new starters and this impacted on conversion rate and lowered due to RTW.

- It's worth considering the impact of the recent HCSA visa that came out last years that enables overseas on sponsorship for visa. This will also have impacted on recruitment stats. More people will have applied and been SL and offered but the reality is the NHS does not financially sign off recruitment of internationally recruited HCAs.

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months **Target: Decrease percentage to below 15% by July 2022.**			**Revised target for Sept 23 -15%**
2019/20 18.2%	2020/21 18.1%	2021/22 **16.4%**.	**2022/23** **16.7%**

- We have seen an increased response rate from 214 to 246 with this indicator and we have also seen a marginal increase in the number of staff experiencing harassment, bullying or abuse from staff in last 12 months – an increase of 0.3%. The median benchmark average for this indicator is 22.8% and has remined stable for past 2 years.

- This year's EDIB action plan includes the introduction of the Kind Life model – an evidenced based approach that reduces bullying and harassment and supports early restorative resolution when conflict does arise

Percentage of staff believing that trust provides equal opportunities for career progression or promotion *NB the data collection and calculation formula have been changed by the national team, to now includes 'don't know' in the base – new figure in brackets for 2019/2020.* **Target: Increase percentage to** 85% by July 2022. Revised target – proportional increase – **60%**			**Revised target for Sept 23** **+60%**
2019/20 82.4% (47.9%)	2020/21 80.3% (56.1%)	2021/22 **57.7%**	**2022 /23** **56.9%**

- This is an area that continues to be a recognised challenge and have lunched the reverse mentoring programme with the aim to address this further.
- The national benchmark average is currently 49.6% but it is clear through this data and staff voice in the networks further needs to be actioned to address the inequalities here.
- This will remain a clear priority and focus in this year's EDIB action plan.

• Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues • Target: Decrease percentage to below 10% by June 2022.			• Revised target for Sept 23 TBC • -10%
• 2019/20 • 9.5%	• 2020/21 • 13.8%	• 2021/22 • 9.6%	• 2022/23 • 10.2%

- The national average this year is benchmarked by comparison at 13.6%.
- In Solent there has been an increase or 0.6% for ethnic minority colleagues experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.
- The response rate for this indicator has gone from 219 to 246, an increase of 27.
- A spotlight needs to remain on this to ensure that this does not continue to climb and a deeper look by People Partners needs to consider service line data so that targeted interventions can be put in place.

NHS Workforce Disability Equality Standard (WDES)

The WDES are a set of ten specific metrics that compare the workplace experience of staff with a disability and non-disabled staff. It allows the Trust to understand the experiences of their staff with adisability and plan to create a more inclusive work environment. As with the WRES the metrics are taken from both ESR and staff survey results.

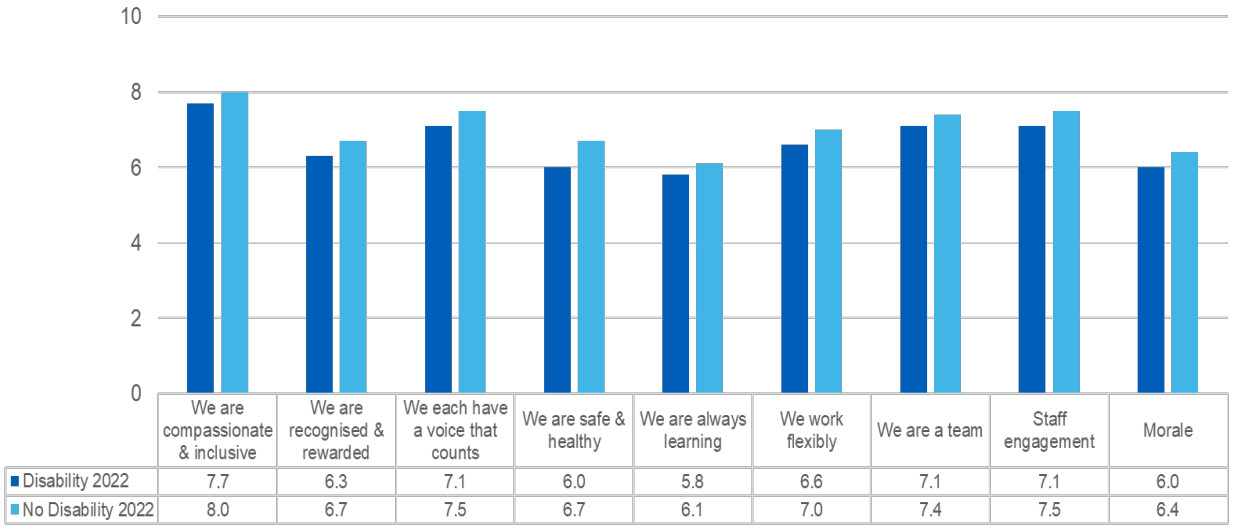
All workforce data has been taken from the ESR records dated 1st April 2022 to 31st March 2023. *Please note that the WDES team only ask for data on substantive staff.*

In 2023 there were 4,430 members of substantive staff, of which 4.4% had a known disability. We have seen an increase in colleagues declaring their disability from 81.3% in 2022 to 83.8% in 2023. However there remains 16% undeclared in ESR.

By comparison of the staff survey returns there appears to be 19% discrepancy ratio – with a much higher declared disability rate, indicating that many colleagues will only declare through the anonymity of the staff survey.

This data is being collected as part of the 2023 data collection for the Workforce Disability Equality Standard (WDES). The aim of WDES is to improve the working and career experiences of Disabled staff in the NHS. The WDES is mandated through the NHS Standard Contract and has been approved as a data collection by the NHSX Data Alliance Partnership. It has also been subject to a data protection impact assessment.

This year's survey suggests we have work to do in meeting the needs of staff with disabilities. Staff with disability rates Solent lower for all 9 measures, with the biggest discrepancy for 'we are safe and healthy'. This is driven by dissatisfaction with both burnout and negative experience with the trust.



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

Below is an infographic that shows the results of the WDES

Where we have seen improvement

<table>
<tr><td colspan="3">

- The percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
- **Target**
- **Increase disability declaration rates on ESR across** Solent to 60% by July 2022 – **revised target 90%**
- **Increase the number of staff with a disability in bands 8a or above to 4%**

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- **Revised target for Sept 23**
- **+90%**
- **+4%**

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<tr><td>

- 2019
- Unknown

</td><td>

- 2020
- Disability status not declared 20.64%

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- 2021
- Disability status not declared 18.7% **(81.3% declared)**
- 524 staff in 8A or above out of those 15 are disable= **2.8%**
- n.b 3.9% of total WF have a disability

</td><td>

- **2022/23**
- **16.2% (83.7% declared)**
- **570 of which 20 = 3.5%**
- **4.4% of total WF**

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</table>

- Engagement work was undertaken with the network to encourage declaring and understanding the barriers to declaring – this has had a positive impact. However, there is further work that is being undertaken to ensure greater psychological safety around declaring disability as well as better and more inclusive leadership and management support and process being in place. When we compared responses (in April 23) of staff survey replies to that declared on ESR there showed to be 18% disparity ratio

- It is worth while noting that national NHS ESR categories (employee records) are outdated in language and do not effectively cover the range of disabilities, therefore it is difficult for staff to change their declaration if they can't see themselves represented in the categories available.

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Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
Target:

- **Equal likelihood of non-disabled staff being appointed from shortlisting across all posts**

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Revised target for Sept 23

1

</td></tr>
<tr><td>2019
1.20</td><td>2020
1.06</td><td>2021
1.28 *(It is possible the 2020 the anomaly)*</td><td>1.11</td></tr>
</table>

- There has been a small positive shift here and the introduction of a new system has helped to support debiasing

- There is further improvement requited here and there will be a number of actions in this year EDIV plan to ensure greater inclusivity in Solents approach to attraction, assessment and selection

i. Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in the last 12 months • **Target: Decrease percentage to below 25%** ii. Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months • **Target: Decrease percentage to below 10%** iii. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months • **Target: Decrease percentage to below 12%**						**Revised target for Sept 23 TBC** **i. Below 25%** **ii. Below 10%** **iii. Below 12%**	
2019		2020		2021		**2022/23**	
i.	29.1%	i.	27.2%	**i.**	**25.8%**	**I.**	**25.9%**
ii.	12.6%	ii.	13.9%	**ii.**	**9.2%**	**II.**	**9.8%**
iii.	15.8%	iii.	16.7%	**iii.**	**15.9%**	**III.**	**14.7%**

- We have had an increased response to this indicator from 589 to 649 colleagues with LT health condition and or disability.

- This is in line with the national median benchmark in so far as the trend has remained stable – we are significantly above the national benchmark average that currently is 32.0%

- We currently sit above the national benchmark, that indicates 12.3% of staff experiencing harassment, bullying or abuse from managers in the last 12 months – however the small increase here indicates that more work is be done with raising awareness – this remains a people priority for Solent. This year we have procured bespoke manager sessions with SimComm academy, and neurodiversity elearning for managers and colleagues from Lexxic, there is additional manager information to be coming from Genius Within.

- A strong improvement of 1.2% from 15.9% to 14.6% staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months – the national benchmark currently at 18.9%. This year we are introducing a new respectful resolution framework and training that will address and support to build a kinder culture and reduce micro aggressions

Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work **Target: Increase percentage to over 90% by July 2022**			**Revised target for Sept 23 TBC**
2019	2020	2021	**2022/23**
83.3%	86.4%	**81.2%**	**82.0%**

- This remains a priority as part of the people strategy and the EDIB plan –the national average for this is 78.8%

- This is an area that remains a priority for this year – A comprehensive reasonable adjustments guidance and provision menu is to be rolled out which will be used to improve our performance in this area.

- This is informed by staff voice and an engagement activity that has been lead and coordinated through the Disability network. The EDNA (that stemmed from the network)

currently has a 13-week waiting and business case being written to extend service to meet demand.

- Education and support for our Managers, People Partners and Occupational Health will be arranged where they can further gain insight and learn from the lived experience.

Where we need to improve

Further work to improve our people polices and practices are required for this year – specifically capability and absence policies.Further education of managers and colleagues around supporting disability and neuro diversity in the workplace is required and ongoing and the voice of lived experience embedded in to policy and practice review.

	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months **Target: Increase percentage to 75% by**		**Revised target for Sept 23 TBC** **+ 75%**
2019 59.7%	2020 58%	2021 **65.3%** This is a notable increase and also goes against the benchmark trend which is pretty stable.	**2022/23** **60.1%**

- A decrease of 5.2% of colleagues who reported harassment bullying or abuse at work – albeit in line with national benchmark.
-
- The staff survey results, specifically the 'we are safe and healthy' domain show that our colleagues are feeling less psychologically safe to raise these issues due to attitudes and behaviors of our colleagues and managers who are often the source of the issue in the first instance. This will need to remain a priority in this this year's EDIB plan to ensure colleagues feel safe to speak up.

6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties **Target: Decrease percentage to below 20%**		**Revised target for Sept 23 TBC**
2019 27.8%	2020 25.9%	2021 **20.3%**	**2022/23** **22.0%**

- We are below the national average of 18.9% with regards to this indicator and that is trending in a positive direction. Given that in Solent this is increased and gone against national trend further investigation is needed to ensure appropriate action can be embedded in to the EDIB action plan to address this.

- We are currently reviewing the absence management people practise framework to ensure a more inclusive approach – this return only furthers strengthens the need for this piece of work and for co creation of this with colleagues with lived experience.

- We are also rolling out a reasonable adjustment framework and reviewing the way these adjustments are funded so that managers can access a central fund.

- The DisAbilty Network have been and will be continue to be, key to ensuring staff voice comes through around this metric and with raising awareness around the health and wellbeing of colleagues with disability and long term health condition

Disability in the Workforce

		Headcount (%)		
Clinical / Non-Clinical	**WDES Banding**	Disability	No Disability	Unknown
Clinical	Band 2	4.3%	80.5%	15.2%
	Band 3	4.2%	83.8%	12.0%
	Band 4	6.3%	80.2%	13.5%
	Band 5	4.1%	84.2%	11.7%
	Band 6	5.5%	81.3%	13.2%
	Band 7	5.0%	77.9%	17.1%
	Band 8a	5.2%	73.4%	21.4%
	Band 8b	2.3%	79.5%	18.2%
	Band 8c	3.6%	60.7%	35.7%
	Band 8d	11.1%	77.8%	11.1%
	Band 9	0.0%	80.0%	20.0%
	Medical & Dental Consultant	1.5%	42.4%	56.1%
	Medical & Dental Non-Consultant Career Grade	2.1%	67.0%	30.9%
	Medical & Dental Trainee Grades	0.0%	29.4%	70.6%
Non Clinical	Band 2	1.5%	74.5%	24.0%
	Band 3	3.6%	80.2%	16.2%
	Band 4	1.6%	76.2%	22.2%
	Band 5	2.4%	86.6%	11.0%
	Band 6	5.4%	75.0%	19.6%
	Band 7	5.8%	79.7%	14.5%
	Band 8a	4.3%	83.0%	12.8%
	Band 8b	4.8%	76.2%	19.0%
	Band 8c	8.3%	87.5%	4.2%
	Band 8d	0.0%	76.9%	23.1%
	Band 9	0.0%	83.3%	16.7%
	Director	0.0%	100.0%	0.0%

Solent NHS Trust's workforce is made up of 4.4 % of staff with a known disability, although there has been a drop from 18.7% in 2022 to 16.2% that have not declared their status.

There is clearly a need to encourage more people declaring their disability status, particularly amongst the medical and dental community. Only 1.5% declared with disability, 46% not stated.

In the non-clinical workforce there is under-representation in bands 2-5.

Table - Breakdown of staff banding and disability

Actions that have been taken to improve the work experience of staff with a disability and long-term health condition include:

- Reverse Mentorship for InclusionProgramme being developed
- Anti-discrimination Taskforce and the implementation of a 2-step hate crime reporting system
- Solents Disabilities Awareness Day Conference
- Managers training and guidance
- Lunch of Employment Disablity Neurodiversity Advice Service
- Neuro Diversity eLearning
- Coaching for neuro divergent colleagues
- Refreshed Terms of reference and Executive sponsorship
- Delayered accountability and assurance framework that supports actions and outcomes and empowers staff voice
- Creation of Reasonable adjustments Framework and transparent funding process
- Accessibility audits for our Solent Sites
- Planned and well-advertised events
- Inclusion of lived experience representation in case review of People Cases/ Employee Relations cases

Analysing Diversity & Inclusion Workforce Data at Solent NHS Trust

The following staff data is as of 31 March 2023 where the total number of substantive staff was 4,430 and provides a snapshot of our staff. Data below is for substantive staff only.

Occupations by Ethnicity

Ethnicity	% Workforce
BAME	12.8%
White	86.0%
Not Stated	1.2%

Table Ethnicity of staff

A deep dive into recruitment has been carried out to ensure that Solent is truly inclusive in its recruitment, and subsequent action plan developed. A working group has been established to now take the findings along with national guidance to change the way attract, assess and select.

Solent are also working with colleagues across the ICS to address recruitment and retention of BAME staff, as well as focusing on a service line level.

Workstream 1 of the diversity and inclusion plan aims to:
Re – design the attraction, recruitment and onboarding process to increase diversity and improve inclusion

Key Success indicators outputs and outcomes will be:

- Working with community partners to access underrepresented communities
- Working with Networks for co-production
- Redesigning Job adverts and JDs
- Implementing Oleeo system
- Redesign of assessment process
- Development and implementation of a diverse Bank of Inclusion Ambassadors *(LH)
- Implementation of comply and explain
- Increase of shortlisted and successful applicants from diverse back grounds
- Train the trainer scalable inclusive recruitment workshop to embedded new ways of working / recruitment
- Improved more accessible volunteering pathways to recruitment (Community Engagement)
- Positive impact on WRES, WDES, MWRES indictors

Age of workforce

Age	% Workforce 2022	% Workforce 2023
<=20 Years	1.6%	0.7%
21-25	6.2%	5.9%
26-30	9.5%	10.5%
31-35	12.9%	13.7%
36-40	11.7%	12.8%
41-45	11.8%	12.6%
46-50	12.0%	11.6%
51-55	12.6%	12.6%
56-60	11.8%	11.3%
61-65	7.7%	6.4%
66-70	1.5%	1.3%
>=71 Years	0.8%	0.6%

Table Age of workforce

There has been a decrease at both ends of the age profile indicating a more centrally distributed age profile. However there has been an increase in headcount across the whole WF and this has impacted on the %. There has been an increase headcount in the range 26-55 of 308, indicating a stable age range. The largest loss of headcount is 42 in the age range 61- 64.

In the age 26- 60 we have increased from 82.3% to 85.2% and the age range 26- 55 we have 70.5% to 73.9%. Increase the central age range of 3.4% increase across 26- 55, as such we have a younger work force that we did a year ago – under 60s have increased by 2.7%

There remains a large proportion of our staff working for the Trust are aged between 51- 60. The Trust has over the past year put plans in place to support an ageing workforce. There has been a successful for first year for the 50+ Staff Network.

This network is a proactive space for connection, support, advocacy, action and education for staff aged 50+. They meet regularly throughout the year and collaborate to explore issues that have been raised and that are important to our colleagues. They are about inspiring change and making sure our Trust is age inclusive, with a focus on health and wellbeing, addressing inequalities and challenging stigma.

This network has newly formed and has started to make enquiries around how best to support people nearing retirement to work out the financial impact of stepping down.

The lowest age group that is represented is those who are aged 71 or over and for those aged 20 or younger.

Sexual Orientation Monitoring - SOM

Sexual Orientation	% Workforce 2022	% Workforce 2023
Heterosexual or straight	79.3%	80.5%
Bisexual	1.3%	1.8%
Gay or Lesbian	1.6%	1.7%
Undecided	Not recorded	0.1%
Other sexual orientation not listed	Not recorded	0.2%
Other/Not stated (person asked but declined to provide a response)	17.7%	15.7%

Table Sexuality of workforce

The LGBTQ+ Staff Network provides a space for LGBT+ staff and allies to come together and talk, share and connect with each other in a safe and positive environment. The network promotes a working environment where all LGBTQ+ staff feel supported, valued and able to be themselves without fear of prejudice. They also enable staff to achieve their potential, challenge discrimination and positively promote equality and acceptance.

The data indicates that a significant proportion of the workforce have not provided an answer to this question. The reasons for this are, of course, multifaceted, but we need to ensure that our staff are not leaving this question unanswered because they fear discrimination.

In response to a Stonewall's Workplace Equality Index for 2021/22, which identified some gaps in how the Trust is supporting the Lesbian, Gay, Bisexual, Transexual Plus (LGBT+) community in the Trust, we developed an action plan covering eight core areas.

These were:

1. Policies and benefits
2. The employee life cycle
3. The LGBT+ Staff Network
4. Empowering individuals
5. Leadership
6. Monitoring
7. Supply chains
8. External Feedback

Work to date to address improvement in these areas included:

- A new Trans Inclusion Policy that explicitly clarifies the Trust's commitment to trans and non-binary staff

- Consistency of policies to avoid confusion and to provide clarity of access to all employees, including LGBTQ+ community, on benefits such as those contained in the Family and Leave
- Support of the new/updated policies by the LGBTQ+ Staff Network
- Public facing policy that explicitly bans biphobic, homophobic and transphobic discrimination in your services written and implemented
- Wider publicity/promotion of new policies
- Staff provided with training around homophobia, transphobia and biphobia; advice on how staff can challenge and report such incidences
- Providing opportunities for all non-LGBT employees to become LGBTQ+ allies to embed LGBT inclusion across the organisation.
- Wider use of the rainbow badge to be promoted and take up documented

Work that is ongoing and still required is:

- Roles flighted on LGBTQ+ inclusive website and diversity fairs
- Share info on LGBTQ+ Staff Network on NHS Jobs and Oleeo
- Recruiting managers are provided with ‘inclusive’ training
- LGBTQ+ awareness days/events are promoted and well attended. The network will hold a minimum of four events, open to members and allies, each financial year.
- Revised TOR to show how the network provides confidential support to all employees on LGBT issues a
- TOR to provide clarity on how staff report biphobic, homophobic or transphobic bullying and harassment incidents
- Implementation of a formal mechanism, by the LGBTQ+ network, for bi and trans issues to be engaged with, promoting itself as inclusive of all LGBTQ+ identities, including those with multiple marginalisations
- Introduction of specific spaces (safe spaces) for underrepresented LGBT groups to encourage people to share experiences
- Engagement events for LGBTQ+ community within the Trust to provide even more opportunities to hear from those who seldom speak at/attend meetings
- Reporting/escalation e.g., to People Committee of issues raised by LGBT Staff Network
- Exploring change of ESR and other work systems to use the term ‘bi’ as an umbrella term instead of ‘bisexual’ when collecting protected characteristics data/monitoring questionnaires
- Adding ‘I use another term’ as a free text option so that all LGBTQ+ staff can correctly identify themselves

Occupation by Gender

Gender	% Workforce
Female	85.9%
Male	14.1%

Table Gender of workforce

Solent has a predominantly female workforce, and this has also been highlighted in the Gender Pay Gapreport. However, currently the national ESR (Electronic System Recording) system only allows individuals to categorise themselves as male or female and there is no option for non-binary staff. This is something that needs to be addressed at a wider level and raised through the HIOW.

Disability

Disability	% Workforce 2022	% Workforce 2023
Yes	3.9%	4.4%
No	77.3%	79.3%
Not stated	18.7%	16.2%

Table Disabled and non-disabled staff

Type of Disability	% Disabled Workforce 2022	% Disabled Workforce 2023
Unspecified	40.3%	48.2%
Learning disability/difficulty	22.8%	16.2%
Long standing illness	15.7%	11.7%
Physical impairment	9.9%	9.6%
Sensory impairment	5.3%	5.6%
Mental health condition	4.3%	6.1%
Other	1.8%	2.5%

Table Type of Disability disclosed

A large proportion of staff have not answered this question. Solent are committed to ensuring that staffwith a disability are supported and that staff feel able to declare their disability without fear of judgement or discrimination. As previously noted the National ESR system has outdated categories which may prevent colleagues from updating their records if they feel the choices available to them are not applicable.

Solent's People Strategy has 4 key themes – one of which is
'Belonging within the NHS'.

The key focused priority for this theme is to:

"Enable access and inclusion for all with an initial focus on disability and long-term conditions with aim of widening to other groups as we make progress."

Religion

Religious Belief	% Workforce 2022	% Workforce 2023
Christianity	45.7%	45%
Atheism	18.0%	19%
Islam	1.8%	1.8%
Hinduism	1.0%	1.1%
Sikhism	0.6%	0.5%
Buddhism	0.5%	0.5%
Judaism	0.1%	0.1%
Other	9.4%	10.2%
Unspecified	0.6%	0.1%
I do not wish to disclose my religion/belief	22.3%	21.8%

Table Religion of workforce

- Our Multifaith Staff Network supports human flourishing in our workplaces. Bringing staff together to celebrate all our diversity of faiths or none, beliefs and cultures in our Trust.
- This network shares knowledge and encourages staff to feel safe to express their faith in the workplace. They offer a safe space for everyone to have a time for reflection and stillness, paying attention to our spirituality is a key element of on-going mental wellbeing.
- The multifaith resource group has been particularly active and supportive to staff throughout thepandemic. Solent's Chaplain has provided a lot of support of staff of all faiths and none.

NHS Jobs – applications, shortlisted and appointed.

Solent's recruitment data and WRES shows the relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants as follows:

2	**Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants** **Target: decreased to 1.2 by July 2022**		**Revised target for Sept 23** **1.2**
2019/20 **1.40**	**2020/21** **1.36**	**2021/22** **1.41**	**2022/23** **1.43**

- It is worthwhile to note, that there is a better % better at Offer – at offer there is a ratio of 1.27.

- However less BAME offers convert to appointments - 30% of those BAME offered do not become appointed, vs 22% White. This drop off is due to RTW checks being carried out after offer – also worth noting there was a large scale NHSE event that recruited and offered but high % did not translate into new starters and this impacted on conversion rate and lowered due to RTW.

- It's worth considering the impact of the recent HCSA visa that came out last years that enables overseas on sponsorship for visa. This will also have impacted on recruitment stats. More people will have applied and been SL and offered but the reality is the NHS does not financially sign off recruitment of internationally recruited HCAs.

Solent's recruitment data and WDES shows the relative likelihood of non-disabled applicants being appointed from shortlisting across all posts compared to applicants with a disability as follows:

2	**Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts** **Target:** • **Equal likelihood of non-disabled staff being appointed from shortlisting across all posts by July 2022**		**Revised target for Sept 23 TBC** **1**
2019 1.20	2020 1.06	2021 **1.28** *(It is possible the 2020 the anomaly)*	**1.11**

Workstream one of the action plans continues to relate to overhauling attraction and recruitment and implementing an inclusive recruitment toolkit for recruiting managers. For more details, please see EDIB action plan for 2023/24.

Equality Diversity, Inclusion and Belonging (EDIB) Action Plan

Last year's EDIB plan action plan was co-designed with colleagues from networks and across the Trust with the aim of supporting the Belonging and Inclusion section of the NHS People plan.

The plan focuses on two specific aspects of the People Promise:

- Promise 1: We are compassionate and inclusive
- Promise 3: We each have a voice that counts

The success of the plan has been measured through various metrics such as WRES, WDES, Staff Survey, Impact Evaluations, KPIS and EDS reporting.

In March 2023, the 2022/23 plan was assessed and scored by NHSE using CQC scoring methodology.

All action plans were carefully and thoroughly reviewed by senior members of the national WRES team, and the scores were based on:

i. *understanding and targeting the most pressing data pinch points,*
ii. *using approaches with an evidence base of success and,*
iii. *with defined measurables*

The 2023/ 23 Solent EDIB plan was scored as 'good'.

Network chairs and members were both instrumental in the design and agreement of the plan and were engaged in the co creation of the plan. Colleagues from the community engagement team and representation from both clinical and corporate service lines were also involved from point of concept through to point of delivery. A collaborative approach to embedding diversity inclusion and belonging is what sits at the heart of the plan.

This plan is positioned in the context of supporting the Delivery of the NHS People and Operational Plan, The People Promise and Solent's People Strategy, as well as aligned to ensure the delivery of positive improvement of the WRES and WDES indicators and ensure that we fulfil our requirements under the Public Sector Duty Equality Act.

The WRES and WDES Data from the 2022 staff survey shows whilst we remain significantly higher than our comparable Trusts across both the WRES and the WDES indicators there has been some small decline indicators - this decline is broadly in line with national trends.

- There has been a very small, almost stable position with regards the 4 WRES indicators and response are in line with national trends.
- There has been a small decline across 5 of the 9 WDES indicators with the other 4 seeing improvement. These shifts are broadly in line with national trends.
- The most significant shift is that of WDES 4B: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months – which has changed from 65.3% to 60.1%.

Our delivery on the people promise1 and 3 remains strong, with Solent being in top performing Trusts for both promises.

The Plan aims to ensure that in Solent we

'Enable every person working in Solent NHS Trust to bring their authentic self to work each day, ensuring we all feel visible, and our identity and contribution is validated and valued'.

The Action Plan for last year had 3 workstreams – all with specific deliverables which are aligned to ensuring delivery of positive progress against the WRES and WDES indicators as well as addressing and taking action considering the well led recommendations as outlined above. It was assessed by CQC standards as good.

This Years EDIB plan has 5 workstreams with all actions linked and measured to WRES/ WDES/ national high impact actions and CQC well led.

- **1 Inclusive recruitment**
- **People Polices and Practice**
- **Education and Awareness**
- **Supporting Clinical Service lines to reduce Health inequalities**
- **Fusion and New Organisation**

Full action plan can be found in appendix. This year's action plan has been developed in a similar way as described above. The aim of the actions outline in the plan are aligned with supporting the delivery of the recent NHS England » NHS equality, diversity, and inclusion improvement plan and the 6 high impact actions outlined in it and detailed below. This plan prioritises the following six high impact actions to address the widely known intersectional impacts of discrimination and bias.

High impact action 1:

- Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

High impact action 2

- Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

High impact action 3:

- Develop and implement an improvement plan to eliminate pay gaps

High impact action 4:

- Develop and implement an improvement plan to address health inequalities within the workforce

High impact action 5:

- Implement a comprehensive induction, onboarding and development programme for internationally recruited staff.

High impact action 6:

- Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Significant projects that aim to improve Diversity, Inclusion and Belonging in Solent.

Celebrating cultural and religious festivals

Celebrating cultural and religious festivals is important for our staff and our patients. Our Multi-Faith staff network has held events through the year celebrating St David's Day, Easter, Ramadan. In April 2023 we held an Iftar event at Western Community Hospital. This was attended by a local Imman and representative from the Central Southampton Mosque. Staff were invited to attend to learn more about the month of Ramadan, the Muslim faith and break fast together with a special meal prepared by the catering team.

Disability History Month

In November and early December, we held two-events mark Disability History Month.
The Managers event on 8 November was aimed at helping people to 'Effectively support and manager disability within the workforce'. It was an online event attended by about 80 people with 61% of attendees reporting they had enjoyed the length and pace of the two-hour event.

- **83% said the interactive format of the session was very effective.**
- **83% felt 'a lot' more confident in having conversations around reasonable adjustments and supporting colleagues with long term conditions, disabilities and neurodivergence because of the session.**

When asked what went well, over 50% remarked on how the interactive nature of the session stimulated their thinking and ability to reflect on the situations unfolding. The remaining comments praised the depth and complexities of the experiences portrayed and how this helped explore different perspectives and uncover unconscious ablism.

Some quotes from attendees:

"I especially enjoyed the way that it was very interactive and allowed us to rewrite the conversations in real time - instead of being left with an uncomfortable unresolved experience."

"I think the session as a whole went well and I think the format and mode of delivery made it accessible to a wider audience perhaps. The SimComm element was powerful and created immediate reactions followed by thoughtful discussions. I liked the fact that I could participate as much or as little as felt comfortable and that even for those who prefer to observe and think there was still impact of the session and learning through others who were more active. The session was facilitated well by the lead facilitator and supported by the network chairs which I think went well as they brought a realness in sharing which complimented the structure. It was good to see so many people join. Thank you for offering this session."

The Disablity Awareness Conference on 2 Dec, which was hybrid, was called Disability Wellbeing in the Workplace. The 6-hour event was attended by 60 people in person with a further 20 online.

Feedback from the event was positive with 88% saying they had enjoyed the length and pace of the event while 94% felt that they have a better understanding of DisAbility Wellbeing in the Workplace because of attending the event. Some comments from attendees were:

"I felt that it met all my needs. It was the most accessible event I've ever attended."

"I love how much thought went into the accessibility, like having a quiet room. I considered it a couple of times through the day, in the end I didn't feel like I needed to use it but I think that was because the option was there, rather than me looking for my nearest exit."

"Really well laid on event. Really interesting content and clearly a lot of thought had gone into making it accessible for everyone."

The evaluations from the conference showed:

- **94.5% felt more confident do you feel in having conversations around reasonable adjustments and supporting colleagues with LTH and Disabilities**
- **100% felt their had a better understanding of Disability Wellbeing in the Workplace as a result of attending the Disablity Conference**

Turning the Tide

We continue to work closely with our ICS partners on the Turning the Tide partnership. The focus is on moving from offering support, advice, and guidance towards working with our systems and organisations across the ICS to ensure growth of deep and meaningful consciousness about BAME health inequalities and employment inequality, with this being evidenced in robust plans to address andmonitored via assurance.

Equality Impact Assessment

During the year, we have reviewed and revised the Equality Impact Analysis (EIA) template (previously called Equality Impact Assessment). The EIA now focuses more on the quality of analysis and how it is used in the decision making and less on the production of a document, which some may have taken as an end in itself.

EIA is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion.

We are encouraging all workstream leads for Project Fusion to undertake EIAs as it is one sure way of ensuring that understand how people, particularly those with protected characteristics, will be affected and what needs to be done to reduce or completely remove any negative harm.

Anti-discrimination and Hate Crime Reporting

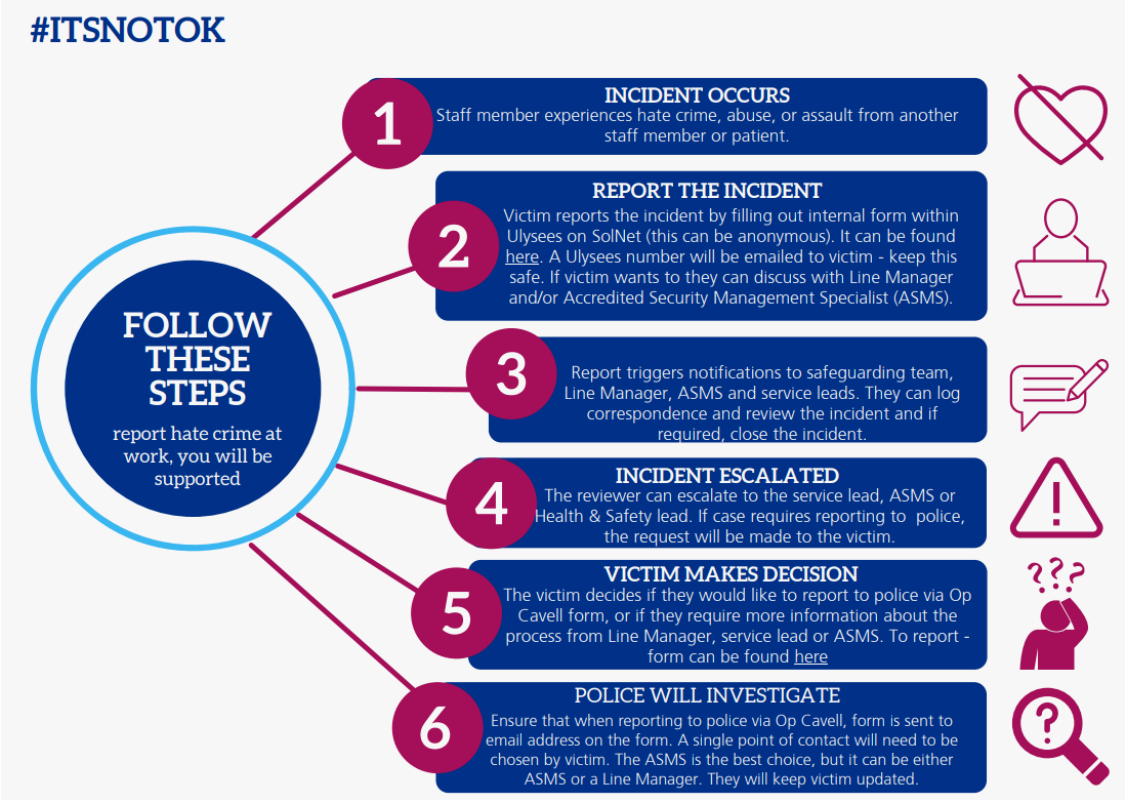
At the heart of everything we do in Solent NHS Trust is the health & wellbeing of those who we provide services to & the staff who work for us. We all have a responsibility to help the Trust fulfil its obligation to minimise risks, by identifying & supporting adults & children who may be prone to or at risk of hate crime.

We are doing this by:

- responding to hate crime & incidents and the threat from those who promote it
- preventing individuals being targeted and ensuring they're given appropriate advice/support
- working with Police & other agencies to report & support
- sign posting to Occupational Health, EAP, Victim Support, Restorative Justice Solutions & PCC

Solent recently launched the 'Ripple' model whereby staff can indicate on any incident report that they require additional support

Over the past year we have launch the #HateHurts Campaign and the 6 step multiagency reporting and support process for colleagues to report and access support when victim of hate crime Staff can now report incidents anonymously if required, for example when whistleblowing, to ensure their manager is not notified and their name is not revealed.



Reverse Mentoring

- In March 2023 our Reverse Mentoring programme began in partnership with Southern Health and facilitated by the Reverse Mentoring Practice.

- Reverse Mentoring is when a junior colleague mentors a senior leader in the organisation. The Mentor leads the relationship, sharing their lived experience in a safe space and enabling the mentee to experience the reality of the barriers and blockers in the organisation that they themselves have not experienced.

- There are 18 Reverse Mentoring relationships underway with 12 mentors from Solent Health.

- The programme is for six months and will conclude in October 2023 with reflective workshops and a full evaluation of the learning from both mentors and mentees.

Leadership Development for colleagues from ethnic minority

The Leading with Confidence Pilot was designed to focus directly on enabling BAME members of staff to effectively lead their team; being confident in flexing their own style and equipping them with the tools to deliver team objectives successfully. After a targeted advertising campaign, we had nine staff who enrolled on to the programme

The delegates learnt to confidently role model leadership behaviors and values, getting the best out of their team and how to manage change effectively. The modules are:

- Building the Future
- Leading with Confidence
- Empowering the Team
- Managing the Successful Change
- Delivering Results

Delegates reported new ways of thinking, understanding, relating to others and behaving included.

“I am encouraging members of the team and my manager to focus on the importance of soft skills when successfully leading a team and how a cohesive, well supported team can feel more empowered to work hard and remain with the organisation. “

“I am a lot more confident with my approach to dealing with stakeholder when managing projects as this is where I believe I can put my leadership skills to use.”

“I am more confident in asking for feedback and pushing for future opportunities. I have become more assertive and have a better idea about what I would like my future role to be.”

“I also feel more supported in my role based on the skills I gained and how enthused other members from around the Trust felt about my service improvement project.”

“Fantastic course that has given myself and underrepresented groups a rare opportunity to show our talents and drive to progress. Shahida created a safe space to discuss and share experiences and was very helpful and supportive outside of the course.”

When the delegates were asked to rate the following statements, all agreed or strongly agreed.

- I have met my original goal / fulfilled the reasons for enrolling onto this programme
- I am a better / more confident leader
- I am more productive/efficient in my role
- I am approaching my work and interactions with others differently

The only neutral comment was in answer to the question “The programme has helped me progress in my career/opened up new opportunities?”

Further to this, targeted communications have been sent to Solent staff promoting the Racial Equality Programme, including “Rising Tide” led by the Hampshire and Isle of Wight Integrated Care Board.

Activating Your Allyship

This programme has run now since March 2023 and took in to meeting the recommendations of the well led review and support workstream 3 – Education and Awareness of the EDIB action plan

- ‘*To ensure that we put greater focus around equality diversity and inclusion’*
- ‘*Ensure that the workstreams secure parity of profile to other successful campaigns’*
- ‘*To ensure you do not remain behind the curve’*

A series of face to face and virtual roadshow presentation and discussion have been delivered. Clinical and corporate service lines have hosted these sessions within their teams’ meetings and in many cases the presentation has been redelivered to the wider team.

The aim of the roadshow was to increase awareness and understanding of allyship, privilege and bias, to provide feedback from the big conversation and the action plan and to create engagement and increase the profile and understanding around diversity, inclusion and belonging, so that it is owned by all.

Around a reach of 200 plus colleagues have engaged in these sessions and the evaluations show that:

- **100% of those attending them found the session to be effective in raising their awareness of EDIB**
- **100% of them had a better understanding of how privilege effects them and others**
- **100% of them had a better understanding of what it is to be an ally**

Inclusive Language - # AskDont Assume Campaign and workshops

A Poster campaign was lunch on social media and through internal communications along with a serries of high impact conversational workshops around inclusive language. Due to the success and the high demand for these workshops the running time of this programme was extended. Around 35 workshops have been delivered to date reaching approximately 613 colleagues.

The impact evaluations show:

- **71% found the inclusive language sessions highly effective**
- **74% had a significantly better understanding and 26% a little more understanding of how inclusive language affects you and others**
- **94.5% felt more confident around speaking up and having conversations around Inclusive Language**

Improving Education, Awareness and Allyship – An Organisational Development approach to improving inclusive culture

As well as the programs detailed above there have been a number of other Learning and development and organisational development type offers. The approach we have taken is one more of facilitation than training, one which uses organisational development principals to drive culture change and improve diversity and inclusion. We had an approx. reach of 3500 plus colleagues through delivering the following:

- Inclusive Language workshops
- Network events
- Activating your Allyship
- Neuro Diversity Coaching workshops
- Prevention of Violence and aggression
- Organisational Belonging
- Service line specific EDIB and Anti Racist interventions
- Unconscious Bias workshops
- Cultural Awareness
- Disablity Awareness
- Positive Action leadership development
- Disablity Awareness conference
- Disability Awareness for managers
- Inclusive and accessible IT Solutions
- Creating Personal and Health Wellbeing Systems for Success
- When does patient choice become discrimination?

The EDIB and the Learning and Development team have worked closely with The People Partnering team to design and deliver specific organisational and cultural development improvement programme to support the development of more inclusive cultures. Approximately 83 support and development offers have been rolled out across different clinical and corporate services lines.

There has been a wide range of reasons as to why these sessions have been commissioned, examples are:

- To ensure all managers who undertake ER investigations are trained and developed to a consistent level, ensuring the thread of best practice and just culture is present, and all policies and processes are adhered to
- To upskill managers and ensure they have the necessary skills and awareness to recruit safely and legally, ensuring best practice and consciousness of EDIB
- To improve inclusion and employee engagement and experience after issues were raised
- To enhance organisational culture
- To enhance and promote an inclusive culture linked to patient experience feedback
- The Workforce Wellbeing Bubble Meeting established by the Heads of People, to provide a platform to discuss, identify and enable improvements to the health and wellbeing, inclusion & belonging of our workforce through a collaborative approach between Service leads, People Partners and Occupational Health and Wellbeing.

Working in partnership with the Learning and Development Team and the networks we have developed a new resource within the Learning Management System (LMS). This is a one stop shop with resources such as leadership tools to use at teams' meetings, ted talks, training and more. https://mylearning.solent.nhs.uk/totara/dashboard/index.php?id=158

Staff Networks

Our Trust currently has six active staff networks, supported by the Diversity and Inclusion Team. The networks are:

- 50+
- Black, Asian and Minority Ethnic (BAME) & Allies
- Carers
- DisAbility & Allies
- LGBTQ+ and Allies
- MultiFaith

Networks provide a space for connection, support, conversation, and reflection. Anyone who works for Solent NHS Trust, either in substantive role or on a bank contract, is welcome to join any or all the networks. The networks host safe spaces for core members only and group meetings for all members, colleagues and allies.

These spaces are there:

- for everyone and anyone within the organisation to come together to discuss issues, without judgement being passed
- to raise awareness of challenges people with protected characteristics are facing so as to push for change
- to offer a supportive 'net' to individuals who for example, are being discriminated against, and need help with either getting it resolved or just share experiences
- as a collective body that holds the Trust to account when it comes to addressing inequities within the organisation
- to celebrate successes, achievements, and important events

As part of workstream 3 of the diversity, inclusion and belonging action plan, we have increased our membership by 40% across all six networks from April 2022 to March 2023 (50+, LGBTQ+ and DisAbility seeing the biggest increases).

We have supported several internal events which have grown the networks, such as events for Disability History Month, which included Effectively Supporting and Managing DisAbility within the Workforce (interactive, online session with scenarios from SimComm Academy aimed at managers) and Disability Wellbeing in the Workplace Event (in-person event in which there were several guest speakers looking at all the connection between disability and wellbeing in the workplace).

These events saw an increase of DisAbility Network membership rise by 45%. During LGBT+ History Month, three online events were held which increased LGBTQ+ Network membership by 52%.

We have increased our membership by:

- regular meetings being held which are sent as calendar invites to members but also advertised in Staff News with a link to the meeting and included on Daily Zoom emails from comms

- creating safe spaces in meetings where colleagues feel they can be themselves, this is evident in the monthly DisAbility Network meetings and where colleagues regularly attend and recommend to their colleagues

- engaging with managers and team leaders to help them release staff for meetings

- ensuring events are being sent as calendar invites to members but also flyers, which are used to promote the networks via comms channels such the closed Facebook group, Staff News and Managers Matters

- through all staff emails from the executive sponsors

- increased level of comms and promotion of events leading to well attended meetings/events

- ensuring each network has a dedicated email address which is checked regularly. These email addresses are used on any comms that is produced for member requests or other queries

- Solnet pages updated to reflect new logo's and information on chairs and Exec Sponsor's

Review of accessibility arrangements

Working in partnership with the Estates team we have developed an Accessibility Building Equality Impact Assessment. This toolkit has been developed using the social model of disability and Access by Design models to support our commitment to taking a creative approach, considering the needs of everyone and incorporating those needs into good, thoughtful processes and practices. This will help achieve an accessible, inclusive environment that enables people to participate fully in all aspects of our organisation and healthcare provision.

The document has taken a 'snapshot' view of the current position to identify works that might reasonably be required under the Equality Act (2010) for our owned and managed building stock.

It identifies budget remedial costs, health and safety risks and has outlined a phased 'Accessibility Plan' to remove all physical barriers over the next 3 years, commencing in Q2 of 2023 with the St Mary's Campus:

- Items which present a Physical Barrier Year 1
- Items which prohibit or limits the service Year 2
- Other Items Year 3

This assessment tool is to be incorporated into the Estates strategic plan and is reported through the Quality Assurance Committee.

In addition, we have designed an audit tool to be used by Managers in their work areas.

- This tool focuses on adjustments and considerations that can be made to create an

accessible, inclusive and welcoming workplace/clinical environment.
- This is due to be piloted in June 2023 in one area, to review and further develop in partnership with staff and patients/service users.

Revised EDIB Policy and new Transgender Inclusion Policy

- The Equality, Diversity, Inclusion and Belonging policy has been updated and refreshed to reflect current practice and processes.

- Inclusive language has been used and it has been reviewed to ensure it complies with accessibility tools, including images with text descriptions and a full explanation of acronyms.

- This policy provides guidance to the organisation on how to meet its statutory and contractual obligations with regard to equality.

- A new Transgender and Non-Binary workforce policy has been developed in partnership with the Solent LGBTQ+ staff network, using best practice examples from Stonewall, Co-Operative Society and Unison.

- This policy provides guidance for staff members and their managers, including toolkits for inclusive conversations and signposting to support mechanisms within the organisation and is due to be published in July 2023.

Embedding of Just Culture and early resolution principals

We recognise that the majority of people do not come to work to intentionally cause harm. In a just and fair culture, it is reasonable to expect that unintended actions and consequences should not be blamed or punished as we recognise that this rarely has positive outcomes.

A respectful resolution approach underpins all our People Practices and the way we manage all interactions and Employee Relations matters.

When unexpected issues arise, they are objectively assessed to understand the whole context of a situation to identify whether there are alternative positive, corrective and/or learning opportunities before any formal action is considered.

People Partnering have regular team case reviews to support and review progress, to appropriately challenge and reflect on whether a just and fair culture is being adopted, to identify themes and to identify whether changes or modifications to practices are necessary.

Reflection and Learning Reviews are held on closed cases where any concerns or challenges have arisen, to objectively reflect on and identify learning and improvements to people practices.

We are currently rolling out a programme call Kindness into Action and Respectful Resolution.

Kindness into Action is blended learning approach that covers the following modules

- Creating kindness: what kindness looks like, and why it's essential, in healthcare
- Undoing unkindness: the true meaning of incivility and its impact on patients and staff
- Kinder feedback: amplifying the positive and speaking up to reduce the negative

Respectful Resolution is blended approach that has been developed which reduces poor behaviors through awareness, reflection, discussion and de-escalation.

Using global best-practice and with clinicians, managers, unions and frontline staff, The Kind life have created a suite of helpful reflection, discussion and decision guides.
In a co-creation workshop with Solent Colleagues, we have tailored and aligned these resources to support better practice around respectful and Early Resolution and further develop a string culture of speaking up.

Occupational Health and Wellbeing

Within Solent, the Occupational Health and Wellbeing (OHWB) service has continued to focus on health inequalities, the health and wellbeing risks of specific groups and the equity of access to professional health and wellbeing services.

The OHWB service is involved in the onboarding process and assesses fitness for duty of all individuals joining the Trust. The service advises and supports managers in implementation of work adjustments for all new or existing staff that may have short- or long-term health issues, mental or physical impairment or disability.

All new starters, and those moving to a new post with different workplace risks, are individually assessed for fitness for duty accounting for their individual health needs, any work adjustments or equipment support they require, any modifications to work patterns, hours or the work environment and any additional specialist support that will enable them to perform their job role to the best of their abilities e.g. Access to Work, Neurodiversity support, Mental Health support.

From a legal perspective, the OHWB service advises the organisation and individual managers on their health and safety duty to individuals to carry out individual risk assessments to minimise the risk of harm to individuals in the workplace e.g. New and Expectant Mothers, Manual Handling, Skin Health Surveillance.

The service maintains clear routes of access to services for all Solent staff and managers who experience illness or absence from work. The management referral process exceeds 150 referrals per month currently and supports staff and managers on the promotion of illness recovery, appropriate work adjustments to achieve this, tailoring returning to work during illness or with disability, and signposting to targeted interventions.

To support the progress of individual cases, Occupational Health (OH) practitioners meet monthly with the People Partnering team to continue to link with employee relation (ER) cases, where health issues arise, and long-term health support and disability.

This collaboration is successful and has been shown to support early identification of barriers, discussions around appropriate work adjustments, identification of further holistic support and supports timely progression of all cases. The monthly meetings enable early intervention and the timeliness and transparency in these cases has shown to lead to early resolution of ER cases and positively impact on a reduction in extended sickness absence, a reduction in presenteeism, a reduction in work-related sickness absence and an increase in workforce availability.

It is known that musculoskeletal (MSK) ill health continues to be a top contributor to both short- and long-term sickness absence in the organisation, and in the last year the OHWB service have reviewed clinical roles ot ensure the correct skill mix to enable maximisation of appointments to address the increase in MSK cases.

The OHWB team have upskill physiotherapy colleagues to increase numbers of targeted appointments for MSK issues and improve response times and give all staff referred for MSK health issues access to specialist MSK support.

Since the pandemic the OHWB service have identified an increase in mental health related cases and also complexity of management referrals to the service. To provide an additional tier of support for these cases, and to continue to maximise on the available

appointments with Occupational Health practitioners, a new extended service providing individual support to individuals with complex health needs has been implemented to complement the existing management referral model.

The model releases the OH practitioners from continuing to manage such cases but provides a lifeline for individuals with long term or complex needs or disability in their successful rehabilitation back to work.

In April 2023, the OHWB service successfully launched the new OPAS G2 portal dashboard. OPAS G2 is an Occupational Health clinical record system that is web based and gives all managers and individuals access to the system 24 hours a day through a dashboard view. This new system will enable more robust data analysis of protected characteristics that are relevant to process as part of the OHWB core services. This data will be gathered as a combination of the data feed from ESR each week and also from data that is recorded by OHWB interventions. This will help to inform where there possible areas of inequality and allow us to identify areas that may need positive action to be taken to reduce inequality.

The OHWB team coordinated a communications plan that was rolled out across the Trust to keep managers and individuals up to date with new functionality, including the provision of ‘quick reference guides’ and simple training videos.

The Solent Health and Wellbeing Plan (HWBP) was developed and launched in October 2022 and was based on the NHS E Health and Wellbeing Framework. The HWB Plan is an ongoing programme of analysis of staff health needs and the prioritisation of needs for both immediate and long-term health risks within the organisation. So far, we have committed to understanding specific health and wellbeing risks and introducing and analysing appropriate interventions.

All Health and Wellbeing Plan pillars in the HWB Plan are under continually review the using a Diagnostic Tool’ to capture work being done, highlight any risks of areas potentially being side-lined (especially as Project Fusion gathers pace and we are in a transitionary period) and which areas are successfully progressing. This has shown overall improvement in most of the pillars and continue to work collaboratively across the Trust.

We are currently targeting Relationships and Fulfilment at Work pillars as well as Improving Personal Health and Wellbeing that support our EDIB work.

The staff survey indicates an increase of staff with disabilities and long-term illness feeling pressurised to come to work. It is suggested that health and wellbeing conversations may not be happening as much as they should be due to time constraints and other pressures. This will be addressed through the re-launch of the Health and Wellbeing Champions (Champions) supported by People Partners in People Services, through the networks and other methods to reignite health and wellbeing conversations as well as education and awareness sessions and guides for managers that will be delivered by the Employment and Disablity Advisory Service (EDNA). Since the launch, the response has been very positive and new Champions and MHFA have already been recruited into teams where there was little or no representation.

We have been aware from survey data that marginalised groups do not feel comfortable speaking up or voicing concerns and perhaps health and wellbeing conversations were not happening. The OHWB service and the Champions and MHFA will continue to support health and wellbeing conversations at team level and ensure that speaking up and voicing concerns is a focus and positive action is taken to improve engagement or minoritised and

marginalised groups. April 2023 has seen the introduction of a Kind Life and the building of a model launched to further support for psychological safety.

The Champions and MHFA are supported both individually and at a 6 weekly network meeting with the OHWB service's Health and Wellbeing Leads.

The staff networks have been developed over the past year, with a significant increase in membership and attendance. This is a significant area of progress. The OHWB service continue to support staff networks to represent workplace health and wellbeing in their groups and to provide health and wellbeing advocacy and guidance for any issues that are raised. The OHWB service also attend the network chair groups of LGBTQA+, BAME, multi-faith, disability, carers and 50+ to continue this support and advocacy.

The Wellbeing team are currently developing a HWB Support Booklet that aims to collate all HWB information/resources/offers available to Solent staff to increase awareness and accessibility. It will include psychological support services, MSK support, menopause and energy management content, and the staff networks have also had input into this to ensure that it is as inclusive as possible.

To support mental health and wellbeing, our Cognitive Behavior Therapists (CBT) continue to support staff psychological health and maintain workforce availability. All mental health cases to the OHWB service are triaged and an appropriate intervention pathway is established e.g. high or low intensity CBT.

The access to CBT has now been improved for staff who would otherwise wait for Improving Access to Psychological Therapies (IAPT) services. The OHWB offer is now improved and clarified giving greater choice and access to treatment or support available both within Solent and beyond these interventions.

The Learning and Development team are currently working in collaboration with OHWB to develop a website dedicated to all current OHWB services and how to access them. Manager and staff will be able to access guides and training guides are currently in production and will be uploaded for the launch of the site in July 2023.

The site has an easy to navigate layout focusing on the 4 core elements of OHWB service, which are Occupational Health, Physiotherapy, Health and Wellbeing and Vaccinations.

- Lack of awareness of potential cultural areas of friction
- Visibility of the service
- Fear of stigmatisation
- Lack of awareness of available mental health support.
- Failure to self-identify mental health need
- Lack of representation in the mental health workforce

Recommendations:

- Talking Change Service to strengthen its relationship with local ethnic minority communities in Portsmouth
- Increased cultural awareness training for staff
- Increase visibility of the service
- Addressing lack of awareness of local mental health services amongst ethnic minority communities
- Addressing job security fears
- Self-identifying the need for mental health services

Chaplaincy Service

Promoting Excellence in Pastoral, Spiritual and Religious care.

The term 'chaplaincy' is not affiliated to any one religion or belief system. Modern health care chaplaincy is a service and profession working within the NHS that is focussed on ensuring that all staff, patients, their, families and carers, be they religious or not, can access pastoral, spiritual or religious support when they need it. Chaplaincy focus continues to provide high standard of pastoral, spiritual care and religious care for all staff, our patients and carers.

What does the Chaplain Provide in Solent NHS Foundation trust?

- **They seek to implement** our Trust's Spiritual, religious and pastoral care strategy in line with national guidelines.
- **Promote and uphold** the Trust's HEART values in providing an excellent chaplaincy service that is responsive, inclusive, holistic and person centred.
- **Support and co-ordinate** spiritual, religious and pastoral needs of service users, carers, staff and visitors irrespective of faith or belief.
- **Ensure faith needs** across the range of faiths are met-connecting with the wider community.
- **Raising awareness** of the importance of faith and culture in the workplace for staff and for our patients and families.
- **Facilitating and promoting events** for staff of differing faiths and religions within the Trust. Celebrating major festivals.
- **Working with D&I team to promote human flourishing and belonging** in the workplace, including promoting and supporting religious identity in the workplace and meeting the spiritual and faith needs of our patients.
- **Chair of the Multi Faith Staff Network Group**. Continues to grow in membership.
- **Visiting patients and staff** on a weekly basis across our hospital sites.
- Responding to needs of staff and patients within 24 hours.
- **Forge relationships** and develop networks and partnerships across the Trust that serve the spiritual needs of patients, staff, and carers.
- **Act as a resource** for ethical issues arising in the Trust.
- **Support staff** by regular visits, reflective practice sessions, Schwartz rounds, one-to-ones, mentoring, working as part of the MDT, debriefing sessions after difficult situations and End of Life Support.
- **Develop and provide** training for all staff in relation to spirituality, pastoral and religious care. Working with the Community Engagement Team on the End of Life Care Strategy.
- **Working and collaborating with other chaplains in Southern Health** NHS Foundation trust, UHS, QAH in Portsmouth, IOWH and Hampshire Hospitals to provide a high standard chaplaincy service across the ICB.
- Working with other chaplains on the **Wellbeing Hub for staff.**
- Working in partnership with chaplains to provide a **robust, evidence-based e-learning on spiritual care** for staff to access across the ICB, some funding has been provided.
- **Provide or facilitate** provision of sacramental ministry when required.
- Working as part of recruitment team for International Nurses, supporting them prior to arrival and in post. Part of the team **facilitating the International Nurses'** Forum.
- Working **with D&I team to promote human flourishing and belonging** in the workplace, including promoting and supporting religious identity in the workplace and meeting the spiritual and faith needs of our patients.
- Responding in a timely and professional manner to **staff crises** and providing support to Teams who are experiencing challenging circumstances.
- **Conducting funerals** for staff who have passed away, supporting their colleagues and families.
- Planning for a small team of volunteers to support chaplaincy provision.

Appendices

EDS Summary Report

NHS Equality Delivery System Rep

WRES, WDES Bank WRES and MWRES Data Table

WRES WDES 4 Year Table March 23 V4.do

Bank WRES and MWRES 23.docx

Working with People and Communities Engagement Report 2022- 2023

Working with people and communities Ann

EDIB Action Plan

Equality Diversity Inclusion Belonging P

Please tell us how you feel about the services we provide.

If you have a compliment, concern or complaint, please contact the Patient Advice and Liaison (PALS) and Complaints Services on:

0800 013 2319

or email:
snhs.solentfeedback@nhs.net

Alternatively, visit:
www.solent.nhs.uk/contact-us

For a translation of this document, an interpreter or a version in

large print or 

or 

please contact Access to Communication

☎ 0300 123 3267

Board and Committee Summary Report

Item 17

NHS Solent NHS Trust

Title of Paper	Annual Health and Safety Report				
Date of paper	July 2023				
Presentation to	In Public Board				
Item No.	17				
Author(s)	Compliance David Keates (Health and Safety Manager), Stuart Francis (Accredited Security Management Specialist), Steven Abraham (Fire Safety Advisor) Chris James (Senior Maintence & Infrastructure Manager)				
Executive Sponsor	[Chair of the Health and Safety Group]				
Executive Summary	Refer to key areas of focus within the report page 4 and 5				
Action Required	For decision?	(Y)	For assurance?	(Y)	
Summary of Recommendations	The Board is asked to: • To receive assurances regarding compliance around proactive and reactive risk management				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Previously considered at	Health & Safety Group Quality Improvement & Risk Group Quality Assurance Committee				

Strategic Priority this paper relates to

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

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								

Contents

Section 1: Executive Summary

This report informs the Trust Board of the activities undertaken in relation to Health, Safety & Welfare and the Health and Safety Group during the year 1st April 2022 – 31st March 2023. It provides assurance on how we are meeting our statutory requirements and best practice evidence for health, safety, welfare, fire, security, and estates compliance.

The report has been produced using the Health & Safety Executive (HSE) guidance 'Managing for health & safety' (HSG65) and covers staff, patients, visitors, and contractors.

Colleagues involved in compiling this annual report are Accredited Security Management Specialist (ASMS), Fire Safety Advisor, Senior Estate and Facilities Maintenance Manager.

The table below provides a summary of each of the key areas reported on and is RAG rated to enable a quick overview to be seen with further detail available within the body of the report:

Section 1: Executive Summary and Health and Safety Response to SARS-CoV-2	
Section 2: Governance and Management Arrangements	
Solent have remained compliant with (section 2 (3) HASAWA	
Solent have remained compliant with section 2 (7) HASAWA	
Health and Safety Executive legislative consultations/changes	
Section 3: Internal Audit	
Health and Safety and Occupational Health Internal Audit	
Section 3: Assessment and Inspections	
COSHH	
External Medical Gas and Above Ground Oil Storage Compound	
Ligature assessments	
Section 4: Additional Covid Work Streams	
Facefit Testing Programme, Covid positive case reviews, Reception screen project	
Section 5: Compliance and Assurance	
External Agencies and reporting of Incidents	
RIDDOR	
DoH Central Alert System (CAS)	
Section 6: Annual Security Management Report	
Strategic Governance	
Lockdown Procedures	
Crime Reduction Surveys	
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Compliance with The Regulatory reform (Fire Safety) Order 2005	
Section 8: Annual Estates Management Report	
Operational Maintenance Dashboard	
General Compliance	
Estates Backlog Maintenance and Strategy	
Water Safety Management and Risk Assessments	
Asbestos Management	
Ventilation Systems	

Section 9: Risks and Issues	
Incident Reporting	
Slip, trip falls	
Section 10: Looking Ahead Refer to Page 29	

To note on exceptions amber ratings above:

- Of the additional Covid Work Streams only the Facefit testing programme is currently rated as Amber, there are mitigating controls in place however due to the volume of retesting it will take time to build a better cooperate resilience Solent will need to ensure we are prepared for any future health emergencies.
- Constant change in original trained fire wardens as departments are moved around different or new buildings, and agile working means it can lead to not enough trained fire wardens on-site. Both the above items are being investigated by Trust management. Option appraisal written and evaluations being considered.
- There is a continuing Estates backlog for maintenance, but all items are costed, prioritised, and being tracked through the backlog maintenance system in line with available resources.

Key areas of focus within the report

Health and safety incidents (refer to page 28, 29)
When comparing the last two years 2021/22 against 2022/23 it shows an increase of total number of reported incidents of circa 27.6%, over the reporting year. The quarterly incident numbers fall in line with the incidents per 1000 patient contacts (Clincal services only)

Further trend analysis is not comparable to the prior year due to the pandemic impact on service restructuring, the impact on service delivery and anticipated future trends due to Covid, forming new norms.
Year to Year Comparison summary of the total number of health and safety reported incidents

- No Harm and Near Miss by Intervention overall % figures accounted for circa 51.3%
- Low Harm Minor Non-Permanent Harm incidents accounted for circa 45.3%
- Minor Non-permanent harm incidents remained very low at 2.7 %.
- Blanks are generally rare

No Harm and Near Miss by intervention quarterly % figures recoded incidents have consistently been higher than Minor Non-Permanent Harm incidents, this falls in line with a positive culture of reporting incident

Falls Prevention Work Streams (refer to Page 9) numerous falls prevention work streams have taken place and Solent NHS Trust has implemented detailed changes to its incident reporting system for incidents related to falls. To support the Clincal ward by ward Falls Environmental audit undertaken aSlipAlert Slip resistance testing machine was purchased and HSE approved accredited training undertaken. In each in patient area a pendulum slip test to measure slip resistance of the floor surface has been undertaken. Results of findings feed back to the falls group.

Security incidents (refer to Page 17). Second year running there was a **19.5%** increase from **951** Incidents to **1137,** incidents the majority of these increases are in relation to Aggressive Verbal Gestures (AVG) incidents patient to staff in AMH due to the acuity of patients.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (**RIDDORs**, (refer to page 11) statutory reporting requirements have been met reportable incidents have increased from 8 up to 20 over the last year. All 20 staff related 6 had No common location or activities identified when incidents took place. Lessons learnt from RIDDOR's have been reported onto Ulysses and through the Health and Safety Group
After a comprehensive investigation 14 Dangerous Occurrences were reported to the HSE related to Covid Outbreak as there was reasonable evidence that more likely than not that staff members caught Covid at work.

Project Fusion Health and safety (refer to page 8) **and ligature management** (refer to page 9) **Integrated Care System (ICS) report**
Health Safety and ligature Workshops, number of meetings held with colleagues to discuss an approach regarding the pro and cons of existing arrangements to formalise a programme management going forward, policies prioritisation undertaken, due diligence paper written.

Some proactive assessments have remained in place including medical gas compounds, COSHH, ligature assessments, Accessibility Access, and Building Equality Impact Assessment and the additional covid secure risk assessments (refer to Page 8, 9, and 10)

Water safety management group (Refer to Page 27) confirm that the risk assessments are complete at the date of report. The remodelling of the HTM 04-01 placed a greater emphasis on the efficacy of the Water Safety Group and the requirement for members to be kept informed and collaborate to achieve identified responses to any high count or outbreak and this continuities throughout the year.

Ventilation management (refer to Page 28) The legacy of the COVID pandemic continues to place an intense scrutiny on all modes of mechanical ventilation particularly re-circulating air systems. The Trust continues to deploy technology that has the potential to improve indoor air quality via an air re-circulation and filtration process and remain under constant review. The formalisation of a Ventilation Safety Group has been delayed but once operational its focus will be on the control, deployment, and rigorous management of these devices and more widely indoor air quality standards.

Executive Summary Health and Safety Response to SARS-CoV-2

As Solent continued to see an improvement in the reduction of COVID-19 case rates, both in terms of staff and patients, with additional restrictions and./ or changes in guidance's throughout Solent. 2023 marks three years since the start of the first national lockdown prompted by the Covid-19 pandemic, which for Solent, we shifted to a more agile working and homeworking model as the government guidance required employers to take *"every possible step to facilitate"* working from home.

However, balancing employers' priorities (including promoting a collaborative work environment, maximising productivity, and reducing costs associated with office premises) with workers' expectations for flexibility continues to present a challenge.

Solent are still navigating changing ways of working with some office-based services returning, some continuing to operate via a hybrid or remote model and as these working modules have changed, we have had to keep under review how we are meeting our duties to ensure a safe and healthy working environment, being mindful of the differences in the risks to employees of working from home and

remotely and working in an office environment. We have adopted and consistently applied a pragmatic approach

Solent continues to have good systems and processes in place to manage health, safety, and welfare which are outlined in this report. These processes are aligned with the legal requirements and no statutory health and safety requirements were affected,

Section 2: Governance and management arrangements

Solent NHS Trust as an employer has appointed one or more competent persons with the necessary skills, knowledge, and experience to assist in helping it meet its legal duties. Solent NHS Trust meets this obligation with the appointment of a Trust full time Health and Safety Manager, and other competent persons are in place regarding estates management, with specialist advisors for fire safety, local security management, and environmental management.

Solent have remained legally compliant (with section 2 (3) and **section 2 (7) HASAWA**) with the Chief Executive Officer (CEO) demonstrating and endorsing to staff, patients and other stakeholders Solent's commitment to health and safety with the signing in December of the health and safety policy statement of intent. The CEO has continued to endorse the appointed Chair (Chief Nurse) with executive lead responsible for health and safety as Chair of the Health and Safety Group. During 2022 / 23 the Chief Nurse changed however the new appoint Chief Nurse continues in the same role, so the terms of reference and the health and safety policy roles and responsibilities weren't changed.

A copy of the signed Health and Safety Statement of Intent can be found in Appendix A.

The Health and Safety Group is compliant in fulfilling its requirements with the representation of both elected accredited unionised representatives of employee safety and non-unionised employees in accordance with the Safety Representatives and Safety Committee Regulations, and the Health and Safety (Consultation with Employees) Regulations and is working effectively with an open culture where attendees are playing an active role in talking through decisions about health and safety to identify joint solutions to issues being raised

The Health and Safety Group met quarterly remotely via Teams on 26th July 2022, 31st October 2022, and 17th January 2023 and 25h April 2023 and all were quorate according to their terms of reference. To support continued attendance and quoracy of meetings the groups secretarial cover issues pre meeting reminders to members to help ensure either representatives or their informed deputies attend. Action/decision actions and minutes are completed and made available. Issues that need escalation are highlighted to QIA and/ or the Board

There are 7 outstanding actions recorded on the action tracker from this year's Health and Safety Group programme and these will be carried forward to next year and will be actioned in quarter one 2022/2023, these outstanding actions have been assessed and carry minimal risk.

Changes in Health and Safety legislation is a standing agenda item on the Health & Safety Group, although for the second-year running has shown a drop in consultation /changes from the Health and Safety Executive during 2022/23, from a health and safety perspective, it will remain as an agenda item to ensure compliance, but also as an opportunity to improve performance

Review outcome and action of the key items are shown below, and any impacts are reflected within organisational policies, Standard Operating Procedures and / or practices

Legislation	Review Outcome	Action taken	Carried forward from Previous year Update

Fire Safety Regulations and Building Regulation	Independent review of building regulations and fire safety to define clearer roles and responsibilities throughout the design and construction process, as well as during a building's occupation.	This was carried forward from last year further update shown below	
The Health and Safety Executive welcomes the Government's Draft Bill to Improve Building and Fire Safety in England	HSE would create a new Building Safety Regulator (BSR). HSE is currently working with other parts of government, key regulators, and industry to establish how the new legislation can be implemented in a practical way and create a new regime that improves building safety standards. The measures contained in the Building Safety Bill (just published at time of report) are unlikely to come into force until 2022.	No action taken as awaiting outcome. Review looks like it initially is related to multi floored housing building only.	The Building Safety Act 2022 introduced a more stringent, regulatory regime for England to make sure that residents living in high-rise buildings are safe and feel safe in their homes The Act underpins the safe design and construction of HRBs through three mandatory gateways processes The Building Safety Regulator (BSR) embedded within the Health and Safety Executive (HSE) will regulate the safety of all buildings in England
Revision of limit values in EH40/2005 "Workplace Exposure Limits - Carcinogens and Mutagens''	6 additional new occupational exposure limits values (OELVs) and amends a single existing OELVs for substances to help protect workers from the ill-health	Applied directly onto the Sypol COSHH Assessments Closed	
Personal protective equipment (PPE) at work regulations	Duties unchanged but extended Under PPER 2022, the types of duties and responsibilities on employers and employees are extended to limb (b) workers In the UK, section 230(3) of the Employment Rights Act 1996's definition of a worker has 2 limbs: Limb (b) describes workers who generally have a more casual employment relationship and work under a contract for service. PER 2022 draws on this definition of worker and captures both employees and limb (b) workers:	Discussions held with appropriate stakeholders. No Action required as all people whatever their role are provided with suitable PPE.	This was reviewed again in April 2022 due to minor changes made via parliament control processes which didn't require any dither changes Closed
HSE Harmonised classification and labelling consultation ECHA public consultation: call for comments	The Great Britain Mandatory Classification and Labelling (GB MCL) process includes the consideration of information gathered from public consultations, conducted by HSE or international bodies such as the European Chemicals Agency (ECHA). ECHA has announced a public consultation on the numerous proposals for harmonised classification and labelling (CLH)	No action taken as awaiting outcome. Review looks like it initially is substances used for crops but may affect the British bee which in turn could affect ant issues around usage of pesticides through grounds and garden contract review process	No action required due to use Only on Crops However, as part of soft FM contract around maintenance of grounds and gardens to protect bees we Solent band the use of pesticides, fungicides, and herbicides. If beehive found, then contact with the local bee association takes place. Closed

	active substances registered under REACH		
HSE Heat warning: Employers must prepare for a warmer future	After record-breaking temperatures and with more hot weather expected Employers need to act to make sure their workplaces are ready for warmer weather in the future	Meeting held with Estates Colleagues to establish plan of mobilisation of some air con units inclusive of maintence into key locations created and implemented. Closed	

Section 3: Project Fusion

Integrated Care System (ICS) report

Health and Safety Workshop, number of meetings held with colleagues in Southern Health to discuss an approach regarding the pro and cons of existing arrangements to formalise a programme management going forward.

Outcome

Health and Safety Workshop

1. **Resources and governance.** Have started to compare management structures.
2. There was some variation in approach around **Risk Governance, Management and Assessments** Trying to combine key components / good ideas in a standard approach.
3. **Reporting** –Capture key Ulysses cause and sub cause groups. Providing examples of reporting.
4. **Index of policies** with review timelines so we can summarise what the similarities and differences are and merger pf policies going forward. Policies prioritised against statutory requirements.
5. **Training list** core specific health, safety, security, and fire training courses being created and delivery methods. started to compare.
6. **Benchmarking** – this will need further work, as data being provided as a basis for the next meetings

Ongoing all reports now being passed through the Project Fusion Program leads

Policies and Procedures developed or reviewed by the Health and Safety Manager and approved by relevant Groups during 2022 /2023 were:

- Central Alert System (CAS) Policy
- Health and Safety Policy roles and responsibilities job title reviewed to capture new appointed Chair of the health and safety Group (Chief of Nursing and Allied Health Professionals), and review of the terms of reference. approved via Policy group Chair's actions.
- Safe use of display screen and mobile devices Policy
- New Mental Health Environmental Risk Management Policy

Section 4: Proactive Assessments and Inspections

Control of Substances Hazardous to Health (COSHH)

During 2022/2023 Solent remained compliant with the COSHH regulations as all assessments are suitable and sufficient, after engagement with service lines in establishing a reduction of the number of substances used has resulted in for the third year running the total number of COSHH assessments being reduced from 248, down to 229 and now during Nov, Dec, Jan, Feb, and March 2022/23 reviews took place and has shown a further reduction down to 213 COSHH assessments.

The online HSE approved COSHH management system there are no substances flagged for restriction of use as all assessment and mitigating controls have been adopted. **Fully compliant**

External Medical Gas and Above Ground Oil Storage Compound Generator Facilities assessments

All of Solent's external oil and medical gas storage compounds, medical gas storage a facilities and Generator Facilities had a routine assessment against applicable NHS guidance and HSE legislative requirements

Spillage response kits installed where necessary **Completed**

Mental Health Environmental Risk Management Assessments "Previously Ligature assessments" Actions undertaken

- New Mental Health Environmental Risk Management Policy(Rewrite of previous AMH007 Ligature Risk Assessment Policy) approved July 2022, as part of this review process the NHS England and Improvement Alert issued to avoid recording lower-level ligature points as "low risk" and the removal of the Manchester Tool was taken into consideration so a new three step process environmental risk review was created (Mental Health Environmental Risk Assessment Review Tool, Other Identified Environmental Risks Table and Environmental Risk Assessment Mitigation Protocol)
- All completed assessments are on Solent where all clinical staff have access which highlights ligature risks, mitigations, any actions required, Hard copies also held on site
- These reviews are all within date and are reviewed and signed off via the Ligature Management Group who meet monthly.
- Clinical teams review sites regularly and update accordingly. Environmental risk review tracking sheet utilised to ensure completion

Conclusion all assessments are compliant with CQC recommendations and all latent risk when it comes to ligature management has a balanced approach around the physical environment itself and the Clincal interventions adopted

Going Forward

- A plan has currently been set up with the intention of completing all the assessments throughout the summer months
  The action tracker below is used to record assessment review dates

Tracking%20Sheet%
20V7%20July%20%2(

- Working with the design time to minimise all ligature points during re-developments.
- Working with services to prioritise any works and support in future training and raising awareness

Project Fusion ligature Management

Ligature management due diligence and Friends review documents completed
Ligature Management is not specifically identified anywhere else with the project Fusion so currently being covered under the health and safety element of the Estates Steering Group on behalf of Clinical for now.

Falls Prevention Work Streams during 2022/2023

To support the Clincal ward by ward Falls Environmental audit undertaken aSlipAlert Slip resistance testing machine was purchased and HSE approved accredited training undertaken. In each in patient area a pendulum slip test to measure slip resistance of the floor surface has been undertaken Refer to action tracker below

Results of findings will be finalised and feed back to the falls group, and records held Solent's online MiCAD data base
Initial finding hasn't highlighted anything significant

2023%20V1%20Pen
dulum%20test%20tr

On-Going

Proactive health and safety activities planning during Q4 and the following year
Accessibility, Access Assessments
The assessment is to carry out a review of the property using the Accessibility Access and Building Equality Impact Assessment, the inspection has been to comment only on the physical aspects of the buildings in terms of barriers to access. Whilst building works might be a solution, they will not be the only solution. There will be alternative ways of resolving
by changing the way that a service is provided either by relocating it to another more accessible position in the building or by providing remote access to the service using digital technology solutions.

A range of alternatives could be developed and costed as part of a further stage, but this is outside the scope of this document.

Creation of Solent's Disabled Access and Building Equality Impact Assessment based on:

- BS 8300:2009 Code of Practice for the Design of Buildings and their approaches to meet the needs of Disabled People.
- The Building Regulations Approved Document Part B, E, K, M and N.
- BS 5588 Part 8 9999 Fire Precautions in the Design and Construction of Buildings: Means of Escape for Disabled People.
- National Disability Code of Practice.
- Disability Rights Commission - Code of Practice. This is to determine the suitability of the accommodation in respect of Disabled Access.

Disabled Access and Building Equality Impact Assessment via the Disability resources group approved.
Creation a programme of assessments for all Solent owned and fully leased buildings.

2023 24 Accessibility Assessment Tracking

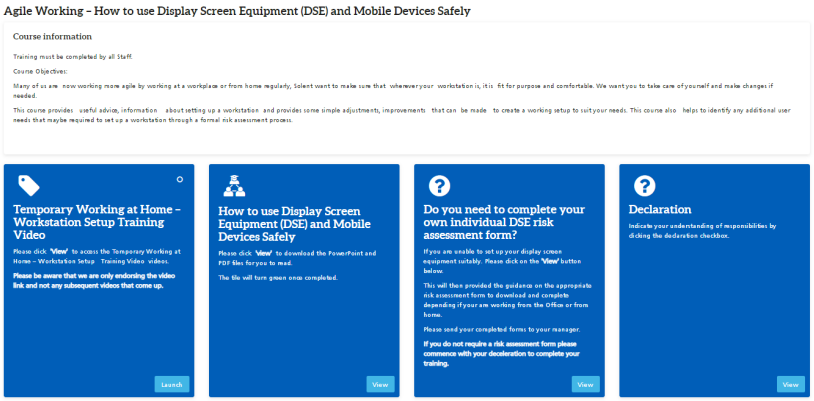
On Going

Section 5: Additional Covid Work Streams

Actions taken

Working collaboratively with key stakeholders regarding the legal elements of working at home, information/instructions on safe ways of working, looking after your mental welfare and training

- DSE Workstation Assessment Checklist and the Home Working DSE Self-Checklist
- Creation of online Agile working training package



Subject: Facefit Testing Programme

As of Jan 2022, the face fit testing was passed onto and now sits under the Health and Safety Manager

Actions taken

- Arrangements made with the Department of Health and Social Care to provide temporarily free trained fit tester who are deployed on an ad hock bases to Solent to assist with the new face fit testing requirement continued throughout the year
- FFP3 Resilience paper presented at QIR 10/10/2022 requesting to in source our own face fit tester

FFP3 Resilience Review Report temp

- In source dedicated face fit tester approved and appointed who can be more adjustable on their support by moulding the approach and delivery around service needs
- Prioritisation of approach retesting programme of high potential staff who may be more likely to have exposure to Covid created (in patient settings Clincal staff, Dental, Physio, community nursing etc)
- Currently have over 110 new and retests booked and reported quarterly via the health and safety group

On Going

Subject: Reusable Respiratory Protective Equipment

Consultation continues with the specialist dental service around the audit on filter function on the daily checks for the Stealth and GVS Eclipse reusable respirators, adjusted check sheet and have also extended the filter life duration and replacement after (days used in the respirator or after hours of clinical use) **On Going**

Subject: Reception screen project

During the first wave of the COVID-19 coronavirus pandemic we took numerous steps to implement safety measures, the installation of physical barriers was an effective way of protecting staff and the public from the spread of the virus.

A reception screen project still running and as and when new receptions are either built or renovated the new approved (IPC, Fire Advisor, ASMS and HS Manager) Pathodan screen is being installed **On Going**

Section 6: Compliance and Assurance

External agencies and reporting of incidents

The Health and Safety Manager can confirm that there were no investigative proceedings being undertaken regarding breaches of health and safety legislative requirements or the Environmental Protection Act by either the Health and Safety Executive or the Environmental Protection Agency. Solent NHS Trust has not received a visit from any external regulatory agency, either pre- planned or because of a specific incident or complaint during 1st April 2022 to 31st March 2023.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR applies to a set of reporting requirements for work activities in Great Britain; the main purpose is to provide reports, where appropriate, to the Health and Safety Executive and to the Local Authorities. Solent were 100% compliant with all reportable incidents under RIDDOR being reported within the stipulated time frame.

Tables below break down the incidents by subject/ affected personnel and % RIDDOR per total no of incidents reported in same year – 4-year comparison

Year	No of reportable RIDDOR's	Direction of change	% RIDDOR per Total No of incidents reported year to year comparisons

2022/2023	20		1.68%
2021/2022	8		0.86%
2020/2021	4		0.55%
2019/2020	9		0.74%
2018/2019	5		0.5%

Staff or member of Public	Location	Injuries	Incidents
Staff	Solent Property	Injury preventing the injured person from working for more than 7 days	4
Staff	Community	Injury preventing the injured person from working for more than 7 days	2
Staff	Solent Property	Incidents involving, biological agents	14

Dangerous Occurrences

Due to a Covid outbreak within Older Person's Mental Health (OPMH) Unit after a comprehensive investigation in identifying current practices by staff being followed (face mask worn in accordance with current WHO and IPC guidelines suitable hygiene practice), identifying the index case, subsequent timelines of positive staff LFT's , incubation periods and the cohort of patients (wanders, invasive of personnel space etc.) there was reasonable evidence that more likely than not this staff member caught Covid at work there were 14 dangerous occurrences reported by the Health and Safety Manager to the Health and Safety Executive.

When a RIDDOR is identified the Health and Safety Manager investigates all RIDDOR incidents providing support and will continue to work with departments to further improve the quality of investigations undertaken and sharing of lessons. Lessons learnt were recorded on all RIDDOR incidents**. Fully Compliant**

Medicines & Healthcare products Regulatory Agency Central Alert System (CAS)

Solent NHS Trust receives safety notices and alerts from several agencies that require consideration and in many cases action by managers and employees. Methods of receiving alerts and notices are through the MHRA Central Alert System (CAS). Internally these alerts are appropriately cascaded to Solent NHS Trust. Services nominated points of contact to whom the notices can be acted upon accordingly.

The table below shows the numbers and breakdown of the type of alerts received via the Medicines & Healthcare products Regulatory Agency Central Alert System (CAS) for 2022/ 2023

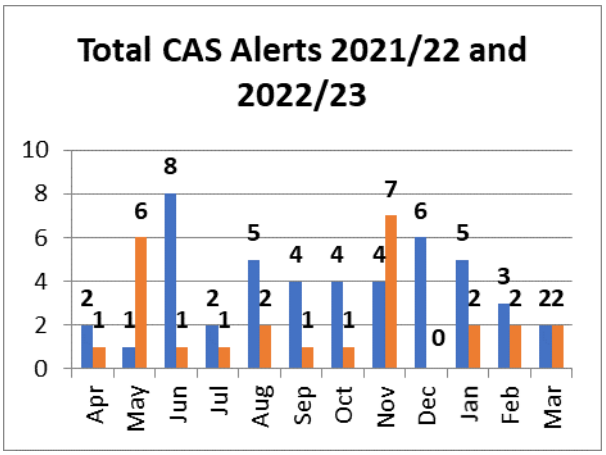
Types of CAS Alerts 2022/23

CAS Alert	Civil Emergency Messages - Medical Device	Civil Emergency Messages - Drug	National Patient Safety Alerts - Medical Device	National Patient Safety Alerts - Drug	Supply Disruption Alert (Drug)	Medical Devices Safety Bulletin	CAS Helpdesk Information Bulletin	Serious Hazards of Transfusion	Civil Emergency Messages - Virus Alert	CAS Helpdesk Team - Instruction to CAS Officers

Total	0	10	4	1	7	0	1	0	1	2

The CAS Officer can confirm that all 26 alerts received were acknowledged within the stipulated timescales and all alerts have been disseminated to the appropriate groups; replies received / tracked and all alerts are compliant with each alert timescale back to the MHRA.

Year to Year Comparison



Summary
Year to Year comparisons chart shows the trends for the last two years of the total number of CAS Alerts. From 2021/22 yearly total of 46 down to 2022/23 yearly total of 26 Circa 43.4% overall reduction

* On 19 September 2020 MHRA issued CHT/2020/002 which stated that, from that date, Medical Device Alerts will no longer be issued. When safety issues with medical devices meet the criteria of a National Patient Safety Alert these will be issued as NatPSAs.

Other MHRA Alerts (not via CAS website

Other MHRA Alert	Public Health Message	Medicines Recall Alert	Medicines Defect Information	Medical Devices Updates (sent to MDSO)	Urgent Heat Health Alert	Medicine Supply Notification	Field Safety Notice Medical Devices (sent to MDSO)
Q4	6	19	27	5	2	3	1

* These are alerts that the MHRA has stipulated do not require a system-wide response, they email the CAS Alerts Administrator for dissemination in the Trust.
The MHRA does not record these alerts on the CAS website or require feedback
The Trust's CAS Administrator sends the alerts to relevant contacts and maintains the alerts in the CAS inbox

Going Forward:

Patient Safety Strategy Project Group
CAS Policy and the Medicines & Healthcare products Regulatory Agency Alert management currently being reviewed as one of the many Patients Safety Strategy work programmes
Work steam 4 National Patient Safety Alerts requires Solent to consider.

- The system for the receipt and actioning of NatPSAs.
- An organisational – wide coordination of response with executive oversight, led by appropriate
  senior healthcare professional(s)
- Executive authorisation and assurance that all actions are complete.
  Board aware of a record of non- compliance with alerts by their designated deadline.

On going

Background work is being undertaken by Quality Systems and Development to utilise the Ulysses Alert Module potentially to start next financial year.

CAS - NPSA alerts meetings held launch of the Learn from Patient Safety Events (LFPSE) on Ulysses in quarter 3 therefore the. alerts module implementation planned during August 2023.

Section 7: Annual Security Management Report

The Accredited Security Management Specialist (ASMS) for Solent has continued in 2022/23 to work to deliver an environment that is safe and secure for all; and continues to ensure that the highest standards of clinical care can continue to be made available to patients. The aim of the ASMS continues to be the protection of NHS staff, resources and infrastructure from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients. Ultimately, this helps to ensure the proper use of valuable NHS resources and a safer, more secure environment in which to deliver and receive care.

The key part is the introduction of the ASMS into each sector of the organisation. As the ASMS role is designed, to provide professional skills, Knowledge, and expertise to tackle security management concerns across a wide range of proactive and reactive issues.

The NHS England Violence and Prevention Reduction standard has now been in place since 2022 but the Standard contract still states that the Trust should have regard to it and doesn't elaborate further on the work streams required to use it. Therefore, until this becomes accepted widely across the NHS this security management annual report will therefore be of a slightly different layout. The report will still hold all the data and information around the years' work in the governance of information, informing and involving, the holding to account of persons and the prevention and detection of crime.

Self-Review Tool (SRT)

The New NHS Standard Condition 24 means that there is no requirement for a Self-Review Tool (SRT). But the ASMS is working on Trust specific SRT and Standards that will work for the new premises taken over as part of the Project Fusion. This work will start now and filter out into late 2024 and will provide us with up-to-date information and to ensure all our sites are getting the right resources.

Investigations

Part of the ASMS role is the Investigation of Incidents (Criminal and Civil) as these may not fall within the public's interest or are unlikely to result in a realistic prospect of conviction due to lack of evidence or doesn't fit current policing triage model. Offences may have been finalised or no further actioned (NFA) by the Police but there could still be evidence that would help the trust to maybe consider a civil remedy or look at possible disciplinary matters.

The ASMS will always attempt to hold to account those offenders who commit crime against the trust. The ASMS also supports the Local Counter Fraud Specialist (LCFS) in any fraud cases where collation of evidence or information is required as per Service Condition 24 (PG33) of the standard contract.

The ASMS also assists with other complex investigations in accordance with CPS and evidential guidelines as well as 2021 NICE Investigate. Interviews will be conducted in line with police and criminal evidence act (PACE) including all interviews under cautions (IUC). This will ensure that any evidence that is collected is done in a timely manner and is up to the required standard with all regard to the continuity of evidence. This will also include working towards the incident reporting investigation and learning policy. All Investigations are undertaken in compliance with relevant and appropriate legislation governing those and criminal investigations:

The ASMS also report to any partnership agencies within a timely manner to ensure that staff and victims are fully supported during difficult times (i.e., H&S, Information Commissioners Office, Local Authority and CQC).

Investigations Commenced in April 2022:

14th April 2022 Damage to a Doctors car within The Limes was recorded on CCTV and passed to the Police for crime reporting under reference **INC-20220414-1256**. All statements and CCTV footage was gathered and provided to the Police as well as details of the named individual. Retrieval of CCTV took longer than normal due to the CGI/ TAC issues with loss of DVR. Police advised the ASMS that the incident (Ulysses Ref: 181321) might be finalised NFA but ASMS fought to get this overturned due to incident being outside of normal work structure and the Police had also sent the request very late. Case charged and sent to court

Investigations Commenced in May 2022:

30th May 2022 Damage caused to a PTZ Camera by Anti-Social Males at WCH was discovered by the ASMS during another investigation it became apparent that the damage had not been spotted by Security during review of CCTV since April 2022 when the incident occurred. The Incident was retrospectively reported to Police and has been already Filed (NFA) by Hampshire Constabulary as it is not regarded as a priority high harm crime and so will not be investigated despite good clear images and all statements and evidence gathered by the ASMS to CPS quality. Camera repair will be likely to cost the Trust over £1400 to replace with no means to hold anyone to account

30th May 2022 A Bates Engineer assaulted a young male (who was responsible for the damage to the camera previously) after he was on site with several others committing Anti-Social Behaviour The incident of assault was captured on CCTV and all evidence passed to the police in a CPS approved formatted file. Police advised that the case would be NFA the day after as the Male victim had not come forward, it was pointed out that they could finalise two crimes here by identifying the male but said they would not be investigating despite the males being easily identifiable, this was raised higher up for discussion with the Chief inspector who regarded this as not a high harm crime so would not be investigated under New Hampshire Police rules.

Investigations Commenced in June 2022:

20th June 2022 Break into Westwood House property via kitchen window broken with a brick and advised that some items had been removed from a room namely Gel hand sanitiser and used to set a fire off in the grounds outside, the damage was not discovered until after the weekend crime reported by head of Maintenance repairs and other concerns being raised with premise manager for site review.

Investigations Commenced in July 2022:

21st July 2022 The Review of Limes and Orchards CCTV, the CCTV system at the limes was reviewed as part of a recent SI investigation and for general audit purposes of all Solent CCTV systems, lessons learnt, and some changes were requested in the way that staff check CCTV system on a regular basis. We are now looking at a backup drive system for failures in the future.

26th July 2022 Sniffer dogs were Provided at the Limes and Orchards to conduct contraband checks of all patient areas and bedrooms, dogs did detect a few substances and those that were found with were dealt with as per trust policy. This may now become a regular occurrence twice yearly but will be based entirely on suspicion and or necessity.

Investigations

Commenced in August 2022: **No ASMS Investigations Conducted**

Commenced in September 2022: **No ASMS Investigations Conducted**

Commenced in October 2022:

7th October 2022 incident in the staff cut through next to Rodney Road, a staff member was approached by members of the public intentions unknown, staff were concerned regarding their safety on site. The incident was reported to the ASMS and estates. ASMS recommended new gates and NET 2 Access which has now been installed and awaiting commission due to NET 2 Issues as well as installation of new lighting within that area.

10th October 2022 Staff at St Marys supported by great partnership working (ASMS and H&S Manager) regarding an appointment with a difficult relative of a patient who has been banned from several NHS establishments for their continued behaviour towards staff. Great intelligence sharing among the NHS staff, and we were able to host two of these much-needed appointments with extra security provision to increase security on site, all went off without issue.

Commenced in November 2022:

4th November 2022 staff member was assaulted by a patient, reported via Ulysses and the Op Cavell process where police investigated. The ASMS provided CPS formatted statements and CCTV evidence to the local police, the victim was contacted by police and between them agreed a way to proceed. Showed good use of the Op Cavell process, victim is happy with action and outcome.

5th November 2022 Damage to a digger was conducted by same teenage males as April and may over the weekend, the digger was provided for CCTV groundworks during the run up to demolition of the old building (Tannersbrook). reported to police and CCTV footage provided to assist with any identification. Incident went unnoticed by Porters on CCTV and therefore was retrospectively recorded the following Monday morning with police, NFA due to not being a high harm crime despite the damage being around £18,000-20,000.

7th November 2022 Thefts of insecure property from various staff rooms reported to the ASMS (AMH). Thefts despite not hitting the police threshold for investigation also had limited evidential material so would have been unlikely that any investigation would have occurred. Despite them not hitting the threshold victims were encouraged to still report for intelligence purposes. Staff have been reminded to secure their valuables and to avoid bringing in expensive items of value to work. Staff have been reminded of the section 3.2.4 of the physical security Policy around the securing of their own property no further thefts have occurred since raising awareness and placing new lockers in the service (see January 2023).

Investigations commenced in December 2022:

16th December 2022 Nuisance phone calls, to services with no evidence of callers' number were reported to Police but no lines of enquiry existed to further the case. Staff were supported and training in nuisance calls to be given to the team in the very near future. Update around the information to gather and the ways in which to record the caller so that evidenced is present

Investigations commenced in January 2023:

13th January 2023 Multiple items were reported missing from a female changing room in the Limes/ Brooker, over a period in January with items going missing regularly a staff member was suspected due to the location and accessibility of the area. A meeting was organised by the ASMS to look at the situation with the service and H&S Manager. Due to the lack of CCTV in that area due to privacy it was not possible to report the thefts to police staff were advised they could but with the inability to glean any evidence of the theft or know who was responsible, sanctions and holding to account would be difficult and unlikely to meet the threshold of prosecution. Changes resulted in staff being advised to ensure that lockers provided were to be used and it became apparent that more lockers were required. These have been provided and staff have been advised to use them for items of personal nature but asked not to bring valuable items in to work and leave them unattended.

Investigations commenced in February 2023:

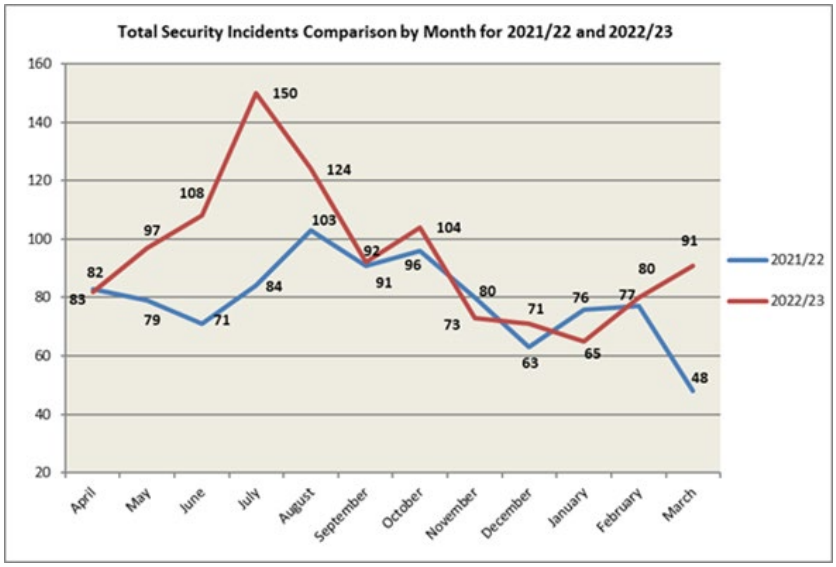
10th February 2023 report of a suspicious male was received via Taplin's Nursery at WCH of an unknown male taking photos of the garden area, children were moved to the inside quickly due to some of the children being on protection orders. The estates and security team raised the query straight away and were very quickly assisted by Estates and projects teams to determine the person present was genuine and had been taking photos for some upcoming building work. Regarded as a miscommunication but it showed quick thinking and diligent work by estates teams with enquiries

made quickly to realise that it was genuine reason for the contractor being there. Good communication in a potentially difficult situation involving minors

Investigations Commenced in March 2023: No ASMS Investigations Conducted

Statistical incident overview

Overall Comparisons by Month for 2021/22 and 2022/23 (Security data):
The below Tables are a statistical overview of all security incidents with comparison from **2021/22 to 2022/23**, this data has been provided from Ulysses of all incidents that have been recorded. There was a **19.5%** increase from **951** Incidents to **1137,** incidents the majority of these increases are in relation to Aggressive Verbal Gestures (AVG) incidents patient to staff in AMH due to the acuity of patients.



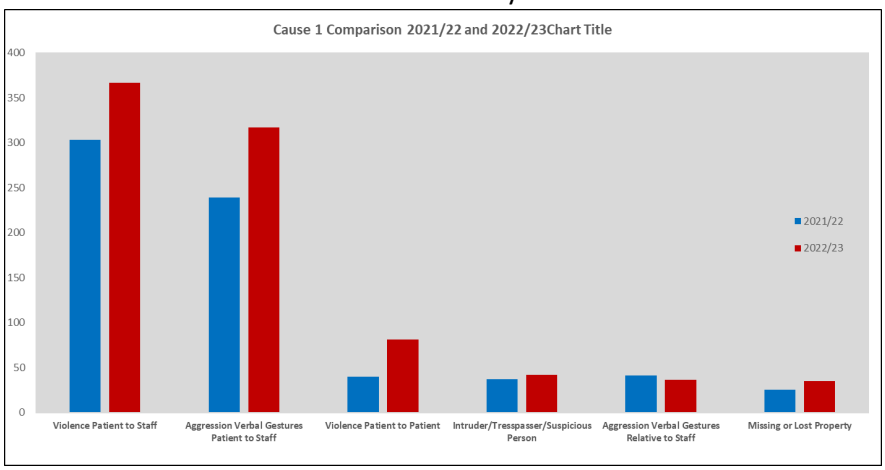
Month	2021/22	2022/23
April	83	82
May	79	97
June	71	108
July	84	150
August	103	124
September	91	92
October	96	104
November	80	73
December	63	71
January	76	65
February	77	80
March	48	91
Totals	**951**	**1137**

Cause 1 Comparisons 2020/21 and 2021/22:
The below Table shows the Cause 1 comparisons incidents for the top 6 affected cause types, Violence Patient to staff remains the highest affected Incident Cause in **2022/2023** financial year compared to **2021/2022** year.

Cause 1 (Top 6)	2021/22	2022/23
Violence Patient to Staff	303	367
Aggression Verbal Gestures Patient to Staff	239	317
Violence Patient to Patient	40	81
Intruder/Tresspasser/Suspicious Person	37	42
Aggression Verbal Gestures Relative to Staff	41	36
Missing or Lost Property	25	35

The below tables show that there has been an increase in Cause 1 Comparisons between **2021/22** and the **2022/23**. There has been an increase in

- Violent Patient to Staff Rose by an extra **64** incidents from **303** to **367** incidents between **2021/22** and **2022/23**.
- AVG (aggression verbal gestures) Patient to Staff Rose by an extra **78** incidents from **239** to **317** between **2021/22** and **2022/23**
- Violence Patient to Patient Rose by **41** incidents from **40** to **81** between **2021/22** and **2022/23**

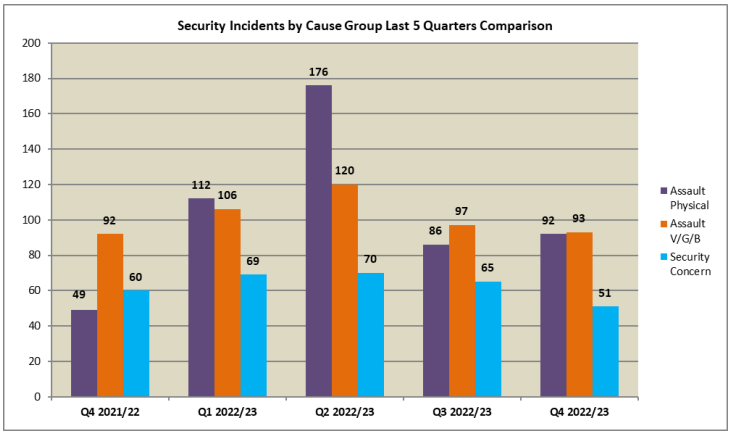


Incidents by Cause Group Last 5 quarters 2020/2021 to 2021/2022

The below table shows the incidents by cause group for the last 5 quarters and covers Assault Physical, Assault VGB (Verbal Gestures, Bullying) and Security Concerns overall.

Cause Group	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
Assault Physical	49	112	176	86	92
Assault V/G/B	92	106	120	97	93
Security Concern	60	69	70	65	51
Total	**201**	**287**	**366**	**248**	**236**

As you can see there have been numerous decreases and increases but Assault Physical and Assault VGB which remains our most affected incident cause. The worst affected Quarter was **Q2** with **366** incidents. This peek was due to 3 patients in separate units causing multiple incidents daily. Those Patients were discharged, and the numbers returned to a more normal range. The best quarter was **Q4** with **201** incidents where Assault physical dropped to our lowest at **49** incidents in **2021/2022**



Security Concerns remained fairly level with a peek in **Q1** and **Q2** **2022/23,** but this was during a heat way and so all incidents rose in some way. There was a drop to **51** incidents in **Q4** **2022/2023** our lowest yet

Assault VGB peaked and troughed in the last 5 quarters with **Q2** **2022/23** being our worst yet amassing **120** incidents. Our lowest was **Q4** **2021/2022** hitting **92** incidents.

CRS (Crime Reduction Surveys)

A Key part of the ASMS role is to conduct security surveys of premises and assets and they can be either proactive or reactive. Each survey may be triggered by something being witnessed or brought to the attention of the ASMS by staff to highlight security issues within Solent property that's owned, controlled, occupied, or leased.

The ASMS attends conducts the review and then creates a report which then provides recommendations on improving various layers of security working from the outside in. this process looks at safety and security and can in some cases be done in connection with Fire safety officer or the health and safety manager. The process is designed to address issues relating to security on site (Perimeter security, Access Control, business continuity, Policy, and Procedure).

The CRS is populated with up-to-date crime data sourced from a police website, where crime data is uploaded from each of the 43 forces quarterly. The website (WWW.POLICE.UK) provides all crime data to better reflect what might be needed, as it provides data on the type and severity of each crime the percentage of each crime and the outcome police have given, this can in some cases help to influence decisions made.

CRS surveys completed in 2022 / 2023 financial year:

CRS Reviews 2022/2023	
1. GWMH Staff Parking 27th April 2022	2. Impact of Dual Role 30th June 2022
3. Theft of Medical Gas 8th September 2022	4. Brambly Grange Dental Security review 22nd September 2022
5. RSH Security / Parking Review 4th October 2022	6. Delme Place Nursing Training wing 18th October 2022
7. Jubilee House Security Review Refurb 30th November 2022	8. Sexual Assault Referral Centre 30th November 2022
9. Rodney Road Security Report 18th April 2023	10. PIA Drone Footage WCH New Build 16th January 2023

LOCKDOWN PROCEDURES AND ACTION CARDS

Changes to Lockdown procedures have been made and as such many of them had expiry dates when they were not really required as over 80% of them just had date changes made so after discussion with the EPRR lead we have decided to change and update lockdowns when any new legislation arrives or when changes to the footprint of the building and its fabric are made.

It is currently sitting at around 95% of all lockdowns in place with some on hold due to changes and refurbishments taking place. The number of lockdowns has been reported to the H&S group and EPRR team through the EPRR leads at their own meetings.

Policy Reviews
The ASMS has reviewed and recommended the update of several Solent policies over the last financial year to ensure that information and procedures are up to date and are effective in ensuring that staff remains aware of what is expected. These will be reviewed further in 2023/24 due to the project fusion.

Polices Reviewed:

1. Policy for Security and Management of Violence and Aggression (PMVA) May 2022
2. Surveillance Camera System Policy (former CCTV Policy) March 2023

NHS COLLABORATION / PARTNERSHIP WORKING
The ASMS continues to build relationships with outside partner agencies to enhance the service provided to the Trust since, these relationships allow the Trust to continue to create a pro security culture among staff the ASMS will attend any Webinar, conference, and other meetings to gather intelligence, information around upcoming changes to the NHS and the security fields.

The following are listed to show the Partnership working.

NHS England
NHSE is one of the regular partnership organisations the ASMS continues to meet with such as webinars and conferences that they hold for all trust staff especially in relation to the NHS Standard contract Condition 24 (V&A) Violence and Aggression there is ongoing work to determine the future of VPR.

Local Counter Fraud Specialist:
The ASMS has assisted the LCFS in the prevention of fraud against the trust and assisted them in distributing alerts trust wide but has only been involved in one possible IG related incident that was quickly assessed and proven to be a concerned staff member who was not fully in receipt of all the evidence and therefore was not an IG incident.

CDLIN Controlled Drug Liaison Network
The ASMS has attended meetings of the CDLIN where the discussion of medicine and prescription safety is conducted, all medical professionals with a link to pharmacy and investigation of incidents can attend these quarterly meetings to discuss best practice and look at the changes in law and legislation around the safety and security of medicines, gases, and other valuable assets.

Dates of Meetings:

- 9th March 2022, 21st September 2022, 7th November 2022, 2nd May 2023

CSSC (Cross-Sector-Security-Communications alerts)
There was **15** CSSC briefings shared with relevant stakeholders this financial year, CSSC system messages are created and submitted as regular updates from the cross-sector security communications which is a government agency. These messages are sent to Local Police forces across the UK, all organisations signed up to the messages such as NHS, and private companies and organisations, these are provided for planned events such as terrorism, anti-government protests, anti-abortion. The ASMS receives these messages roughly every 2 weeks unless threat or changes in certain law requires that one is sent, they are therefore forwarded to the relevant stakeholders. As soon as they are received.

Conclusion and Going Forward:
The ASMS will be concentrating on the changes to security concerns that have been raised by the government agencies where they have expressed concern over older technology and technology from

some specific countries, Namely CCTV and Access Control systems. Much of the advice has been to only use these cameras within public areas and ensure they do not look at sensitive areas. The Trust does have some of these cameras due to their availability and the fact they are affordable, but we do not have any of these systems in our sensitive areas (The orchards, the Limes and Kite unit) these use British or American made systems that are standalone and are not connected to the internet (Mobotix and IDIS) these systems are not affected or discussed in security service briefings, advice is to remove them if they are in sensitive areas immediately.

The Orchards CCTV

The CCTV within the Orchards is a Mobotix system and is around 15 years of age and needs some much-needed upgrade to a new system. The current system has several blind spots that were highlighted during a death in the unit and a programme of daily checking has had to be introduced to ensure that it is recording after some concerning dropout of the recording system in 2021. The aim will be to review the CCTV system and recommend a new system to be procured and fitted in the new financial year.

Net 2

The Trust currently uses Net 2 technology that is around 10 years old to run its access control system despite there being much newer Technology from Paxton. The tech has started to cause issues with accessing and setting up users and doors. This may be due in part to the way in which Solent has set up the access partitions or that Net 2 is starting to show its age. Net 2 at this stage may not be the safest and most secure technology to safeguard our sensitive areas and so maybe we need to look at newer technology as the current system may not be protecting the trust as well as it could be. The ASMS wishes to review the use of Net 2 in the next financial year and work with all relevant stakeholders to look at alternative solutions or solution to speed up and make the current system more robust.

Section 8: Annual Fire Management Report

Fire Safety Advisor and Estate Projects

The Fire Safety Advisor continues to be involved in numerous new Estate's project work during this year from the planning stage meetings with architects, mechanical and electrical engineer consultants and the building contractor. Support continues with on-site construction inspections and through to final testing of fire and ventilation related systems, the testing of lifts and inspection of shafts, then finally building compliance inspection and agreement the premise or area is now safe for occupation.

Some of these projects have included: -

- The closing of the old Jubilee House building in Cosham and the transfer to a new ward in the Portsmouth City Council owned building called Harry Sotnick House.
- The continuing replacement and installation of new lifts at St Marys.
- Continuing refurbishment and repair of the mental health in-patient wards at The Orchards in St James Campus Portsmouth.
- The demolition of a ground floor wing and rebuild of a replacement 3 storey new hospital wing at Western Community Hospital, Southampton.
- Further refurbishment strip-out, repair and rebuild of the Bitterne Health Centre.
- New build Dental unit at Andover War memorial Hospital.

Collaborative Working

Harry Sotnick House: The new ward installed at this premise is on the first floor, as opposed to Jubilee coming from a ground floor situation which always makes emergency evacuation easier. The Fire Safety Advisor has worked with Portsmouth City Council, the CCG and Estates Officer to provide this new first floor ward with evacuation equipment, and then provided training sessions. The purchasing of equipment was hampered by the effects of manufacturing stopping during the Pandemic period, this caused a long delay in the delivery of a patient transfer trolley which is required to the transfer of bed-bound patients to achieve horizontal evacuation from one fire

compartment to another. In addition, the Fire Safety Advisor authored new Fire Procedure and Evacuation Protocols for Harry Sotnick House building as Portsmouth City Council did not have a fire officer at that time.

Somerstown Dental Unit: A project that continued from the previous year was Solent's Dental unit expansion at Somerstown in Portsmouth. This unusual community building straddles an inner-city dual carriageway. The Fire Safety Advisor who worked with the architect used his knowledge to re-design the fire compliance of the ground floor of this City Council building, the new fire plans where submitted, and permission was given for the go-ahead by Hampshire Fire and Rescue and Building Control.

As the new build progressed the project came to a halt when it was discovered that the original plans did not show that the ventilation system the implications of this was that all work had to stop until a resolve could be found. The Fire Safety Advisor proposed an acceptable solution and because of his knowledge of the necessary council departments over a week he got appointments with a myriad of council officials to get the new alteration plans accepted and necessary permissions given.

Trust Smoking and Tobacco Control Committee: The Trust Fire Safety Advisor was invited to join this Trust Mental Health Nursing Committee which is linked into the national consultation framework, he attended both national and trust meetings. The matters discussed and advice given helped to shape a new Trust Policy and Protocols.

Identified Concerns

During this year the Fire Safety Advisor has identified a concern that the Trust Learning and Development no longer have staff facing trainers, instead they have referred all face-to-face training to the Trust department's that deals with that specialism. This has given a heavy workload burden for one person specialism who have other priorities, and with the increase turnover of new nursing staff, plus the constant change in fire wardens as departments are moved around different or new buildings. This also has some relation to another identified problem identified to Trust management as agile working means there is often no or not enough trained fire wardens on-site. Both the above items are now being investigated by Trust management.

Fire Risk Assessments

The Trust Fire Risk Assessments (FRA) provides Estates with monitoring and feedback for remediation and assurance. Evidence of these assessments is held on the Trust MICAD system. Quarterly assurance reports are generated and sent to the Trust Health and Safety Group who oversee specific issues and actions.

Fire Risk Assessments (FRA) are subject to an FRA review on a periodic basis in accordance with Solent Fire Safety Policy

Further operational checks are carried out inclusive of, but not limited to, weekly fire alarm testing, monthly emergency light testing, annual portable fire equipment checks and annual fire evacuation drills. Evidence of these checks is held on the Trust MICAD system, also on the Estates maintenance electronic recording system

All of Solent NHS Trust buildings and landlord buildings where Solent have either the majority occupation or have significant size departments are compliant with The Regulatory Reform (Fire Safety) Order 2005 as all meet the criteria of a valid FRA in place because they are recent, regularly carried out, suitable and sufficient, and provided by a qualified person.

Risk ratings from both Fire Risk Assessments and operational checks are allocated against each site and an Estates maintenance tracking meeting of identified fire safety related risks is held with an Estates Officer. This process assists the production of the Maintenance Assurance Report presented at a monthly meeting with the Solent Estates Maintenance Management team.

During the year of 2022/23 all Estates FRA risk items identified in the Southampton, Portsmouth and near areas have been dealt with or are in the process of completion or sent to the Head of Estates Maintenance for inclusion in a forward programme of works.

Holding fire safety risk items for a following financial year is acceptable, if you can show that overall, you have balanced your financial ability with solving identified higher risk items (especially when they have been identified as items to receive immediate attention). To this end Solent maintenance Estates Officers have consulted with the competent person for fire safety to help Estates grade the identified risks in order of time and risk importance, these are then entered onto the Trust Estates Maintenance Risk Tracker which provides a constant up to date record.

Actual fire incidents reported during 2022/23 are as follows:
Q2 the incident labelled Fire-Other was youths trying to start a grass fire within the St James grounds, a member of staff alerted the site security. Investigated and complete
Q4 9/1/23 - RSH– night staff left a microwave unattended and had dialled too many minutes for heating the content, a small explosion of the contents caused damage to equipment, top and socket. Incident investigated and all remedial actions followed to completion and advise given to staff

Statistical Fire incidents reported 2022 / 2023
The Trust continues to have an enviable record on fire statistics which is achieved via a combination of staff fire training and fire risk assessments being more readily factored into Estate's maintenance and projects work: -

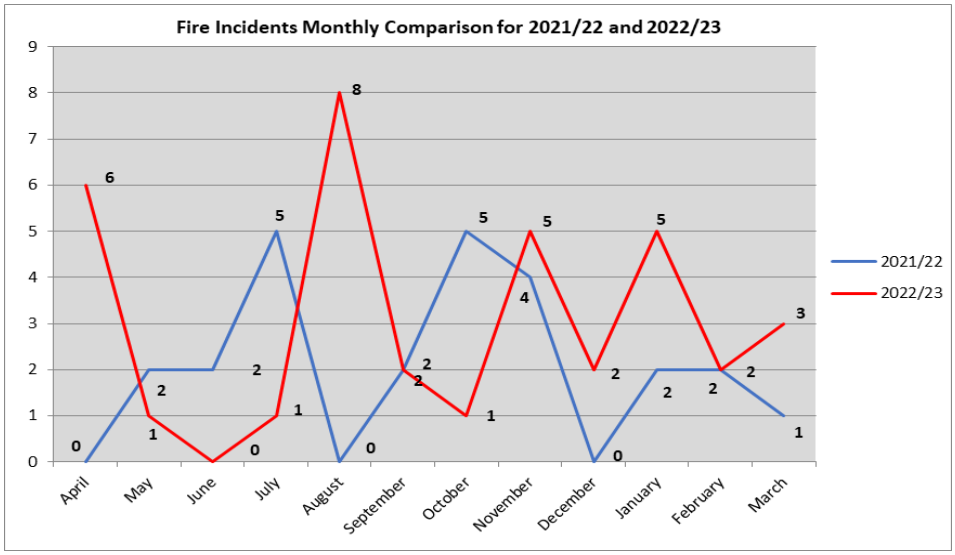
Actual Impact 2019/20 to 2022/23 Comparison

Actual Impact	2019/20	2020/21	2021/22	2022/23
1 - No Harm	**23**	**17**	**17**	**28**
2 - Near Miss (By Intervention)	**0**	**1**	**8**	**8**
3 - Minor, Non-Permanent Harm (Up to 1M)	**5**	**1**	**2**	**0**
4 - Moderate, Semi Permanent Harm (Up to 1Y)	**0**	**0**	**0**	**0**
5 - Major, Permanent Harm	**0**	**0**	**0**	**0**
Blank	**0**	**2**	**0**	**0**
Total	28	21	27	36

Cause 1	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
Fire - Arson	**0**	**0**	**0**	**0**
Fire - False Alarm	**4**	**7**	**5**	**6**
Fire - Accidental	**0**	**0**	**0**	**1**
Fire - Faulty Equipment	**0**	**0**	**0**	**0**
Fire - Hazard	**1**	**0**	**0**	**0**
Fire - Smoke Related	**2**	**3**	**3**	**3**
Fire - Other	**0**	**1**	**0**	**0**
Fire - Actual	**0**	**0**	**0**	**0**
Total	7	11	8	10

Cause 1 Comparison 2017/18 to 2022/23

Cause 1	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Fire - Actual	2	1	3	3	0	1
Fire - False Alarm	27	20	10	14	19	23
Fire - Arson	1	3	2	0	3	0
Fire - Faulty Equipment	5	7	1	0	0	0
Fire - Hazard	10	10	1	0	0	0
Fire - Smoke Related	10	7	5	0	3	11
Fire - Accidental	0	0	0	0	2	0
Fire - Other	29	8	6	4	0	1
Anti-Social Behaviour	1	0	0	0	0	0
Burns and Scalds	1	0	0	0	0	0
Equipment Accident Non-Medical	1	0	0	0	0	0
Lack of Security	1	0	0	0	0	0
Legal Subst Found - Not Permtd	1	0	0	0	0	0
Unknown Cause	1	0	0	0	0	0
Totals	90	56	28	21	27	36



Conclusion

There has been a small increase from 2021/22 of 27 incidents being reported to 2022/23 of 36 incidents being reported during 2021/22. Of the 36 incidents 28 were either attributed to 'No Harm' and 8 to 'Near Miss' (by Intervention) which proves a positive Trust culture of incident reporting. All near miss

incidents are scrutinised by the Fire Safety Advisor to determine if advice or training is required.

Continued Future Actions
The Fire Safety Advisor will continue to work with staff to provide fire strategy and evacuation training, and regularly meet with Estates to ensure improvements that will keep Solent NHS Trust in an enviable position with very low fire incident figures. The Fire Safety Advisor will be providing Fire compliance advice and knowledge for best practice on the continuing and forthcoming Trust build projects.

Section 9: Estates and Facilities Management Report 01 April 2022 – 31 March 2023

Operational Background: The in-house Solent NHS Trust estate maintenance provision completed its second full year in operation on the 31st of March 2023 following the transfer of responsibility from the previous commercial partner, Kier Workplace Services.

Statutory controls and constraints were applied to Solent's Estate Maintenance Department to ensure a rigorous level of statutory, mandatory and industry good practise maintenance and inspection is continuously carried out across all estate assets and engineering systems. This being prescribed by SFG 20 (Health) which remains a robust national database duly linked to any legislative change and administered within Estates via our computer-aided facilities management system (QFM®).

The demand for Hard FM related services has continued to rise over the period of post-pandemic recovery with significant pressure around the availability of space and environmental systems falling from the drive to reduce clinical backlog.

The number of physical assets recorded across the Solent NHS Trust Estate and subject to routine preventative maintenance activity has broadly remained constant at 13231 (from 13229 during 2021/22 reporting period). This number reflects both the loss of assets resulting from the demolition of Tannersbrook Ward at Western Community Hospital as well as additions of new geographical sites such as Delme 2, Fareham.

Operational Maintenance Dashboard: Statutory and mandatory maintenance was carried out to comply with Legislation, Good Industry Practice and NHS requirements and guidelines whilst keeping patients, visitors, and staff safe within all our built environments. For the reporting period the table below represents the planned and reactive maintenance activity along with a level of work attributed to misuse by service users:

Maintenance Activity Dashboard April 2022 – March 2023	
Planned Preventative Maintenance Tasks scheduled and completed.	**7006** *(5549 in 2021-22)*
Reactive/Corrective Maintenance Tasks requested and completed.	**6907** *(5709 in 2021-22)*
Damage/Misuse related tasks associated Reactive calls.	**524 (7.5% of reactive activity)** *(493 (9% of reactive activity) in 2021-22*

The summary overview is that PPM activity has increased due primarily to an increased directly employed workforce and better utilisation of specialist contractor resources. Changes in maintenance statutory and technical guidance have not significantly impacted the work plan over the reporting period. Reactive maintenance demand was, for a consecutive year, significantly up on the previous period and above pre-pandemic levels in part due to employees returning to the workplace an increased use of the estate and particularly hot record-breaking summer period which generated increases in plant and services breakdown rates.

Damage/Misuse associated defects whilst increasing in number by 31 events have recorded a reduction in percentage terms of 1.5% from the previous period though this is not considered to be a consequence of any pre-determined interventions.

General Compliance: The wider Solent Estates team have the responsibility for maintenance of all compliance documentation. To ensure these records are kept up to date and are accurately stored, they are held on a property database software system, MICAD. This platform operates a self-audit tool and is

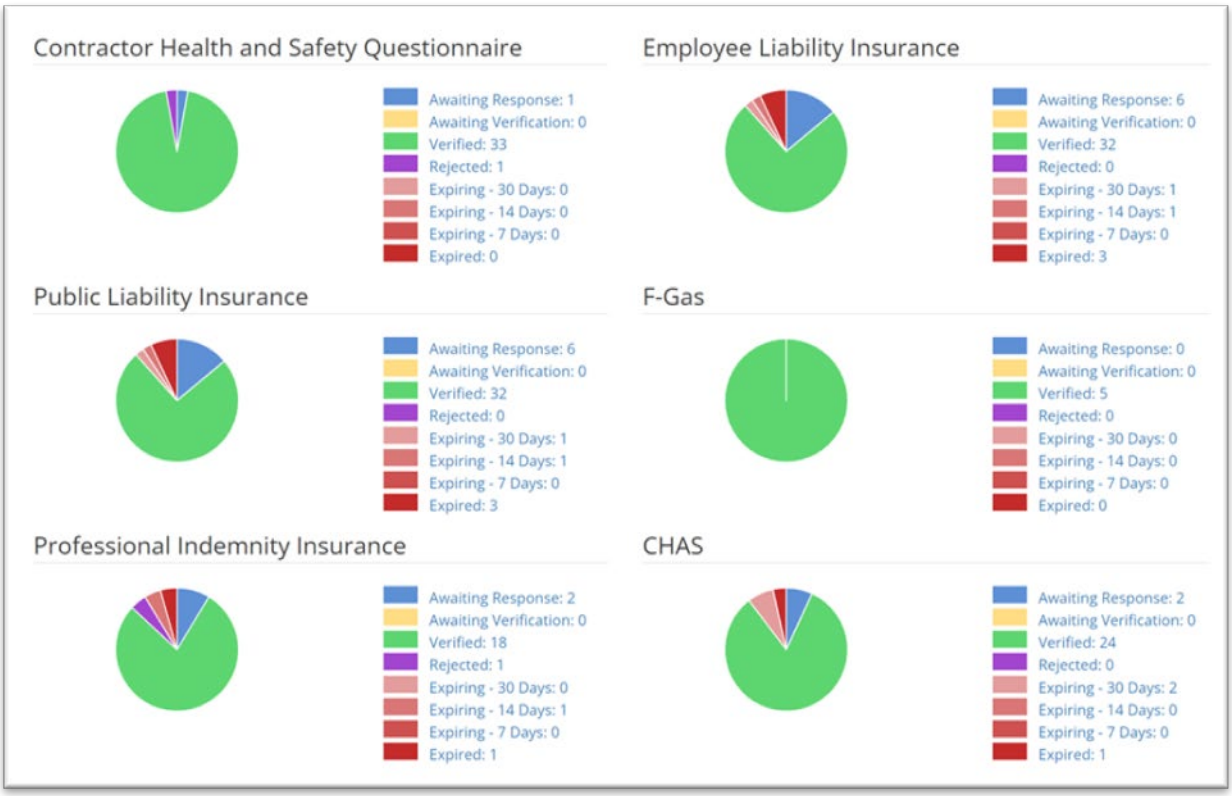
managed by the Estates Asset Management Team, currently no independent auditing of the retained documentation is in evidence. Records and discipline specific certification is also retained by the maintenance service within its CAFM system in the event of a legal challenge.

In addition to the Trusts current catalogue of freehold properties, Solent continues to occupy a number of premises as Leasehold or Licenced Tenants. An annual exercise is in place to contact landlords for written assurance they are adequately meeting their obligations in accommodating Trust staff, this continues to be monitored by Solent's Asset Management Team.

In accordance with Department of Health technical guidance (HTM 00) the organisation should identify and appoint in writing individuals suitably competent and with responsibility for the management oversight of critical technical systems (i.e., electrical, healthcare ventilation and medical gases). Having reviewed the current situation, significant progress has been previously achieved in identifying and appointing appropriate individuals to the roles of Authorising Engineer, Responsible Person, Authorised Person and Competent Person, which permits the necessary discharge of technical management responsibility and authority.

A pro-active approach to training and competency development in all relevant Hard FM areas has continued across the wider department and more specifically toward the maintenance management and operational teams.

Specialist sub-contractors continue to provide a critical support mechanism to the delivery of regulatory maintenance activity, but this can also present a risk potential to the Trust if not suitably managed. Within the reporting period the Estate Maintenance Department has robustly operated a cloud-based control of contractors database (Verature®) whereby business essential criteria such as insurances, staff competencies and site-specific induction records are retained for each contractor and provides a dynamic compliance dashboard (March 2023 view inserted below). Sub-contractors who breach the permissible criteria are warned and subsequently suspended from activity within the Trust.



Estates Backlog Maintenance and Strategy: The Trust has continued to manage, review and further develop its long-term maintenance programme in line with published NHS Backlog Maintenance Guidance, formed from life cycle and condition-based assessments, this provides data informing our backlog maintenance programme, position, and value. The Estate Maintenance Department has been

working to fully develop a 15+ year Major Maintenance Plan to provide an established strategy for future capital investment which aligns with and compliments our forward looking Net Zero and Decarbonisation agendas. The Trust Board continues to support the programme through approved financial commitment.

Entries within the major maintenance programme are risk assessed using the recognised NHS 5x5 risk matrix and reviewed annually in consultation with Trust stakeholders to prioritise and where necessary re-prioritise works to be presented and authorised.

Current assessments and reviews place the backlog maintenance value for the reporting period in the region of £18.7 million.

Water Safety Management and Risk Assessments: To comply with our legal duties, employers, and those with responsibilities for the control of premises should identify and assess sources of risk, this includes checking whether conditions are present which encourage bacterial growth e.g., adverse water temperatures outside recommended standards as well as infrequently used outlets.

Water safety and hygiene control measures are being carried out at all our geographical sites to various and differing levels to mitigate the risks from Legionella and Pseudomonas also to promote quality wholesome water. The meeting schedule of the Water Safety Group has been subject to review during the later stages of the reporting period and is being enhanced by the appointment of an industry registered Authorising Engineer who will provide auditing and additional levels of governance.
Water Hygiene Risk Assessments are subject to constant review and re-prioritisation based upon changing environmental, susceptible audience and engineering system conditions. Assessments have commenced for clinical spaces which fall into the geometry of augmented care as determined by advice within relevant health technical memoranda. Recommendations from the water risk assessments are fed into the Annual Water Safety Plan for which the Water Safety Group and independent Authorising Engineer has oversight.

Tests are routinely carried out to ensure that premises are being maintained to reduce the risk from either contaminated water or water temperature breaches. These testing regimes are required to be carried out monthly and form part of the comprehensive Planned Preventative Maintenance (PPM) schedules as recommended by HTM 04-01 Part B and the HSE document L8 (HSG 274).
The Estates Department has sought over the period to create substantive links with its geographical water undertakers (Southern Water and Portsmouth Water) in an effort to enhance business continuity planning and greater compliance to the requirements of the prevailing Water Regulations which mandate notification and formal approval ahead of the connection of any additional water outlets in all non-residential premises.

The Water Hygiene and Safety Policy includes a defined process of immediate notification, action, and supervision by selected Trust Personnel in the event of a suspected 'high count' or confirmed case of Legionella or similar. Those personnel who will be informed to ensure a suitably weighted and proportionate response include the Responsible Person (Water), Head of Infection Prevention and Control, the Trust Health & Safety Manager, Deputy Director of Estates & Facilities, and remaining membership of the Trust Water Safety Group. The remodelling of the HTM 04-01 during 2016 placed a greater emphasis on the efficacy of the Water Safety Group and the requirement for members to be kept informed and collaborate to achieve identified responses to any high count or outbreak.

Asbestos Management: The control of asbestos is covered under several items of legislation; every nondomestic building is required to have an asbestos register, containing an asbestos management survey which identifies the potential presence of known materials of concern. The MICAD system deployed by Solent NHS Trust hosts the asbestos registers for those buildings owned and operated by the Trust, this intelligence has been enhanced by the depositing of survey information on a room-by-room basis enabling the identification of 'hot spots' on floor plans.

The completion of annual statutory re-inspections (October 2022) of known or presumed asbestos locations have provided status updates on the presence and condition of any asbestos material and any

actions required to reduce the risk of contamination in accordance with the requirements of the Control of Asbestos Regulations 2012.

Any Capital Works or invasive maintenance works remain subject to a full Refurbishment and Demolition Survey, and operational contractors are directed to the asbestos registers and surveys before carrying out any maintenance or interventional works.

A formal programme of Asbestos Awareness Training and Annual Refresher Training continues to be delivered for all estate operations, project managers and allied support team individuals.

During the reporting period the most significant asbestos risk held by Solent NHS Trust located at Jubilee House, Cosham has been fully remediated via the buildings comprehensive programme of refurbishment to accommodate the relocation of MSK services from Queen Alexandra Hospital.

Ventilation Systems: The legacy of the COVID pandemic continues to place an intense scrutiny on all modes of mechanical ventilation particularly re-circulating air systems and has tested technical expertise nationally. Industry as well as healthcare specific advice has continued to evolve and be reviewed during the reporting period and throughout there has been a significant effort to increase delivered air volumes and thus room air change rates in response to the increased viral loading.

This advice has not altered as we have emerged from the controls imposed over the preceding periods though the conflict with energy usage and management is becoming more emboldened and will present increasing challenges for the future.

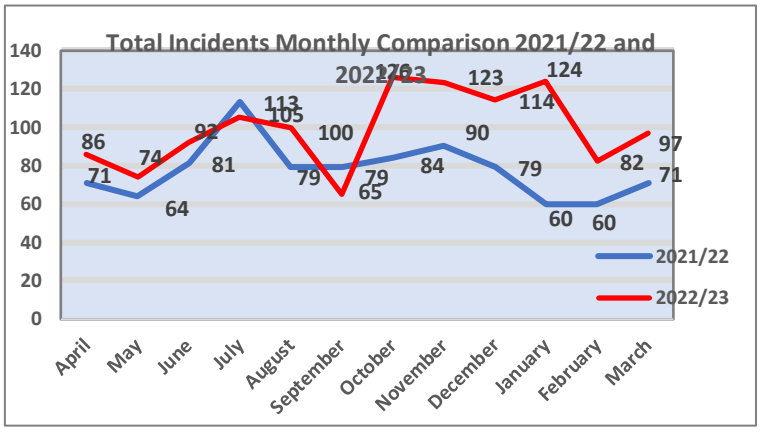
The Trust continues to deploy technology that has the potential to improve indoor air quality via an air re-circulation and filtration process, this remains a cause for significant concern due to the evidence of internal surface contamination of the units. The use of these units in an effort to reduce fallow time should remain under constant review as with the widespread use in clinical settings of portable room cooling units, with both examples promoting re-circulation of existing room air.

The formalisation of a Ventilation Safety Group has been delayed but once operational its focus will be on the control, deployment, and rigorous management of these devices and more widely indoor air quality standards.

Section 10: Risks and Issues

Below is a statistical health and safety overview of all health and safety incidents reported by members of Solent NHS Trust. It covers the overall number of incidents reported and identifies general reporting trends against year-to-year comparisons.

Graph below Total health and safety incidents reported Monthly Comparisons



Y

ear to Year quarterly comparison

Q1 increase of 14.2% from 216 to 252

Q2 marginal decrease from 271 to 270

Trend Analysis

Summary

Year to Year comparisons chart shows the trend for Quarter One to Four and total monthly number of reported incidents.

When comparing the last two years 2021/22 against 2022/23 it shows an increase of total number of reported incidents of circa 27.6%.

Q3 significant increase from 253 to 363
Q4 significant increase from 191 to 303

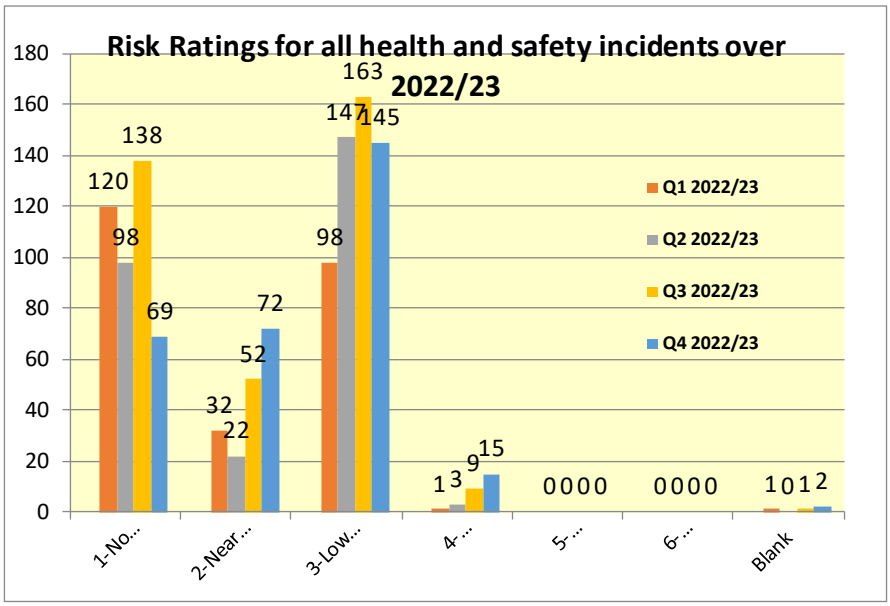
When comparing the last two years against 2021/2022 against 2022 /2023 shows an increase of total number of reported incidents over the last two years of circa 27.6%. This indicates that making comparisons over a two-year period not possible due the working with the pandemic impact on service on continuing due to positive outbreaks of Covid forming new norms in correlation in incidents per 1000m patient contacts (Clincal services only).

Summary

4. Risk Rating and Percentage of Risk Ratings

Risk Ratings for All health and safety Incidents during 2022/ 2023

Actual Impact	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
1-No Harm	120	98	138	69
2-Near Miss	32	22	52	72
3-Low Harm	98	147	163	145
4-Moderate Semi-Perm	1	3	9	15
5-Major, Permanent	0	0	0	0
6-Catastrophic, Death	0	0	0	0
Blank	1	0	1	2
Total	**252**	**270**	**363**	**303**



Percentage of Risk Ratings for All health and safety Incidents during 2022/ 2023

Actual Impact	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
1-No Harm	47.6	36.3	38	22.8
2-Near Miss	12.7	8.2	14.3	23.8
3-Minor Non-Perm	38.9	54.4	44.9	47.8
4-Moderate Semi-Perm	0.4	1.1	2.5	4.9
Blank	0.4	0	0.3	0.7
Total %	**100**	**100**	**100**	**100**

Year to Year Comparison summary of the total number of health and safety reported incidents

- No Harm and Near Miss by Intervention overall % figures accounted for circa 51.3%
- Low Harm Minor Non-Permanent Harm incidents accounted for circa 45.3%
- Minor Non-permanent harm incidents remained very low at 2.7 %.
- Blanks are generally rare.

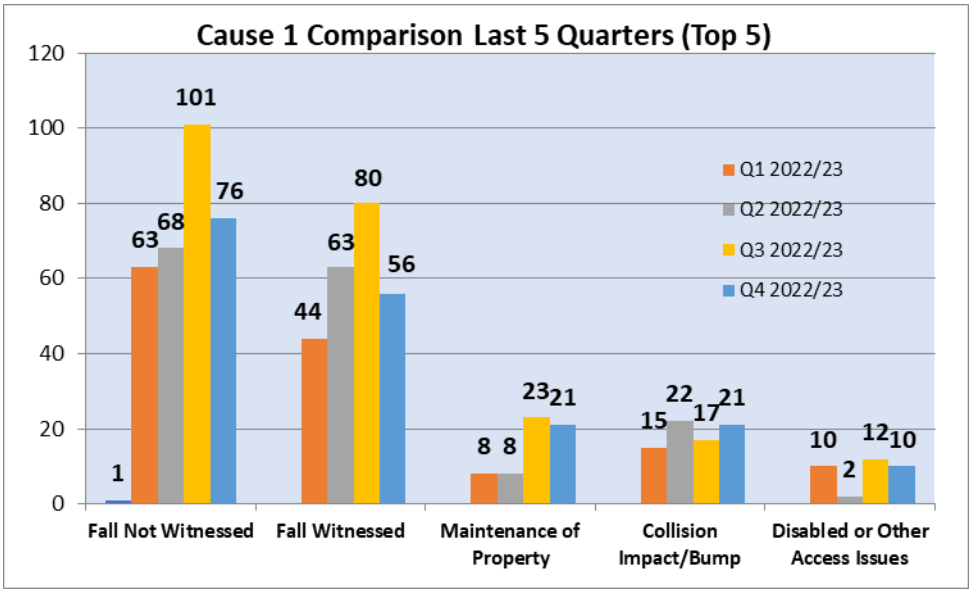
Conclusion

For the second consecutive year the high level of No Harm and Near Miss by Intervention reported incidents fall in line with a positive culture of reporting, and this data has made a difference in providing evidence of potential risks, weakness in operational issues and/or estate infrastructure

Cause One Comparisons

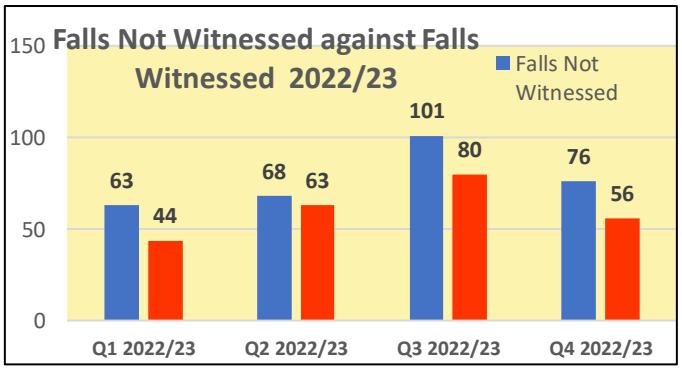
. Cause One Comparisons

Cause 0ne Comparisons for 2022/23 (Top 5 cause groups)



Breakdown

Slips, trips, and falls witnessed and not witnessed remains for the third consecutive year the highest percentage of reported health and safety incidents. During Q1 accounted for Circa 42.5%**,** Q2 Circa 48.6% and Q3 50.4% and Q4 43.8%of the total number of reportable health and safety incidents.



Summary

Falls witnessed % differences against falls not witnessed over the year have remained consistent, with falls witnessed just trending below falls not witnessed

Refer to Falls Prevention Work Streams Above (refer to page 9)

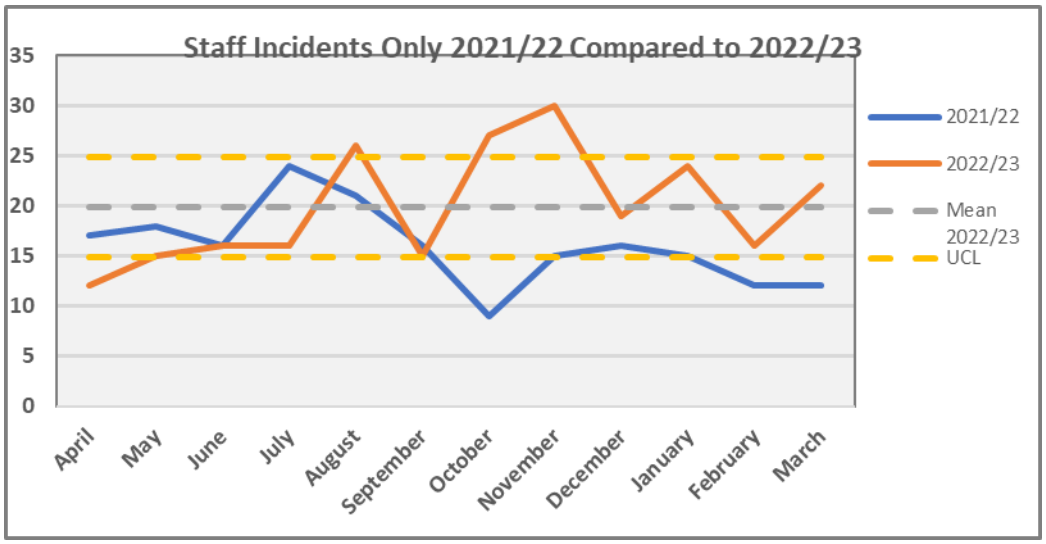
In addition

Slip resistant testing kit currently being reviewed to assess the slip resistance of flooring that complies with the HSE slip values recommendations. Micad drawings sent to Slip Test Ltd awaiting response

The other top three cause groups (maintence of buildings, collision/ impact/bump, disabled or other access issues) throughout the year have been tracked and addressed accordingly and no obvious trends or themes have been identified

Staff Related Incidents ONLY

Total Number of STAFF ONLY INCIDENTS reported year to year comparisons



Staff Incidents Only 2020/21 Compared to 2021/22

Month	2021/22	2022/23
April	17	12
May	18	15
June	16	16
July	24	16
August	21	26
September	16	15
October	9	27
November	15	30
December	16	19
January	15	24
February	12	16
March	12	22
Totals	**191**	**238**

Summary

Total number of incidents has generally remained within the lower section of the upper and lower limits

Compared to the previous year Quarter One shows a decrease of reportable incidents, down from 51 to 43 circa 15.68% reduction and during Q2 a marginal decrease from 61 to 57, Q3 shows an increase from 40 to 76 and Q4 and increase from 39 to 62

Risk Rating Staff incidents ONLY

Staff Actual Impact	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
1- No Harm	11	6	13	12
2- Near Miss (by Intervention)	1	1	4	10
3 – Low Harm (Up to 1 M)	31	50	47	39
4- Moderate, Semi Permanent Harm (Upton 1	0	0	1	0
Total	**43**	**57**	**65**	**61**

Conclusion

No -harm and near miss (by intervention) accounts for 24.3%of the total number of staff incidents reported, as with previous years the incidents remain similar and come from all services and the use of the on-line web-based reporting system is well known.

This, as with the previous year, is an encouraging position as the trends shows that organisations that have good levels of reporting have corresponding improved patient safety cultures and reflect a positive safety reporting culture

Section 11: Looking Ahead

Health and Safety Manager will be focusing on several areas within the report during the next 12 months:

- Establish the potential completion of Disability Discrimination Act assessments for Solent owned properties.
- Work in collaboration with Other Trusts to create an implantation plan regarding a sensible approach to health and safety within Project Fusion and play a supportive role in any future re-set proposals
- Support the development and implementation of all proposed subject matter expert sub-groups.
- The Compliance team will continue to work closely with Estates and Facilities Management Teams as a key partner in all new build, refurbishment projects or acquisitions of new buildings. Provide expert advice and support, and authorised compliant status sign off to issues that are identified within sites that relate to statutory compliance with appropriate legislation and NHS Technical documents (Health Technical Memorandums and Health Building Notes).
- Be responsive and supportive during the pending pandemic issues.

The progress of the past year overall has been successful, and the Compliance team will continue to make a concentrated effort to see things to completion.

A thank you to the Senior Management Team for the acknowledgement and action of some the above urgent improvement shown in this report

Health and Safety compliance team due to the continuation of the increased workload and Project Fusion will need to allocate sufficient time throughout the challenging and stressful period we will operating in.

As with last year Solent continues to have good systems and processes in place to manage health and safety and the processes are aligned with the legal requirements with active staff side consultation and involvement being integral to the continued success of health and safety

I personally would like to thank all our colleagues for their continued support.

Author: David Keates
Job Title: Health and Safety Manager Solent NHS Trust
Date; July 2023

APPENDIX A
HEALTH AND SAFETY POLICY STATEMENT OF INTENT

This health and safety policy statement of Intent identifies the commitment of Solent NHS Trust to provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, patients, visitors, and other persons affected by the Trust 's undertaking or omissions.
Health, safety, and welfare is the responsibility of all Directors, Heads of Department, Managers, responsible persons both clinical/ nonclinical and employees and is an integral important part of their duties. The Trust's commitment to health and safety therefore ranks equally with all other aims, objectives, and activities.

The Health and Safety Policy defines responsibilities and identifies general and specific arrangements relating to the Trust's undertaking which extends to all premises, buildings, and working activities throughout the Trust. The health and safety policy are supported by other more detailed policies which will be read in conjunction with it

A copy of the health and safety policy is made available to all employees on the Trust intranet, where employees do not have access to the intranet, line managers are to make such arrangements as may be necessary to ensure employees have access to this policy.

The Trust ensures that all employees are fully aware of their legal obligations to take reasonable care for their own health and safety and that of other persons who may be affected by their acts or omissions whilst at work. All employees are legally required to co-operate with their employer regarding health and safety matters, not to misuse or interfere with anything provided for safety so the Trust can fulfil its legal obligations.

To enable the effective implementation of the health and safety policy and the performance of all tasks safely and without risk to employees, patients or visitors, staff will be provided with suitable and sufficient information, instruction, and training.

To encourage and promote effective consultation, communication and co-operation between management and employees, all departments shall develop appropriate systems by which the contributions and concerns of employees can be raised at departmental management meetings, and the Health and Safety Subcommittee.

This health and safety policy statement of intent shall be reviewed and amended annually, or as dictated by significant changes to legislation and/or Trust policies or adverse conditions, whichever is the sooner.

Andrew Strevens
Chief Executive
December 2022

Title of Paper	Solent's Patient Safety Incident Response Plan 2023/24 (PSIRP)
Date of paper	22/09/2023
Presentation to	Public Board
Item No.	18.1
Author(s)	Quality & Governance Team
Executive Sponsor	Angela Anderson
Executive Summary	• Solent have written this PSIRP with the knowledge that following the transitional period, and before the new Organisation is formed, it will be reviewed with our fusion partners, to develop one plan. • It is a requirement that all Organisations publish their PSIRP. • Two years of patient and staff safety data was reviewed to formulate this plan. • The plan is flexible and when new patient safety themes/ risks emerge the plan can be amended to reflect this. • New learning methods are included in this plan, with information on how these will be applied and for what incidents. • The oversight management process has been included. • Patient Safety training requirements to implement this plan has been included.

Action Required	For decision?	Y	For assurance?	N
Summary of Recommendations	Public Board: Approve the Solent Patient Safety Incident Response Plan			
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 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	X	9.Belonging to the NHS		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		15. Partnership and added value	X
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	Sigificant		Sufficient		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								

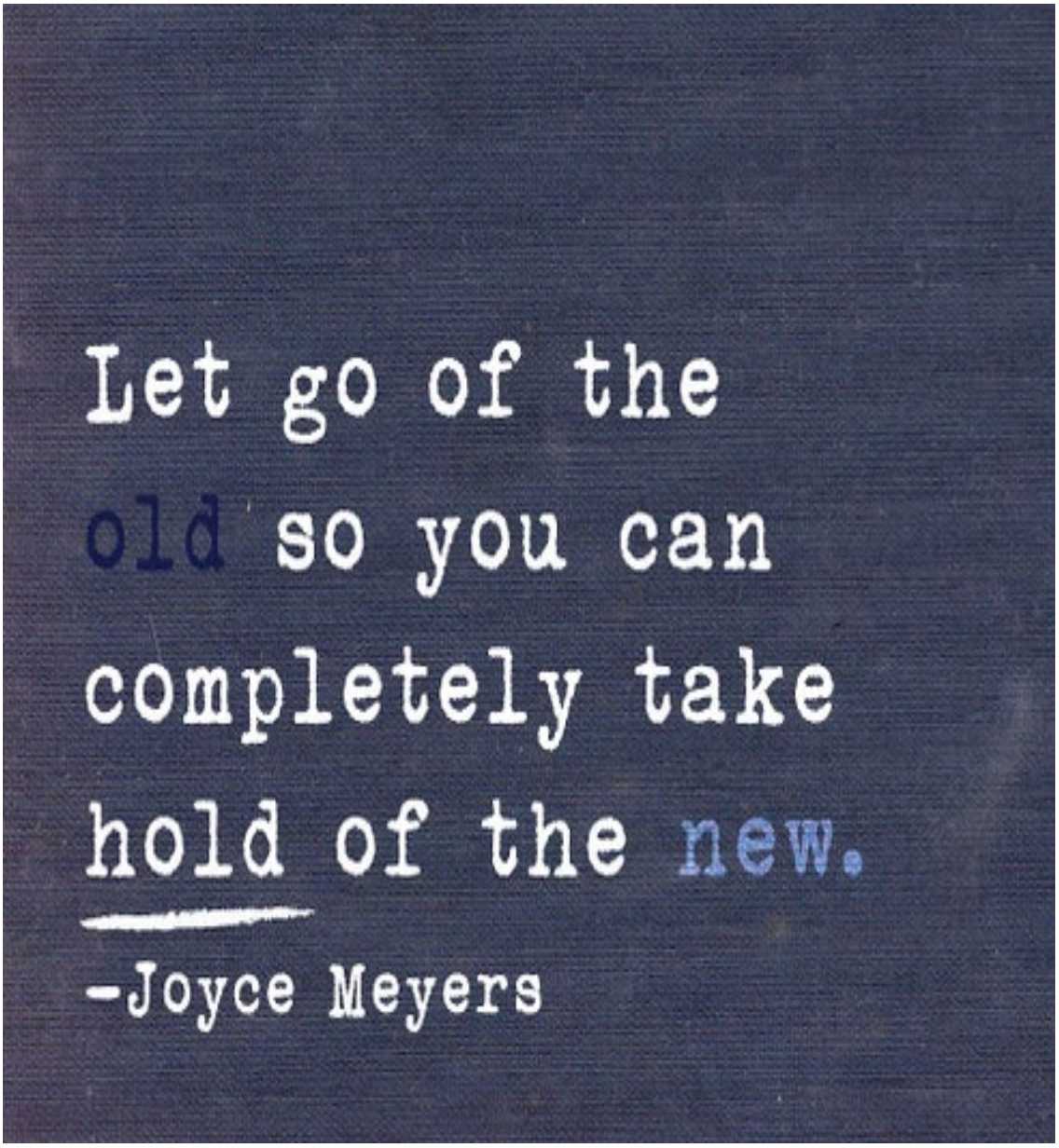
Solent NHS Trust Patient Safety Incident Response Plan (PSIRP)

2023/24

Effective date: 30th October 2023

Estimated refresh date: 31st March 2024 (Re Project FUSION)

	NAME	TITLE	SIGNATURE	DATE
Author	**Teresa Power**	**Patient Safety Specialist, Operational Lead**		
	Pauline Jeffrey	**Head of Quality and Safety**		
Reviewer	**Aderemi Aderibigbe**	**Associate Director for Quality, Safety, Governance and Risk**		
Authoriser	**Trust Public Board and ICB**			


Let go of the
old so you can
completely take
hold of the new.
-Joyce Meyers

Forward

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen, including the factors which contribute to them."

Aiden Fowler, National Director of Patient Safety, NHS England

The Patient Safety Incident Response Framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing and calling it something different but a cultural and system shift in our thinking and our response to patient safety incidents and how we learn from them and make improvements to prevent a recurrence.

Previously we have had set timescales and external organisations to approve what we do. PSIRF gives us is a set of principles what we will work to, and we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn but we acknowledge that PSIRF gives us the opportunity to use a variety of learning response tools, not just investigations, to understand our learning and to determine our areas of improvement to keep our patients safe.

PSIRF rightly has an important focus on engaging with our patients, families, and carers to ensure their voice is the golden thread in any of our patient safety investigations. Our Patient Safety Partners are integral in this approach to provide a fair challenge to us to ensure the patient voice is involved at all stages in our patient safety responses.

PSIRF recognises the importance of engaging with staff, providing an inclusive and supportive approach to their learning**.** The support of our staff following a patient safety incident has been a fundamental focus for Solent. We have developed a staff support model, which includes safety chats and signposting to support within Solent (RIPPLE model). We have fostered a culture that encourages staff to report patient safety incidents and to be supported to do so, without fear of blame.

As we move into adopting this new way of managing our patient safety incidents, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF Implementation, responding and adapting as needed if our approach is not achieving what we expect it to, with support from our Stakeholders, including our Integrated Care Board.

We really welcome the implementation of our plan to provide us with further opportunity to learn and improve to provide safe, effective, and compassionate care of our patients, their families and carers whilst protecting the wellbeing of our staff.
Dan and Angela to review/ amend and endorse.

Contents

Introduction

This patient safety incident response plan sets out how **Solent NHS Trust** intends to respond to patient safety incidents over the period until 31st March 2024. Its aim is to inform staff and our people of the new ways we will be working.

The plan is not a permanent rule that cannot be changed, and it is anticipated that the plan will be combined with plans from other organisations within project FUSION in readiness for transition to the new organisation from 1st April 2024. In addition, the Integrated Care Board will also be undertaking quarterly review meetings.

Solent will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

The plan is underpinned by our Patient Safety Incident Response Policy.

Our services

Solent NHS Trust provides community and mental health services to people who live in Portsmouth, Southampton, Hampshire, and the Isle of Wight. Our overall aim is keeping more people healthy, safe, and independent at or close to home.

Solent have eight service lines providing the following.

- Mental Health Services - Inpatient and Community Mental Health for people who require specialist assessment, care and treatment by a dedicated multidisciplinary team and learning disability services.

- Adults Portsmouth – Inpatient rehabilitation and discharge to assess. Specialist Palliative care, rehab and reablement, community nursing, urgent Community Response, diabetes, occupational therapy, physiotherapy, speech and language therapy, pulmonary rehabilitation and home oxygen, care home support, heart failure, bladder and bowel, community neuro service, clinical advisory team, admission avoidance and supported discharge services.

- Children and Family Services - Childrens nursing, child and adolescent mental health, health visiting, paediatric medical, paediatric therapies, and school nursing

- Adults Southampton – Neuro rehab services, rehab and reablement, community nursing, neuro inpatient unit, Parkinson's, epilepsy, multiple sclerosis specialist nursing, elderly frail inpatient unit, occupational therapy, physiotherapy, speech and language therapy, care home support, admiral nursing, bladder, and bowel, respiratory, diabetes, tissue viability, heart failure, admission avoidance, stoma care and supported discharge services.

- Primary Care – GP and homeless healthcare services

- Muscular skeletal physiotherapy and podiatry – tuberculosis, rheumatology, specialist physiotherapy, physiotherapy, long COVID, chronic pain and podiatry.

- Sexual Health – Genitourinary medicine, reproductive health, HIV outpatient services, sexual health promotion, termination of pregnancies, psychosexual counselling, vasectomy services and sexual assault referral centre.

- Specialist Dental –Oral health care and dental treatment (including treatment under conscious sedation) for children and adults that have a special need or an impairment, disability and/or complex medical condition. This includes those with Learning Disabilities, Severe physical problems, Challenging Behaviour, Autistic Spectrum Disorders, Frail/elderly or housebound (delivered in Care Homes and patient's homes), Bariatric difficulties, Severe Mental Health Conditions, Severe or debilitating dental phobia, Patients who have undergone head and neck radiotherapy.

Defining our patient safety incident profile

We have a continuous commitment to learning from patient safety incidents as demonstrated in our response to the Patient Safety Strategy 2019. We have developed our approach to be a learning Organisation over many years. Solent has a nationally recognised Academy of Research and Improvement which has supported many Quality Improvement initiatives in Solent and directly supported the Quality and Safety team in the implementation of Safety, Excellence, and Improvement Forums. In addition, we have a strong safety thread running from Service Lines to our Board. As shown in appendix A.

PSIRF sets no rules or thresholds to determine what needs to be learned from, to inform improvement, apart from the national requirements listed on page 12. To fully implement the Framework, the Trust has completed a review of the types of patient safety incidents occurring in our services to understand where we need to focus to enable continuous learning and improvement.

The PSIRF Implementation Team has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identifying and specifying the methods to be used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on page 14.

Stakeholder engagement

The PSIRF implementation team commenced planning for PSIRF in advance of the release of documents in August 2022. We worked closely with our neighbouring Trusts and would like to say thank you, to the Isle of Wight Trust, as early adopters of PSIRF the insight into their journey has been invaluable. We also accessed information from several PSIRF early adopter organisations to enable us to understand the practicalities of planning for and implementation of PSIRF. This included gathering information on the learning response tools they were using. Which has been invaluable in helping us determine which we will use.

In 2022 the Trust Board, Quality Assurance Committee, Quality, Improvement and Risk Committee all received presentations on the fundamental changes that PSIRF would bring to how we understand, learn, and improve Patient Safety.

A PSIRF Implementation team was formed and following a team briefing we commenced our preparation. Our Integrated Care Board colleagues were part of this team along with our Patient Safety Partners. We also had the Head of Improvement attend from a Quality Improvement perspective.

The development of our Patient Safety Incident Response Framework plan followed the nationally recommended implementation project phases and a summary of how we did this is outlined below:

- Patient Safety Specialists attending NHSE PSIRF webinars.
- Patient Safety Specialist, Operational lead to develop plan and monitor workstreams.
- Implementation Team meetings
- Workstreams for Learning Responses, Communication, Involving those affected by patient safety events, Safety data analysis, Training and education and Oversight/Governance.
- Oversight Group meetings with Chief of Nursing and Allied, Healthcare Professionals and Deputy Chief Medical Officer.
- Updates provided to Quality, Improvement and Risk Group, Quality Assurance Committee, and the Trust Board.
- Hampshire and Isle of Wight Patient Safety Incident Response Framework group
- Project Fusion PSIRF Group

During the latter part of the development of our plan we have shared and sought support from our Community Partners and Healthwatch, with a robust sign off process as detailed in appendix B.

We considered our capacity to respond to patient safety incidents and the level of training our staff would require. See appendix C.

Data Analysis

To define our Patient Safety Incident Response profile, we conducted an analysis of our safety data from a variety of sources, qualitative and quantitative. They are as follows.

- Patient Safety Incidents from our Incident system between 1st April 2021 to 31st March 2023. It was suggested by NHSE that Organisations analyse two - three years of data. Solent agreed to analyse two years of data, as the patient safety profile in Solent for the previous year was heavily impacted by the pandemic.

- Serious Incidents and High-Risk Incidents
- Complaints and Service Concerns
- Freedom to Speak up cases.
- Patient and staff surveys results
- Risks
- Claims
- Coroners feedback
- Mortality and Structured Judgement Reviews
- Health and Safety Reports
- Thematic Reviews
- Audits
- Inequalities data

From the data analysis we were able to identify the top patient safety issues across the organisation and some which were specific to just one service line as detailed in Table 1.

Table 1

Category	Detail
Medication Incidents	Administration of medication - top primary cause of medication incidents
Pressure Ulcers	Developed or deteriorated in Solent's care
Communication in Mental Health Services	With relatives and/or next of kin
Communication in Child and Family Services	With patients/parents/carers/legal guardians
Transferring care between Organisations in Adult Services Southampton, Adult Services Portsmouth, and Mental Health Services	Documentation and Communication
Slips, trips, and falls	Inpatients are the highest reporters
Do not Attempt Cardiopulmonary Resuscitation (DNACPR)	Advanced care planning and locating documentation
Staffing/ workforce and capacity	Identified as a safety risk, but no evidence of patient harm because of the risk
Recognising physical deterioration in inpatients	Focus is on inpatient wards due to incident levels
Waiting Lists	This is a safety risk, not seeing evidence of significant patient harm as a result, but emerging picture with the implementation of formal assessment using the harm tool
Suspected Suicides	In Mental Health Services
Clinical Delay involving more than one patient	In Dental Services

Following analysis, the Safety Data workstream agreed a recommended list of priorities for Solent's first PSIRP. Page 14

Defining our patient safety improvement profile

The Trust has consciously developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity. Improvement events are held annually, the services consider what audit, evaluation, and quality improvement projects, they plan to undertake. The Trust will not wait until these planning events but use the skills and support available to them from the Academy of Research and Improvement, ensuring that staff within the Patient Safety team are also skilled in Quality Improvement methodology. We have reviewed our Quality, Improvement and Risk Group and divided into a two monthly cycle. Month one focusses on Safety and Risk and the following month on learning and Improvement.

We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

The National Patient Safety Strategy has identified National improvement programmes for Mental Health, Managing the Deteriorating Patient, Safety of Older people, Medicines Safety and Antimicrobial Resistance and Healthcare Associated Infections, all of which we are actively engaged in as an organisation. More information is found in appendix D.

Our patient safety incident response plan: national requirements

Given that we have finite resources for patient safety incident responses, we intend to use those resources to maximise improvement. The framework allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

The national framework includes a list of incidents that require a mandated patient safety incident response as set out in table 2 and we fully endorse this approach as it supports the aim to learn and improve within a Just Culture. The table reflects the national priorities that are relevant to us, and our approach to these incidents are described below.

Table 2

Patient safety incident type	Required response	Anticipated improvement route
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria)	Locally led Patient Safety Incident Investigation (PSII).	Create local organisational actions and feed these into Quality Improvement processes
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally led Patient Safety Incident Investigation	Create local organisational actions and feed these into the Quality Improvement processes
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team for consideration for an independent patient safety incident investigation. Locally led Patient Safety Incident Investigation may be required	Respond to recommendations as required and feed actions into the Quality Improvement processes to evidence learning and changes to practice as a result.
Domestic homicides	Referred to the NHS England Regional Independent Investigation Team for consideration for an independent patient safety incident investigation. Locally led Patient Safety Incident Investigation may be required	Respond to recommendations as required and feed actions into the Quality Improvement processes to evidence learning and changes to practice as a result.
Incidents meeting the Never Events criteria 2018: for our Trust this relates specifically to non-collapsible curtain rails which may be used as a ligature point plus falls from poorly restricted windows, head, or neck entrapment in bed rails, misplaced naso or oro gastric tubes, overdose of insulin due to abbreviations or incorrect devices, scalding of patients.	Locally led Patient Safety Incident Investigation	Create local organisational actions and feed these into the Quality Improvement processes to evidence learning and changes to practice as a result.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led Patient Safety Incident Investigation (Or other response) may be required alongside the LeDeR – organisations should consult.	Respond to recommendations as required and feed actions into Quality Improvement processes to evidence learning and changes to practice as a result.
Child deaths	Joint Agency Team to lead the review in collaboration with the internal Safeguarding Team as per the Trust Safeguarding Policy.	Respond to recommendations as required and feed actions into the Quality Improvement processes to evidence learning and

	Refer for Child Death Overview Panel review.	changes to practice as a result.
Safeguarding incidents in which: Babies, children, and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to female genital mutilation, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead as per the Trust Safeguarding Policy. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	Respond to recommendations as required and feed actions into Quality Improvement processes to evidence learning and changes to practice as a result.
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes	Create local organisational actions and feed these into the Quality Improvement processes to evidence learning and changes to practice as a result.

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety data from a variety of sources, we have determined that the Trust's local patient safety priorities will be as described in table 3 below.

Table 3

Patient safety incident type or issue	Planned response	How will findings from planned response lead to improvement?
Medication Administration errors	Review by Medicines Safety Officer using bespoke template followed by monthly thematic analysis to medicine management group. After Action Review where significant learning has been identified.	It will identify any themes or trends that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Pressure Ulcers (In Solent Care newly acquired or deterioration)	Review by Tissue Viability specialists using bespoke template followed by monthly thematic analysis to Tissue viability steering group. After Action Review where significant learning has been identified	It will identify any themes or trends that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and Quality, Risk, and Improvement Group.
Communication issues with relatives when patients are receiving care from Mental Health Services	Multi-Disciplinary Team Review	It will identify any themes that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.

Communication issues with patients/ parents/carers and Legal Guardians receiving Child and Family Services care	Multi-Disciplinary Team Review	It will identify any themes that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Inpatient slips, trips and falls	SWARM Huddle (Also known as Hot debrief)	It will identify any immediate local safety actions from all those involved. It may also identify any themes that require a quality improvement approach (QI) Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Delayed Recognition of Physical Deterioration in all inpatient services	After Action Review	It will identify local safety actions from those involved and any areas that require a quality improvement approach (QI) Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Suspected completed /attempted Suicides in inpatients and patients receiving care under crisis pathway	After Action Review / Patient Safety Incident Investigation	It will identify any relevant local and organisational safety improvements based on an individual case or themes. A quality improvement approach will be considered.
Clinical Delay involving one patient where significant learning has occurred or multiple patients where significant learning may or may not have occurred	Multidisciplinary team (MDT) review / Patient Safety Incident Investigation	It will identify any local and organisational safety improvements. A quality improvement approach will be considered.

Whilst this list has been agreed, it is not fixed and will be subject to continuous review and update in the context of emerging safety issues. Within our resource analysis, we have also established capacity for additional ad-hoc PSII or thematic analysis where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

All incidents will continue to be reported in line with the Trusts existing patient safety incident reporting guidance. (Appendix E details provides more detail on these incidents) and principles described in the framework.

For near miss or no harm incidents we propose to manage these at a local level with ongoing thematic analysis via existing Trust processes which may lead to new, or supplement existing improvement work.

Any incident resulting in moderate harm or above will continue to be managed in accordance with Being Open and Duty of Candour requirements.

Completed thematic reviews will be reviewed and discussed at their appropriate forums to identify required improvement actions.

Mortality reviews will not form part of the process unless they are a safety incident. The Trust's learning from deaths policy will apply for mortality reviews.

Learning Response Methods

We will be using the following learning response methods which all include our frontline team's involvement to respond and learn from our local patient safety priorities:

Table 4

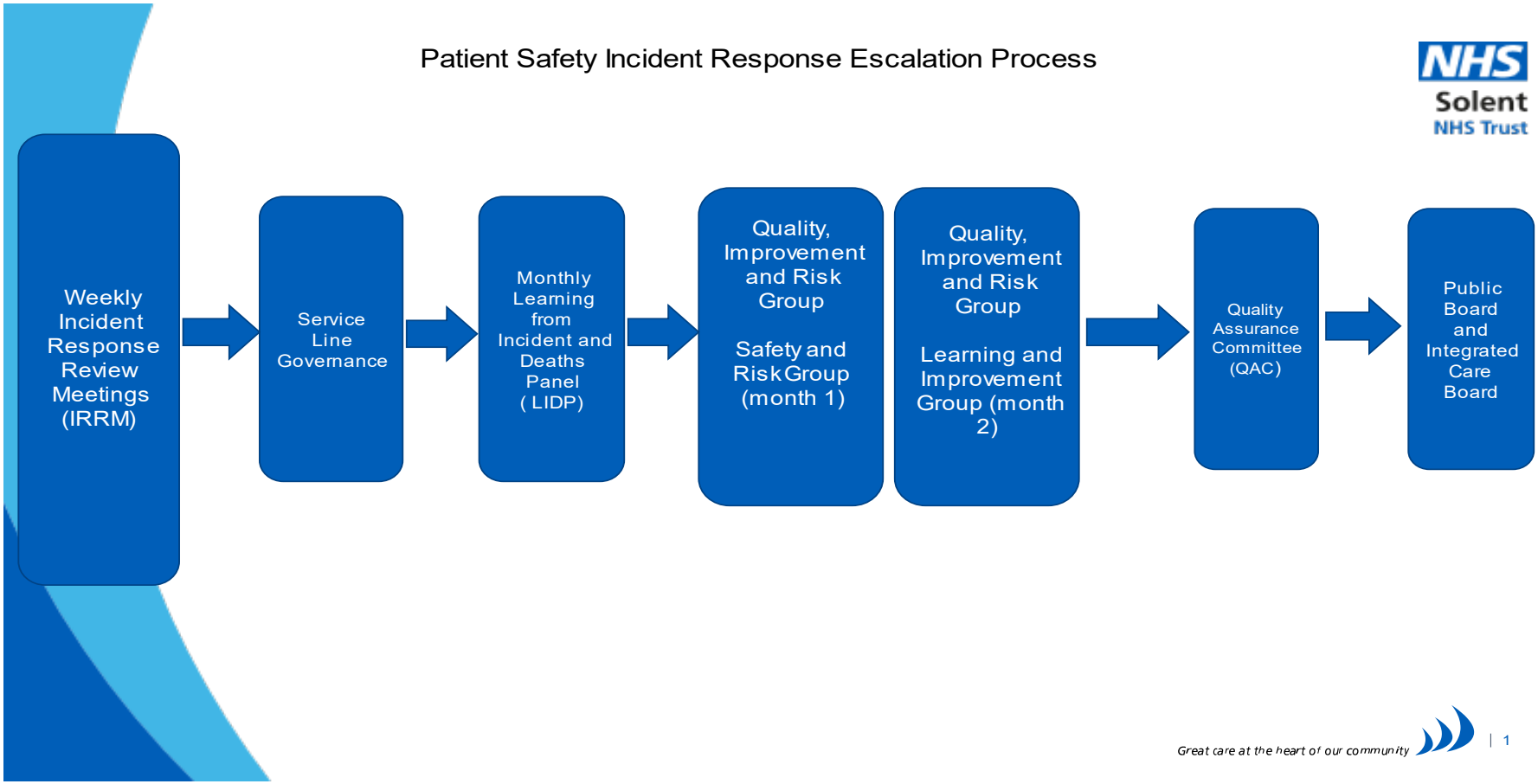
Learning Tool	What is it?	Who leads it?	Timeframes
SWARM Huddle (Hot Debrief)	SWARM-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. It occurs straight after the incident, where the team involved get together to discuss the incident and identify immediate learning or actions to be taken forward	Senior Lead who was not involved in the incident	Day of the event, but in exceptional circumstances within forty-eight hours.
Thematic review	An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e., work as done. A thematic review can identify patterns in data to help answer questions, show	Trained Investigating Officers.	Within forty to sixty calendar days

	links, or identify issues. Typically involves using qualitative (e.g., open text survey responses, field sketches, incident reports and information sourced through conversations and interviews) rather than quantitative data to identify safety themes and issues		
After Action Review	An After-Action Review is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to and promote success for the future. It is a structured, facilitated discussion of an event, the outcome of which gives the individuals involved an understanding of why the outcome differed from that expected and the learning to assist improvement or why the action was particularly successful. After action review generates insight from the various perspectives of the multi-disciplinary team.	Led by a trained After-action review Conductor - this could be anyone from within the multi-disciplinary team, local or remote to the participants	Within thirty calendar days
Patient Safety Incident Investigation	An in-depth review of a single patient safety incident or cluster of events to understand what happened and how (replaces the Serious Incident/Red Root Cause Analysis investigations)	Trained Investigating Officers	Within six months but it is dependent on the complexity of the case and in agreement with patient/family
Multi-Disciplinary Team Review	The multidisciplinary team (MDT) review supports teams to: 1. Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents) 2. Agree, through open discussion, the key contributory factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. 3. To explore a safety theme, pathway, or process. 4. To gain insight into 'work as done' in a health and social care system.	To be led by a patient safety facilitator who will use the MDT as source of data for learning about a series of events or a theme	Within thirty calendar days

Clinical Teams will be responsible for undertaking local learning responses such as Swarm Huddle, After Action Review and Multi-Disciplinary Reviews/ However during the transition phase they will receive support from the Quality and Safety Team.

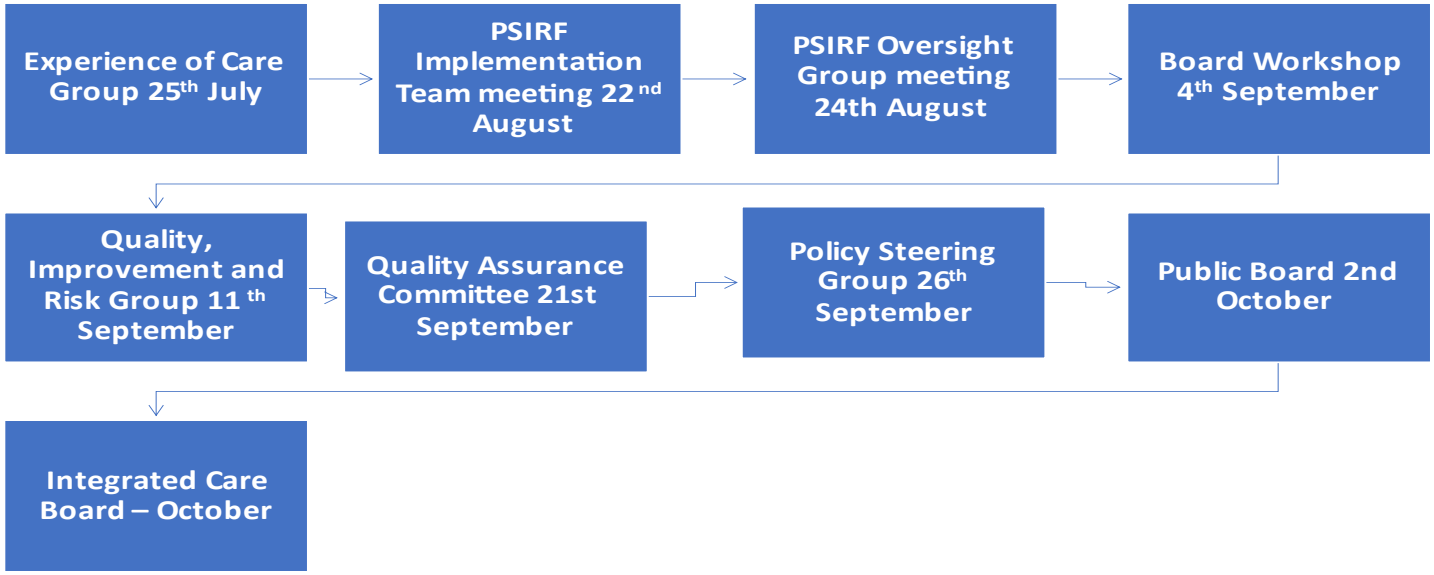
In addition, support training on the learning response tools will be delivered across the Trust via our Quality and Safety Team. A trained patient safety event response lead will undertake all Patient Safety Incident Investigations.

Appendix A - Patient Safety Incident Response Escalation Process



Appendix B

Approval process for Solent's Patient Safety Incident Response Plan and Policy



TP August 2023 V2

Appendix C - Patient Safety Training in Solent

The Patient Safety Incident Response Framework identifies the following patient safety training requirements.

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety incidents	2 days/12 hours	• Introduction to complex systems, systems thinking, human factors • Learning response methods • Safety action development, measurement and monitoring	✓		✓
Oversight of learning from patient safety incidents	1 day/6 hours	• Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of candour; just culture, being open and apologising • Effective communication and involvement • Sharing findings; Signposting to support		✓	✓
Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • Systems approach to safety • Avoiding inappropriate blame; creating a just culture	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• Stay up to date with best practice • Contribute to minimum of two learning responses	✓	✓	✓

Solent has considered how the training will be provided and following a training options appraisals, the following was agreed as detailed in the table below.

Solent's approach to PSIRF training

All staff	Registrants, Managers and Patient Experience and Safety roles	Board	Learning Response leads	Engagement Leads	Oversight Roles
•Level 1- Essentials for Patient Safety	•Level 1 – Essentials for Patient Safety •Level 2 – Access to Practice	•Level 1 – Essentials for Patient Safety •Level 1 – Essentials for Patient Safety (Board and Senior leadership team)	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Systems Approach to Learning from Patient Safety •Involving those affected by patient safety incidents in the learning process • Expected to stay up to date and contribute to two learning responses, annually	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Involving those affected by patient safety incidents in the learning process •Expected to stay up to date and contribute to two learning responses, annually	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Systems Approach to Learning from Patient Safety •Involving those affected by patient safety incidents in the learning process •Oversight of learning from patient safety incidents •Expected to stay up to date and contribute to two learning responses, annually

The Oversight role

The Oversight role has always been important in the approval of Patient Safety Investigations however it is even more important due to the changes PSIRF brings with Organisations overseeing their own learning responses. It has been agreed that the following roles are an integral part of this process and will receive the Oversight training.

- Chief of Nursing and Allied Health Professionals
- Chief Medical Officer
- Deputy Chief of Nursing and Allied Health Professionals
- Deputy Chief Medical Officers
- Associate Director of Quality, Safety, Governance and Risk
- Head of Quality and Safety
- Heads of Quality and Professions for all service lines
- Clinical Directors for all service lines
- Patient Safety Specialist, Operational Lead

Appendix D

National Patient Safety Improvement Programmes

	Programme Title	Details of local aims	Monitoring
National Improvement Programmes	**Preventing deterioration and sepsis**	• Continue to embed NEWS2 recognition, response, and escalation. • Introduction to PEWS, in community Paediatric services.	• Quarterly Deteriorating Patient and Resuscitation Steering Group. • Engaged in Wessex Academy Managing Deteriorating Patients Programme
	Mental health programme	• Reduction in self-harm • Suicide prevention • Improving therapeutic inpatient environments • Reducing restrictive practice • Improving sexual safety • Improving access to physical health and primary care services in all settings	• Restrictive Practice Management Group • Engaged in Reducing Restrictive Practice Improvement Programmes • Engaged in Wessex Academy Mental Health Programme
	Medicines safety	• Roll out of Electronic Prescribing and Medicines Administration (EPMA) Local priorities also include: • Service user involvement with medication treatments • Self-administration	• Medicine Management Group with Chair's Assurance reporting to QIR
	Learning Disabilities programme	• Embed STAMP and STOMP • Embed Ask, Listen, Do • Ensure timely access to care and treatment reviews.	• Learning Disabilities Strategy Group

		• Improved access to physical health and primary care services	
	Safety of older people	• Improving nutrition and hydration • Safer mobility – reducing falls. • Safer skin – reducing pressure damage. • Increase in healing rates and compression for leg ulcers following the lower limb pathway. • Identifying and care planning for frailty	• Nutrition and Hydration Steering Group • Fall improvement project. • Tissue Viability Steering Group with Chairs Assurance reporting to QIR
	Antimicrobial resistance and healthcare-associated infections	• Strengthen antimicrobial stewardship. • Reduce healthcare acquired infections	• Medicine Management Group with Chair's Assurance reporting to QIR

Appendix E

Patient safety incident type or issue	Planned response	Anticipated improvement route
Death's that do not meet Solent's PSIRP	Review by Mortality process and SJR/SJR plus (including family input)	Create local safety actions and feed these into the quality improvement programme when required.
Documentation/IG Breach	Review by operational managers in conjunction with IG team with cross system reporting, as necessary. Continued monitoring through IG/Security meetings. IG team to organise the IG breach strategy meetings and any subsequent investigations, except when there are patient safety concerns, these will be organised by the Quality and Safety team. Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Patient Violence and aggression	Review by operational managers in conjunction with Security Management Specialist Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Equipment failure of Medical Devices	Review by operational managers in conjunction with Medical Devices Safety Officer Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Missing patient/Absconding/Absence without leave	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Safeguarding	Review by operational managers in conjunction with Safeguarding to ensure referrals made to facilitate external review. Continued monitoring of records to determine any emerging risks/issues outside of Safeguarding remit	Create local safety actions and feed these into the quality improvement programme when required.

Access / admission/ transfer / discharge	Review by operational managers in conjunction with service leads and cross system reporting, as necessary. Continued monitoring of records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Infection prevention and control incidents such as: • Patients who are clostridium difficile toxin positive (>48 hrs after admission) • Escherichia coli, Methicillin-Sensitive Staphylococcus Aureus (MSSA), Methicillin-Resistant Staphylococcus Aureus (MRSA), Pseudomonas, Klebsiella blood stream Infections (>48hrs after admission) • Deaths from health care associated infections (inpatient and community settings where staff have given hands on care) • Any incident of concern can be added to the process at the time e.g., outbreak causing ward closure or decontamination issue	Review by operational managers in conjunction with Infection Control and Prevention team and cross system reporting, as necessary. Continue holding outbreak meetings. Provide a report following closure of the outbreak, to include good practice and areas of learning. Continue nationally required external reporting for specific infection groups. Continued monitoring of incident records to determine any emerging risks/issues. Infection Prevention and Control team to undertake initial review and identify learning. To escalate to Quality and Safety team if there are significant safety concerns. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Self-harm	Review by operational managers in conjunction with subject matter experts	Create local safety actions and feed these into the quality

	Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised.	improvement programme when required.
Venous thromboembolism	Review by operational managers in conjunction with subject matter experts. Risks/issues to be reviewed by learning response tool if required, where patient safety is compromised.	Create local safety actions and feed these into the quality improvement programme when required.

Title of Paper	Solent's Patient Safety Incident Response Policy
Date of paper	22/09/23
Presentation to	Trust Public Board
Item No.	18.2
Author(s)	Quality & Governance Team
Executive Sponsor	Angela Anderson
Executive Summary	• Solent have written this policy with the knowledge that following the transitional period, and before the new Organisation is formed, it will be reviewed with our fusion partners, to develop one policy. • It is s a requirement that all Organisations have a Patient Safety Incident Response Policy as part of the implementation of PSIRF. • The policy details the process for managing our Patient Safety Incident Response plan, through Improvement and Oversight.

Action Required	For decision?	N	For assurance?	Y
Summary of Recommendations	The Trust Public Board is asked to: Review the Solent Patient Safety Incident Response Policy The policy is being presented for ratification at the Policy Steering Group on 26th September 2023.			
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	No Previous Committees			

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	X	10. New ways of working	X	14. Supportive Environments	X
4. Life-course approach		11. Growing for the future		15. Partnership and added value	X
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

Level of Assurance *(tick one)*	Sigificant		Sufficient		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								

Solent's Patient Safety Incident Response Policy

Effective date: 30th October 2023

Estimated refresh date: 31st March 2024

	NAME	TITLE	SIGNATURE	DATE
Author	**Aderemi Aderibigbe** **Teresa Power**	**Associate Director of Quality, Safety, Governance and Risk** **Patient Safety Specialist, Operational Lead**		
Reviewer	**Angela Anderson**	**Chief of Nursing and Allied Health Professionals**		
Authoriser	**-**			

Contents

Purpose

Solent NHS Trust provides community, learning disability mental health services to people who live in Portsmouth, Southampton, Hampshire, and the Isle of Wight. Our overall aim is keeping more people healthy, safe, and independent at or close to home, and we believe this policy will help us do that.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **Solent NHS Trust's** approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all **Solent NHS Trust services.**

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, safeguarding, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

This policy also acknowledges that there will be other types of incidents reported within the organisation that are not patient safety incidents. This may include incidents affecting staff, estates and facilities incidents, information technology or information governance incidents, finance incidents and other corporate or organisation incidents that are not directly related to patient safety. Response to these incidents will be outside the scope of this policy and are not included in our PSIRP.

Our patient safety culture

Solent NHS Trust adopts the principle of Just Culture which means that we ensure staff involved in patient safety incidents are supported and treated fairly. Over the years, we have adopted several initiatives to foster a good patient safety culture. This includes:

- Our adoption and incorporation into policy of the NHS England Just Culture Guide
- The **R**esponding to **I**ndividuals **P**ost-event to **P**revent **L**ong term **E**ffects "RIPPLE" Model, our bespoke approach to supporting staff involved in patient safety incidents which gives opportunity for individuals to request support as part of incident reporting. This model pulls together the suite of already existing staff support resources under one clear framework for staff.

Stage 1 - event	Stage 2 – immediate actions	Stage 3 - notification	Stage 4 – wellness response	Stage 5 - reflection
	Within 48 hours	**Within 72 hours**	**Within 2 weeks**	**Up to 3 months**
Event Occurs 	Take immediate safety actions if required	Ulysses – tick box for additional support if required	Arrange facilitated peer support session	Reflective practice/safety chat
	Shift leader/manager response – initial debrief	IRM – identify staff support required	Arrange formal debrief – TRiM	Schwartz round
	Escalation to senior/on call manager if required	Specialist advice if relevant to the incident e.g. security	Group/wellbeing supervision	Consider accessing resources via Occupational Health/Talking therapy

Figure 1: The RIPPLE Model

- Our safety chats (Safe Tea Chats) which provide opportunity for groups of staff across our services to have an opportunity to engage in an informal conversation about safety within their services. Providing opportunities to discuss safety concerns and options for improvement in an informal non-threatening environment.
- Our series of Schwartz Rounds also provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.
- We also currently run workshops on psychological safety, kindness, and civility for services where needs are identified with particular focus on the impact of these on patient safety.
- We provide sessions on psychological safety, kindness and civility and compassionate leadership on Solent's preceptorship programme.

The leadership of the organisation has embraced, championed, and fostered a safety culture within the organisation over the years by supporting, endorsing, and engaging in the above initiatives. This has been evident in positive outcome in our staff survey results over the years with our organisations performance in metrics specific to patient (and staff) safety being among the top for comparable Trusts.

Looking forwards, our adoption of PSIRF will enhance our safety culture through the creation of a stronger link from incident reporting through to improvement. The principles we adopt will include putting those affected by patient safety incident (staff, patients, families, and carers) at the front of our learning and improvement. This will continue to foster continuous improvement in the Trust's safety culture.

We will also continue to ensure our approach to learning from patient safety events continues to focus solely on systems learning and improvement, and will exclude any attempt to apportion blame, liability, root cause or define cause of death and or whether this was avoidable or otherwise.

Patient safety partners

Solent NHS Trust was one of the national early adopters of the approach to include patient safety partners in the managing of patient safety events within the NHS in line with the NHS Framework for Involving Patients in Patient Safety, part of the NHS Patient Safety Strategy 2019. As a result, a team of patient safety partners have been recruited by the organisation with dedicated roles in the organisational management of safety.

Our approach to involving our patient safety partners and maximising the benefits to our safety culture, learning and improvement is set out in our Patient Safety Partner Involvement Policy. The principle has been to train and develop Patient Safety Partners (PSPs) to a national standard, to ensure impact on and influencing local, system and national safety policy.

Our Patient Safety Partners (PSP) are people who support effective safety governance within the Trust by working in partnership with our staff, providing a different perspective on patient safety which is not influenced by organisational bias or historical systems, resulting in a patient-centred approach to provide safer healthcare.

The interaction of the PSP within the Trust is complex, and Patient Safety Partner Involvement Policy sets out how various teams within the organisation interacts with the PSP team. The policy also defines the PSP task profile which is varied including participation in key safety meetings and committees, representing the patients', families', or carers' voice, co-design of development of patient safety initiatives and providing a 'critical friend' view to safety related information.

The PSP is not an employee within the Trust which enables them to provide an independent perspective. They are remunerated for their time and can claim 'out of pocket' expenses. We have involved them in the development of this policy, our Patient Safety Incident Response Plan and will involve them in any future reviews of these documents

Addressing health inequalities

Health inequalities are 'unfair and avoidable differences in health across populations and between different groups within society' (The King's Fund 2020). They arise because of the different conditions in which we are born, live, work and age, and are affected by the factors that determine how easy it is for people to access healthy choices equally – for example, services are designed, funded and run in a way that meant they are equally accessible for everyone; or government policies that prioritise tackling health inequalities and supporting people to turn this into a reality.

Solent NHS Trust recognises we have a major role to play in reducing health inequalities within the communities we serve and in our wider health system. The Trust has a well-embedded communities engagement strategy that listens to and ensure the voices of our communities are at the fore of our activities. This includes working with our communities to develop our annual quality and safety priorities.

As part of the implementation of PSIRF, the Trust has committed to seeking options to capture protected characteristics of those involved in patient safety incidents to ensure we are able to review, understand and address potential inequalities. In addition to recording, at the point of reporting on our systems, and to ensure potential gaps in recording are addressed, all tools we use to respond to patient safety incidents will prompt recording of protected characteristics and consideration of inequalities, including when developing safety actions.

The Trust's commitment is to:

- ensure our communities are involved in the development of the policies and plans relating to implementation of PSIRF.
- engage and involve patients, families and staff following a patient safety incident with clear consideration of their different needs.
- uphold a system-based approach (not a 'person focused' approach) and ensure staff have the relevant training and skill development to support this approach. This will support the development of a just culture and reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce.

We will adopt an intelligent approach to using the data captured to identify any disproportionate risk to patients with specific characteristics and use this information to inform our patient safety incident response and improvement activities.

Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

Our Alongside Communities – the Solent approach to engagement and inclusion also describes our objectives for achieving health equality through:

- Making it easy for our diverse communities to access our services.
- Recruiting and retaining the right people from diverse communities, offering a local route to employment and career development
- Valuing and respecting those who use our services and our people as individuals.
- Offering and providing learning and development opportunities to our diverse workforce to help them fulfil their greatest potential.
- Supporting people with caring responsibilities, those who work with us and those in the local community.
- Further developing our inclusive approach to volunteering, providing step up opportunities into employment.

Engaging and involving patients, families and staff following a patient safety incident

Solent NHS Trust is committed to ensuring the principles of engagement as described by our community, underpins our work. We shall make sure our community voice is heard and that it counts. **Alongside Communities** – the Solent approach to engagement and inclusion describes the journey we are taking with our communities as partners, to improve health, reduce health inequalities and improve the experience of care. It provides a framework for 2020 – 2025, and within that the flexibility to respond to the everchanging nature of health services provision and, most importantly, the things that matter most to the community we serve.

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

At **Solent NHS Trust** we believe that where an event has led to harm (of any level), patients, their families and carers should receive an explanation and apology as soon as possible after the event and that staff feel confident to apologise at the time of the event or when it is recognised, there and then. As a result, we have developed a policy on Being Open and Duty of Candour. Within the context of this policy, this approach is referred to as Being Open. We are committed to being open and transparent in all cases of patient safety where harm is noted and take this responsibility very seriously. This is a duty for all staff when interacting with or supporting the person who is the subject of a patient safety event.

Communication with the person who is a subject of harm (or their next of kin in cases where they have died or lack capacity), must take place as soon as reasonably possible after the event and must be appropriate to the needs of the individual(s). Staff must ensure that a prompt, genuine apology is offered (using the word “sorry”) and an open and honest discussion held with the patient, family, or carers, providing an explanation of facts known at the time of the initial discussion.

Solent NHS Trust, like all NHS organisations, also have a statutory Duty of Candour, which is a legal requirement that states that patients or their families/carers will be informed when a safety incident has occurred that has caused significant harm. The Statutory Duty of Candour (DoC) applies for incidents which could or do result in Moderate Harm, Severe Harm, or Death (or prolonged psychological harm) because of our care provision (or omission of care). The Statute has requirements in how this duty must be enacted and for how all elements of the Duty of Candour are completed.

All discussions must be documented fully in the patient notes and for all incidents meeting the statutory Duty of Candour, an apology and explanation must be offered in writing to the patient, family, or carer. Where this letter is declined, it must be clearly documented in the patient records (if the patient declines) and on the incident reporting system, Ulysses. Our response to such incidents must be explained to the patient, family or carers and they must be offered the opportunity to be included in the completion of the response activities under PSIRF including participating in any reviews, or systems-based investigations. The outputs of such responses must also be shared in a way that considers their needs. Preferred communication methods with the patient, family or carer should be discussed and documented, including any rejection of further involvement in incident response activities.

The Trust commits to ensuring that outputs of incidents responses are shared with the patient, family, or carers within 10 days of being approved. If they do not wish to see the output, this must be documented on the incident reporting system. Should they change their mind later, it will be made available to them. The patient, family or carer must also be provided with a named service contact details who will coordinate liaison with the family.

The Trust also has a dedicated Family Liaison service and consideration must be given to discussion with the service regarding whether it is appropriate to involve the service in liaison with the patient and/or their family in relation to the safety incident.

While outside the scope of this policy, the Trust also has a Patient Advice and Liaison service and a clear approach to managing patient and service user complaints. There is also a well-established Freedom to Speak Up Guardian function. All these provide routes for people - patients, families, carers, and friends and staff to provide feedback to us whether it be a concern, comment, complaint or compliment about care or any aspect of the Trust services.

In addition, there are a variety of additional resources, available locally and nationally that can help those affected by a Patient Safety incident and we will work with patients, families, and carers to signpost to their preferred source for this. Examples are:

Complaint's advocacy

https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy

The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings, and review information given during the complaints.

Healthwatch

https://www.healthwatch.co.uk/

Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters. You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site: https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman

https://www.ombudsman.org.uk/

The PHSO makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Learning from deaths – Information for families

https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/

This explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

National guidance for NHS trusts engaging with bereaved families.

https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Help is at Hand – for those bereaved by suicide.

https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

This is specifically for those bereaved by suicide and offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support

https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/
This provides information for staff and families and has been developed by the London region independent investigation team in collaboration with the London Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support

These sites offer support and practical guidance for those who have lost a child in infancy or at any age.
https://www.childbereavementuk.org/grieving-for-a-child-of-any-age
https://www.lullabytrust.org.uk/bereavement-support

Citizens Advice Bureau

https://www.citizensadvice.org.uk/ The Citizens advice bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care receive

Patient safety incident response planning

In line with the requirements of PSIRF, Solent NHS Trust will take a proportionate approach to our response to patient safety incidents to ensure that the focus is on maximising learning and improvement rather than basing our responses on arbitrary and subjective definitions of harm. There are nationally set patient safety incidents response requirements, and we will align our response appropriately to these national standards. These will be in addition to our locally define safety priorities.

Resources and training to support patient safety incident response.

It is a mandatory requirement for all Solent staff to complete the level 1 Patient safety training, for our board to complete the level 1 board training and our managers and registrants to complete level 2 Access to practice training. This provides a foundation of understanding patient safety for all staff.

Solent has a bank team of Investigators. They are supported by Patient Safety Specialist, Operational lead and the Quality and Safety team. Alongside some subject matter investigators who are already substantively employed by Solent.

Investigators, the Patient Safety Specialist Operational lead and Quality and Safety Manager have undertaken the following HSIB training.

- System approach to learning from patient safety incidents
- Involving those affected by patient safety incidents in the learning process.
- Investigative Interviewing
- Demystifying Thematic Analysis

This will remain a stipulation for the investigator role.

Staff in an oversight role, commissioning and signing off the investigation must have undertaken the following training.

- Systems approach to learning from patient safety incidents
- Oversight of learning from patient safety incidents
- Involving those affected by patient safety incidents in the learning process.

These staff include.

- Chief of Nursing and Allied Health Professionals
- Chief Medical Officer
- Deputy Chief of Nursing and Allied Health Professionals
- Deputy Chief Medical Officer
- Associate Director of Quality, Safety, Governance and Risk

- Head of Quality and Safety
- Heads of Quality and Professions for all services lines
- Clinical Directors for service lines
- Patient Safety Specialist, Operational Lead

Our patient safety incident response plan

Our plan sets out how **Solent NHS Trust** intends to respond to patient safety incidents over a period of up to 31st March 2024 as we transition to a new organisation from 1st April 2024. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The plan details how the Trust will meet the national requirements and our local priorities and pre-determined proportionate response. The plan has been developed with our people – staff, patients, carers, relatives, and communities, and will be subject to ongoing review, development, and revision to ensure it stays up to date with emerging priorities. We have also used insights from our data (qualitative and quantitative), our history and our strategies to define response requirements and proportionality.

Our Current Patient Safety Incidents Response Plan can be accessed at:

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. From 1st April 2024, we will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports,

improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Patient safety incident reporting arrangements

All Solent NHS Trust staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system (currently Ulysses) and will record the level of harm they know has been experienced by the person affected (see Trust Guidance for Harm Reporting Appendix 1).

Service Managers will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion in line with the Trust Plan. This should include consideration and prompting to teams where Duty of Candour applies (See Trust policy on Being Open and Duty of Candour).

Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the Service Line (see Patient safety incident response decision-making below).

Service Lines Leads (Head of Quality and Professions), or Specialist Practice leads (e.g., Safeguarding, health and safety, pharmacy) will highlight to the Patient Safety team any incident which appears to meet the requirement for reporting externally based on the Trust Plan. The external reporting requirements may be to allow the Trust to fulfil mandatory reporting requirements, to work in a transparent and collaborative way with our ICB or regional NHS England teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

Patient safety incident response decision-making

The Trust Incident Response Review Meetings (IRRM) panel will have delegated responsibility for the consideration of incidents for PSII and validation of response approach adopted on a weekly basis for incidents reported in-week. The meetings will be led by the executive lead for patient safety in the Trust, currently the Chief of Nursing and Allied Health Professions. Details of oversight arrangements are provided in the Oversight roles and responsibilities section of this policy.

The Learning from Incidents and Death panel will have oversight of the outcomes of all responses including patient safety incidents investigations to ensure such review outputs and recommendations are founded on a systems-based approach and that safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

Assurance of process and output effectiveness will be through the Quality Improvement and Risk (QIR) Group to the Quality Assurance Committee (QAC) and Board.

Responding to cross-system incidents/issues

The Trust will have relevant ICBs representatives as members of our routine Incident Response Review meetings. This will ensure they are party to all discussions and are able to fulfil a role in identifying cross-system issues requiring system-wide response. Through the Trust's Quality and Safety team, who will be point of contact for cross-system response, the ICB will play a coordination role for system response. It is anticipated that the ICB will have representation on relevant safety groups of all providers within the system and therefore help with triangulating themes and facilitating system response.

Incidents identified as presenting potential for significant learning and improvement for another provider will be communicated back to the provider by the Trust's quality and safety team to their peer within the other provider. Where themes of safety events affecting individual external providers are identified, the Trust will share relevant insights with the provider and the ICB as appropriate.

The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Timeframes for learning responses

The Trust will work on the principle that extended response timescales can have detrimental impact on those involved in patient safety incidents, therefore will ensure all responses are completed within the timescales set out in the table below.

Response Tool/ Type	Timescales for Response
Systems-based PSII	6 months
After Action Reviews	30 calendar days
Swarm Huddle	48 hours
Thematic Review	30 calendar days
Multi-Disciplinary Review	30 calendar days

Recognising the involvement of our patients, families and carers in the learning responses is a focus for PSIRF, therefore the timescales for the response needed to be flexible and agreed with those involved. However, these should be not later than the timescales listed above.

We also recognise that there will be instances where we are not able to adhere to the timescales we have set out, for example, when additional information required are not immediately available, when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information. In these exceptional circumstances, the Trust will agree an extended timeframe with those affected.

Safety action development and monitoring improvement.

Solent NHS Trust approach to safety action development starts by identifying and agreeing those aspects of the work system where change could reduce risk and potential for harm (i.e., 'areas for improvement' or system issues). Actions to reduce risk (i.e., safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are then defined.

Safety action development will involve the learning response team, local (and broader, e.g., leadership, management) team to design and implement, quality improvement team and those affected by the incident.

A variety of methods will be used for the development of safety actions. This will include:

- For service specific / local context actions: Interviews, Observations, Focus groups, Desktop reviews, Simulation/testing, Standard quality improvement methods such as PDSA cycles.
- For wider organisational context safety action: Qualitative review of patient safety learning response findings, Surveys, Literature reviews – what has worked well elsewhere? Focus groups, Consensus panel – reaches a wider group of members with experience of work.

Agreed safety actions will be included in the learning response report (e.g., patient safety incident investigation (PSII) report) after an individual incident response or in a wider Trust safety improvement plan as appropriate.

The Trust will implement a robust monitoring process for agreed safety actions through centralised recording on the Trust Risk Management System (currently Ulysses). Our approach is to continue being curious by inquiring about how things are working and monitor that safety actions we put in place remain impactful and are sustainable.

Each completed safety action will be presented monthly for agreement at relevant Service Line Governance Board and subsequently for assurance at the Quality Improvement and Risk Group.

Safety improvement plans

Solent NHS Trust safety improvement plans bring together findings from various responses to patient safety incidents and issues. They will take the form of:

- an organisation-wide safety improvement plan summarising improvement work themes aligned to our Patient Safety Incidents Response Plan
- individual safety improvement plans aligned to individual patient safety incident investigation that focus on a specific service, pathway, or location.

Progress reporting on our safety improvement plans will be through:

- Bimonthly Service line improvement and progress reports against improvement actions and plans to the Quality Improvement and Risk Group.
- Quarterly reports by the quality and safety team on patient safety and improvement to the Quality Improvement and Risk Group.
- Annual patient safety improvement report to Quality Improvement and Risk Group, Quality Assurance Committee and Board, part of great care section of Trust annual report.

Oversight roles and responsibilities

Solent NHS Trust oversight arrangement for patient safety incident response works with the following underlying principles:

- We focus on enabling and monitoring improvement in the safety of care, not simply monitoring the quality of the investigation.
- We ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
- We respond to patient safety incidents for learning as an active strategy towards continuous improvement, and not a reflection of our organisation having done something wrong.
- We adopt a collaborative approach to the oversight of our response to patient safety incidents in recognition of the fact that meaningful oversight cannot be developed and maintained by individuals or organisations working in isolation.
- Our approach to oversight is one that fosters a climate of openness to encourage consideration of different perspectives, discussion around weaknesses in systems and a willingness to suggest solutions.
- We recognise that leaders in the organisation have a unique opportunity to do more than measure and monitor, we therefore adopt an oversight approach that asks questions rather than judge, to enable the use of position of power to influence improvement through curiosity.

Our Trust board is responsible and accountable for effective patient safety incident management in the organisation. This includes supporting and participating in cross-system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

The Trust board has delegated the Chief of Nursing and Allied Health Professionals as the PSIRF executive lead. As executive lead, they provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required.

The Chief of Nursing and Allied Health Professionals:

- supported by the rest of the executive team/board, oversees the development, review and approval of the organisation's policy and plan for patient safety incident response, ensuring they meet the expectations set out in the patient safety incident response standards where relevant.
- ensures patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the quality assurance committee (QAC) and other relevant board sub-committee(s), Quality Improvement and Risk (QIR) Group, Service Line Governance Boards, and other relevant Governance meetings within the Trust.
- ensures roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

- have specific responsibility to quality assure learning response outputs by:
    - reviewing PSII reports in line with the patient safety incident response standards and signing it off as finalised, with support by relevant colleagues at the Learning from Incidents and Deaths Panel.
    - reviewing for quality assurance at the Learning from Incidents and Deaths Panel, a sample of all learning response methods other than PSII where a full report for submission have not been produced.

Solent Oversight and Assurance Approach

In line with the Oversight roles and responsibilities specification, the Trust will adopt the framework below as guide to our approach to oversight and governance of PSIRF:

Oversight & Governance Area	Oversight Questions	Where is Assurance Tracked	How is Assurance and oversight gained
Engagement and involvement of those affected by patient safety incidents	How do we ensure those affected by patient safety incidents are engaged and involved in any learning response?	Weekly Incident Response Review Meetings (IRRM) and Monthly Learning from Incidents and Deaths Panel (LIDP)	IRRM will cover/document discussion around engagement of those affected and set PSII commissioning requirements for involvement. LIDP will gain assurance of involvement as part of sign off for PSIIs and quality assurance of non-PSIIs. There will be routine attendance to IRRM/LIDP extended ICB colleagues and patient safety partners
	Does engagement include prompt and effective communication between those affected by a patient safety incident and our organisation?	IRRM Service Line Governance Meetings Quality Improvement and Risk (QIR) /Quality Assurance Committee (QAC)	IRRM confirms being open/effective DoC application. Duty of Candour (DoC) compliance tracking at service line governance meetings DoC compliance report to QIR/QAC Service line governance tracking and escalation to QIR tracking of complaints relating to ineffective communication throughout PSI management
	Does engagement and involvement occur respectfully and according to individual needs	LIDP	Review of section on engagement and involvement within PSII reports to assure of process tailored to needs. Seek assurance on involvement as part of review of samples of other non-PSII responses
	How do we know how well our processes are working? What are the current barriers?	QIR/QAC	Reports to QIR/QAC on incident management KPIs including DoC / time to closure based on response types etc.

Oversight & Governance Area	Oversight Questions	Where is Assurance Tracked	How is Assurance and oversight gained
			Feedback reports to QIR/QAC – feedback from those involved in PSIIs – patients/staff
	Are patients or staff with protected characteristics represented more often than others in any of our incidents and responses? What are the organisational or cultural reasons behind this?	QIR / QAC	Analysis report of incidents/harm/responses by protected characteristics to QIR/QAC Participation of patient safety partners and staff networks in evaluating outcomes
Policy, planning and governance	Does our patient safety incident response plan match the risks that feel tangible to us as an organisation?	Quality Performance Review Meeting (QPRM)/QIR/Clinical Executive Group (CEG)	Review of QPRM escalations to QIR in context of PSIRP Review of risk pyramid report to QIR in the context of PSIRP Quarterly PSIRP sense- checking at CEG/QIR
	Does emerging intelligence match our assumptions about the biggest risks in our plan?		
	Can we demonstrate wide collaboration and stakeholder involvement in the development and maintenance of our plan?	PSIRF Implementation/Transition/ Review group QIR	Stakeholder involvement in group. ICB/patient safety partners participation in QIR review of PSIRP Community engagement/consultation on draft PSIRP after each significant refresh
	Does our plan demonstrate a thorough analysis of data and provide a clear rationale for the selection of patient safety incidents for further learning?	PSIRF Implementation/Transition/ Review group QIR	Data/Thematic Analysis workstream outputs presented to PSIRF implementation group and QIR. Check and challenge session at both forums to inform selection of priority incidents. Consideration of draft plan at Implementation group/QIR annually to ensure rationale is clearly described within PSIRP
	Is our ICB assisting cross-organisation working and information sharing?	LIDP/QIR/QAC HIOW Quality Board	ICB attendance and participation in LIDP/QIR/QAC HIOW Quality Board with Solent attendance
	How do we choose our response to a patient safety incident?	IRRM	IRRM will on a weekly basis consider incidents from previous week, where they fit in our PSIRP and check that appropriate responses in line with

Oversight & Governance Area	Oversight Questions	Where is Assurance Tracked	How is Assurance and oversight gained
			PSIRP are on track. Where incidents sit outside current PSIRP, then IRRM will decide on appropriate response
	How do we support those who bring 'bad news' or surprises about organisational safety?	QIR	PSIRP/Policy clearly describes a just culture approach, place of freedom to speak up, RIPPLE and other management support. Quarterly PSIRP sense-checking at QIR considers relevant reports
Competence and capacity	Are we employing and continuously developing expertise in patient safety science for key roles?	PSIRF Implementation Group / QIR	Training needs analysis discussed and agreed at implementation group. Training needs analysis discussed and approved at QIR. Training-level required clearly aligned to specific role, hence noted as automatic requirement if post-holder changes
	Are our learning responses adequately resourced (including funding, time, equipment, and training)?	Chief of Nursing and AHPs Directorate (CND) Business meeting / Corporate Performance Review meeting / LIDP	PSII investigators team directory Quality assessment as part of sign off at LIDP. Resource implication for non-PSII responses will be described in PSIRP and subject to ongoing review
	Are training and competence requirements met for learning response leads?	QIR	PSII investigators team training / competence checklist – update report to QIR For Non-PSII response leads training/competence requirements checklist – update report to QIR
	Do we have the competence within our teams to feel we can confidently have conversations with patients and families about patient safety incidents?	QIR	Staff training needs defined – Level 1 and 2 compliance. HQPs and service line governance staff training on involving those affected by PSI
	Does our ICB have its own continuous development plans in patient safety	ICB	ICB

Oversight & Governance Area	Oversight Questions	Where is Assurance Tracked	How is Assurance and oversight gained
	science training and competence to enable it to participate effectively?		
	Are our teams confident in having conversations with patients and families affected by an incident but where an individual learning response will not be completed in response?	Service line governance / IRRM/LIDP/QIR	Reporting on PSIs where learning responses were not completed. Report triangulating complaints related to PSIs with no learning response. Clear guidance and support for staff in fulfilling the DoC requirements for notifiable incidents
Proportionate responses	How are we triangulating insight from our responses to patient safety incidents?	QIR	Thematic analysis reports to QIR quarterly
	Are we using recognised system-based methodologies for data collection and analysis?	LIDP	Check as part of Quality assuring PSIIs for sign-off. Training in systems-based methodology for all PSII investigators
	Is external guidance/information used to inform patient safety responses and findings?	LIDP	Check as part of Quality assuring PSIIs for sign-off.
	Do we have collaborative arrangements with our ICB to facilitate cross-system learning responses? This includes processes for recognising when support may be required and raising this with ICB colleagues	LIDP/QIR/QAC HIOW Quality Board	ICB representation on Trust meetings – LIDP/QIR/QAC. HIOW quality board in place for cross system discussion and learning
	Are learning responses completed in a timely manner in line with expectations of those affected?	LIDP	Timeliness of learning responses considered as part of quality assurance and sign of PSII reports
Safety actions and improvement	How easy is it to make an improvement in our organisation? Is time, priority and expertise given to those who need it?	QIR/QAC	Improvement session bimonthly at QIR to consider ease and expertise. Improvement Academy reports to QIR/QAC

Oversight & Governance Area	Oversight Questions	Where is Assurance Tracked	How is Assurance and oversight gained
	Do we have and use processes to share emergent intelligence and receive support from external partners (e.g., ICSs, regional and national NHS teams, royal colleges, professional associations, patient groups, charities etc)	IRRM/ LIDP/QIR HIOW learning and sharing network.	Pathway for sharing emergent intelligence identified and actioned from IRRM/LIDP/QIR with ICB support through attendance. Solent attend ICB-led HIOW learning and sharing network
	How do we assess the sustainability of our safety actions and improvements?	QIR	Quarterly audit report of completed safety actions and improvement for effectiveness/assurance of completion – report to QIR. Programme of annual retrospective re-audit of safety/improvement actions for assurance that they are embedded in practice - Report to QIR

The Trust's oversight arrangements ensures that mechanisms for the ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement are embedded as part of our overarching quality governance arrangements. This is done through a cycle of routine reporting to the quality assurance committee (QAC) and other relevant board sub-committee(s), Quality Improvement and Risk (QIR) Group, Service Line Governance Boards, and other relevant Governance meetings within the Trust.

The leadership team monitors the balance of resources going into patient safety incident response versus improvement. Repeat responses are avoided where sufficient learning is available to enable the development and implementation of a safety improvement plan. There is clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement.

Updates to the Trust policy and plan is made as required as part of regular oversight processes with an overall review of the patient safety incident response policy undertaken at least every four years alongside a review of all safety actions, and a refresh of the Trust Patient Safety Incident Response Plan every 12 – 18 months.

There is clear arrangement for collaboration with our health and social care partners across the system, ICB and our communities for responding effectively to patient safety incidents, and ensuring learning and improvements result from our response.

Training requirements

Solent have recognised the importance for all staff to receive training on patient safety, no matter their role in the Organisation. The graphic below, details the training requirements for each role. Level's 1 and 2 is available via My Learning, the Learning Management System and is mandatory. HSIB and an external provider provide all the other training for those in the oversight role, engagement leads and learning response leads.

Solent's approach to PSIRF training

All staff	Registrants, Managers and Patient Experience and Safety roles	Board	Learning Response leads	Engagement Leads	Oversight Roles
•Level 1- Essentials for Patient Safety	•Level 1 – Essentials for Patient Safety •Level 2 – Access to Practice	•Level 1 – Essentials for Patient Safety •Level 1 – Essentials for Patient Safety (Board and Senior leadership team)	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Systems Approach to Learning from Patient Safety •Involving those affected by patient safety incidents in the learning process • Expected to stay up to date and contribute to two learning responses, annually	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Involving those affected by patient safety incidents in the learning process •Expected to stay up to date and contribute to two learning responses, annually	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Systems Approach to Learning from Patient Safety •Involving those affected by patient safety incidents in the learning process •Oversight of learning from patient safety incidents •Expected to stay up to date and contribute to two learning responses, annually

Complaints and appeals.

Solent NHS Trust is committed to dealing with complaints about the services we provide. We are committed to meeting the requirements of the Local Authority Social Services and NHS England Complaints Policy (2017) and reflecting the recommendations from the Francis report (2013) and the 'Complaints Standards Framework' (PHSO, 2020).

Solent NHS Trust want to ensure that complaints are viewed through a user lens whereby all complaints are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. Ultimately, we want all service users to be able to say: 'I felt confident to speak up and making my complaint was simple. 'I felt listened to and understood.' 'I felt that my complaint made a difference.'

We have a policy for Management of Complaints, Service Concerns and Feedback that acknowledges the 'Complaints Standard Framework' (PHSO, 2020) and reflect how Solent aims to:

- Promote a learning and improvement culture.
- Positively seek feedback.
- Being thorough and fair
- Give fair and accountable decisions.

The policy outlines the expectations that patients, families and the community can expect when they raise a complaint with the Trust. We have different routes for people to tell their story including through:

- Service Concern - If a person raises an issue with a service or service line provided by Solent NHS Trust and would like a quick response and resolution, the issue can be dealt with as a service concern that will be resolved by the respective Service Leadership Team
- Advice and Signposting: If a person needs to seek information but is unsure how to do this, the PALS and Complaints Team will explain the process and then signpost the person's enquiry to the correct service line. If the PALS handler requires additional information, they will support the person by asking the right questions to enable them to direct the enquiry to the appropriate service line.
- Raising a Complaint: If a person wishes to make a formal complaint, we will ensure that they are supported and updated throughout and that the process will be explained clearly.
- Professional Feedback: Professional Feedback, is feedback which is received from someone who is raising a complaint on behalf of someone else in their professional capacity.

- Member of Parliament feedback: We can receive feedback from Members of Parliament (MP) who have been approached by their constituent. Depending on the enquiry, we will review the correspondence, and decide on the most appropriate process for resolving. This will either be via our complaints or service concern process, or as an advice and signposting.

Our complaints process is detailed in an easy and clear format.

The contact details for the PALS & Complaints Service are.

Telephone: 0800 0132319 or

Email: pals@solent.nhs.uk

Where people are not satisfied with how we have dealt with their complaint and would like to take the matter further, they are can also contact the Parliamentary Health Service Ombudsman who makes final decisions on unresolved complaints about the NHS in England. It is an independent service which is free for everyone to use. To take complaint to the Ombudsman individuals can visit www.ombudsman.org.uk/make-a-complaint or write to:

The Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London, SW1P 4QP
Telephone 0345 015 4033
Email: phso.enquiries@ombudsman.org.uk

References

The King's Fund (2020). 'Health inequalities – our position'. The King's Fund website. Available at: www.kingsfund.org.uk/projects/positions/healthinequalities (accessed on 23 April 2021).

Appendices

Appendix 1

Physical Harm Grades	Guidance on Grading - Definition
No physical harm	No physical harm
Low physical harm	Low physical harm is when **all the** following apply: • minimal harm occurred - patient(s) required extra observation or minor treatment. • did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit. • did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication. • did not or is unlikely to affect that patient's independence. • did not or is unlikely to affect the success of treatment for existing health conditions
Moderate physical harm	Moderate harm is when **at least one** of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and did not need immediate lifesaving intervention. • has limited or is likely to limit the patient's independence, but for less than 6 months. • has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm
Severe physical harm	Severe harm is when **at least one** of the following apply: • permanent harm / permanent alteration of the physiology • needed immediate life-saving clinical intervention. • is likely to have reduced the patient's life expectancy. • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment.

	• has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions. • has limited or is likely to limit the patient's independence for 6 months or more.
Fatal	You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death. On Ulysses there will be an option later to estimate to what extent it is considered a patient safety incident contributed to the death. This incident will also follow the Trust usual learning from deaths process.

Psychological Harm Grades	**Guidance on Grading – Definition** ***Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available later.***
No psychological harm	Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.
Low psychological harm	Low psychological harm is when **at least one** of the following apply: • distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit. • distress that did not or is unlikely to affect the patient's normal activities for more than a few days. • distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition
Moderate psychological harm	Moderate psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that extends for less than six months. • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months.

	• distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months
Severe psychological harm	Severe psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that continues for more than six months. • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months. • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

Appendix 2 – Equality Impact Assessment

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity, and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation, and other conduct prohibited by the Equality Act of 2010.
- **advance equality of opportunity** between people who share a protected characteristic and people who do not.
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy.**
- **considering what evidence there is to support the decision and identifying any gaps.**
- **ensuring it is an informed decision.**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Quality and Governance	
Title of Change:	New Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	No changes	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g., adjustment to the policy)*
Sex			Not applicable	
Gender reassignment			Not applicable	

Disability			Not applicable	
Age			Not applicable	
Sexual Orientation			Not applicable	
Pregnancy and maternity			Not applicable	
Marriage and civil partnership			Not applicable	
Religion or belief			Not applicable	
Race			Not applicable	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers, or other voluntary sector groups?)	Yes	Patient Safety Partners, involved in the development of the policy.
Have you taken into consideration any regulations, professional standards?	Yes	

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?	The Head of Quality and Safety		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Teresa Power*	*Date:*	

Item No.	١٩		Presentation to	Trust Board – In Public		
Date of paper	21 September 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)
July – August 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	Aug-23 Current Performance		Aug-23 Trending Performance	Aug-23 Variance	Jul-23 Current Performance		Jul-23 Trending Performance	Jul-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%	86.0%				90.0%			
	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

VTE Risk Assessments

Compliance on VTE Risk Assessments has dipped again in August 2023, however this has not triggered a significant variation on the making data count methodology. As previously reported, processes to ensure risk assessments are documented are being reinforced, however review of non-compliant records has shown all patients were given appropriate prophylaxis and no harm had occurred as a result of undocumented risk assessments.

Incident Reporting

When comparing the same period in 2022, there has been a small increase in the number of incidents reported by 1% in July/August 2023. This direction of travel is further reinforced when looking at the overall trend for the number of incidents, a continuing upward trajectory as shown in Figure 1 below.

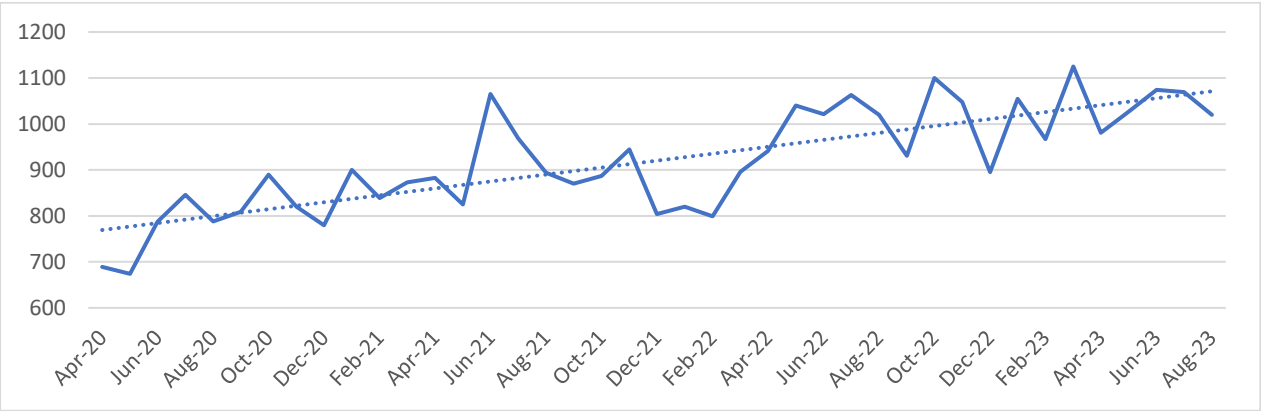


Figure 1: Total number of incidents reported by month

The number of incidents reported per 1,000 patient contacts continues to exceed the upper control limit, reflecting a continually improving reporting culture with the organisation.

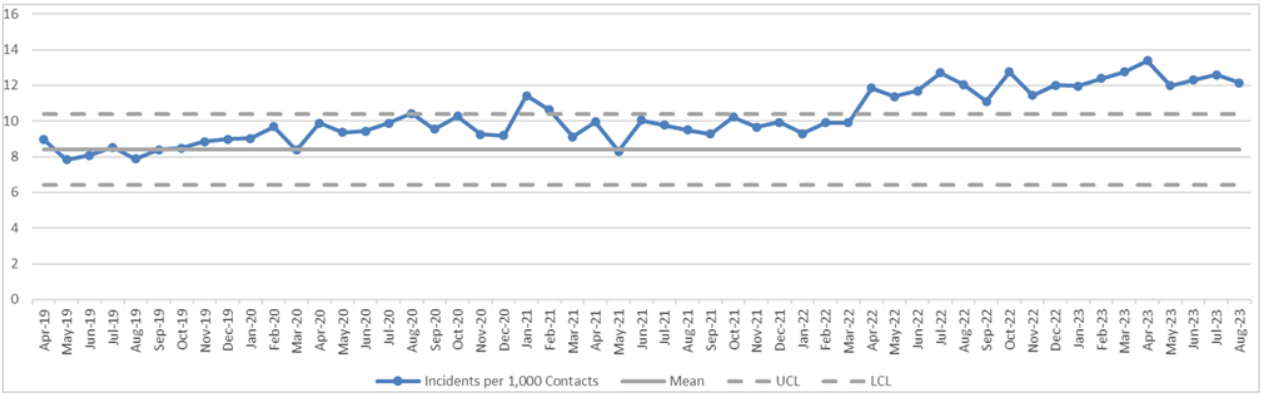


Figure 2: Incidents per 1,000 patient contacts

Following NHS England guidance, Solent introduced updated definitions of harm in October 2022, which outlined that definitions should be based on the actual harm to the individual irrespective of whether any acts or omissions in care contributed to that harm. This has resulted in a more consistent classification of incidents and an increase in the number of incidents reporting Low Harm or Above. Figure 3 below indicates that whilst there has been a steady increase in harm reporting, the figures remain within the upper control limit. The Quality & Governance Team will continue to monitor this shift and a more detailed analysis is now due be undertaken.

Level of Harm Reported	2022/23 (Jul – Aug)	2023/24 (Jul – Aug)	Difference	% change
No Harm/Near Miss	1376	1210	-166	-12.1%
Low Harm or above	704	890	186	26.4%

Figure 3: Number of incidents reported by level of harm

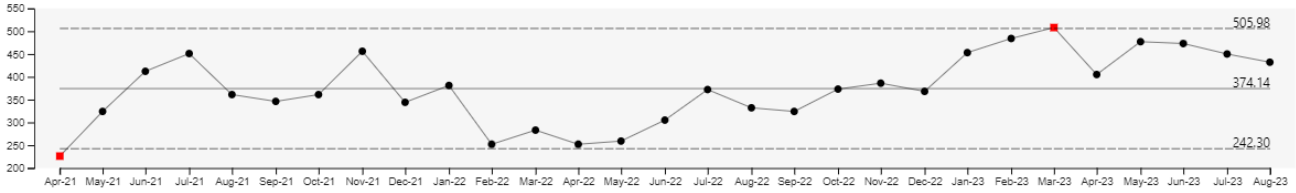


Figure 4: Number of incidents reported of Low Harm or above.

2. Caring

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Aug-23 Current Performance		Aug-23 Trending Performance	Aug-23 Variance	Jul-23 Current Performance		Jul-23 Trending Performance	Jul-23 Variance
Caring	Community FFT % positive*	E	95.0%	98.7%				98.3%			
	Mental Health FFT % positive*	E	95.0%	96.2%				94.2%			
	People Pulse Survey - Advocacy Theme (Recommended for Care & Employment)	E	0	-				-			
	Mixed Sex breaches*	E	0	0				0			
	Plaudits	I	-	94				106			

b. Key Performance Exceptions

Mental Health FFT %

The Friends and Family Test (FFT) scores for Mental Health have flagged a significant negative variation as performance has been below the mean level for 6 or more consecutive months, despite being above target in the most recent period. Solent are proud that the positive feedback received within Mental Health has been stable for more than 18 months, whilst the service is seeing an increasingly complex caseload.

c. Spotlight On: Patient Experience and Feedback

There has been a 20% increase in the number of FFT responses received in July/August compared to the same period in 2022. Of the 4590 responses completed in July and August 2023, 4358 (95%) people told us that, 'overall they were happy with the experience received', which is also an improvement from 94% in the same period last year.

When comparing the July/August period for FFT feedback, an increase in responses was noted across all service lines with a significant increase in Sexual Health Services. The team have advised that one contributing factor towards this increase is the introduction of a volunteer specifically supporting FFT. The children's service line responses have also been consistently higher, using iPads within clinic to capture feedback from the School Aged Immunisations team.

The PALS & Complaints team have secured a volunteer who will be visiting our wards and services to gather real time feedback from patients, carers, or anyone supporting someone to access our services. We hope to build upon this method of gathering feedback in the next few months, with members of the PALS & Complaints teams linking with people face-to-face to seek feedback on their experiences of having visited our services. This is a great opportunity to continue to seek early resolutions to concerns when they arise.

3. Effective

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Aug-23 Current Performance		Aug-23 Trending Performance	Aug-23 Variance	Jul-23 Current Performance		Jul-23 Trending Performance	Jul-23 Variance
Effective	Bed Occupancy - Brambles (Community)	I	92.0%	92.7%				94.6%			
	Bed Occupancy - Fanshawe (Community)	I	92.0%	98.0%				92.7%			
	Bed Occupancy - Jubilee (Community)	I	92.0%	98.2%				97.0%			
	Bed Occupancy - Spinnaker (Community)	I	92.0%	93.3%				95.4%			
	Bed Occupancy - Brooker (OPMH)	I	85.0%	54.4%				56.6%			
	Bed Occupancy - Hawthorns (Adult MH)	I	85.0%	71.6%				86.5%			
	Bed Occupancy - Maples (Adult MH)	I	85.0%	86.1%				84.2%			
	Bed Occupancy - Kite (Acquired Brain Injury)	I	92.0%	92.6%				82.9%			
	Bed Occupancy - Snowdon (Neuro Rehab)	I	92.0%	95.9%				98.4%			
	Length of Stay - Brambles (Community)	I	24.0	22.7				20.6			
	Length of Stay - Fanshawe (Community)	I	24.0	25.3				18.6			
	Length of Stay - Jubilee (Community)	I	18.0	40.4				46.2			
	Length of Stay - Spinnaker (Community)	I	24.0	17.2				18.3			
	Length of Stay - Brooker (OPMH)	I	78.5	37.5				33.6			
	Length of Stay - Hawthorns (Adult MH)	I	34.9	12.3				11.0			
	Length of Stay - Maples (Adult MH)	I	48.6	17.6				30.9			
	Length of Stay - Kite (Acquired Brain Injury)	-	-	65.0				57.0			
	Length of Stay - Snowdon (Neuro Rehab)	-	-	24.0				22.0			
	Non-Criteria to Reside (NCtR) [patient count]	-	-	24				26			
	% clients in settled accommodation	E	59.0%	84.7%				55.5%			

Bed Occupancy – Brambles, Fanshawe, Jubilee, Spinnaker

As the local system is in OPEL4 status, community beds in both Southampton and Portsmouth are trying to be filled as much as possible, to improve system flow and support our acute partners whilst under pressure. This is not likely to improve in the near future, especially with increased pressure as we move into the autumn and winter period. Whilst these metrics are flagging as breaching the 92% quality target, this overachievement is contributing to the reduction of pressure within the system, therefore overperformance is viewed positively.

In addition to the increased occupancy rates in our community wards, our virtual wards are experiencing significant pressure, with activity exceeding capacity frequently during September. Further information on Virtual wards can be found in section 3b.

Bed Occupancy – Hawthorns

Occupancy on Hawthorns has decreased during August as 5 beds were closed due to limited Responsible Clinician cover. For more information, see section 4c. Service Line Performance Review Meetings (PRMs) – Key Areas of Exception.

Bed Occupancy – Brooker

Occupancy rates on Brooker are low as a result of the introduction of an Intensive Support Team (IST) which is utilising the same staff and resource as the ward to manage patients in the community, which is reducing the need for patients to have an inpatient stay. Occupancy rates continue to be monitored against the standard commissioned bed base for the ward.

Length of Stay – Jubilee

The average length of stay on Jubilee remains higher than the target level due to long standing patients on the ward because of the lack of onward flow within Social Care, particularly in Hampshire. Some of the longest length of stay patients have been discharged during this period, however the position is likely to deteriorate further in the coming months.

b. Key Performance Exceptions

Elective Recovery Framework (ERF)

Performance against the Elective Recovery Framework is positive with local data indicating an overperformance of £131k at M5 compared to the most recently published baselines (v5.6). The overperformance has not been included within our financial positions as achievement of this money is dependant on the achievement of ERF across the whole ICS.

	Activity actual	Activity Plan	Activity variance	Income actual	Income Plan	Income variance
Cardiology	535	527	8	£102,185	£100,657	£1,528
CPMS Child Protection/LAC	552	341	211	£106,536	£65,813	£40,723
CPMS General Paediatrics	55	33	22	£13,585	£8,151	£5,434
CPMS Neuro-disability	457	381	76	£88,201	£73,533	£14,668
Diabetes	21	45	-24	£3,003	£6,435	-£3,432
Pain Management	437	371	66	£100,510	£85,330	£15,180
Physiotherapy	8405	8942	-537	£1,622,165	£1,725,806	-£103,641
T&O	4971	4075	896	£894,780	£733,500	£161,280
	15433	**14715**	**718**	**£2,930,965**	**£2,799,225**	**£131,740**

Figure 5: Cumulative ERF performance at M5 compared to ICB baseline v5.6 (unadjusted)

The baselines adjustments submitted at the start of the financial year have still not yet been applied to the published figures (v5.6), however we have received assurance from NHS England that these will be accounted for in the next iteration. The adjustments seek to resolve some discrepancies in the profiling of activity across the treatment functions due to historical data quality issues with the source data, and account for the

reduction in Physiotherapy activity through the introduction of the FCP pathway. This will likely result in a slight positive shift in performance.

Significant work has been undertaken to assure the quality of the information being submitted for ERF, resulting in the improved position at M5. Clarification is being sought around the ability to refresh data that is outside of the SUS flex and freeze timescales, with providers requesting the ability to continuously refresh the year-to-date position with each month's submission.

Urgent Community Response (UCR) – 2-Hour Performance

In January 2023, the Southampton UCR team changed their recording of UCR referrals to try and improve patient flow into the service. This is now being reverted as it was not aligned to the national methodology and negatively impacted compliance with the 2-hour target. This change, along with the implementation of a new triage tool currently used in the Portsmouth UCR service, additional capacity/workload reviews for late shifts to reduce visits carried over to the next day, should bring performance back up above the 70% target by October.

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
2 Hour Referrals	272	288	318	330	381	351	417	383	401	432	453	439	4465
Compliant	207	232	213	219	241	217	242	249	243	273	285	305	2926
Compliance %	76%	81%	67%	66%	63%	62%	58%	65%	61%	63%	63%	69%	66%

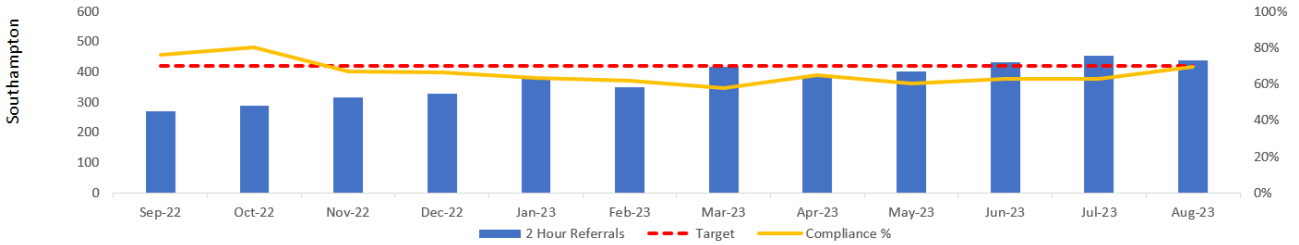


Figure 6: Southampton UCR 2-hour compliance, previous 12 months

Compliance with the 2-hour urgent community response target continues to be around the target rate for the previous rolling 12-months in Portsmouth. The activity carried out in August has not yet been fully validated and is expected to be in line with previous performance once this exercise has been completed. The delay in validating activity has been escalated within the Service Line Performance, and processes are expected to improve in the coming months.

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
2 Hour Referrals	411	400	350	421	336	265	292	263	281	259	301	316	3895
Compliant	307	296	246	222	215	186	229	206	226	171	213	173	2690
Compliance %	75%	74%	70%	53%	64%	70%	78%	78%	80%	66%	71%	55%	69%

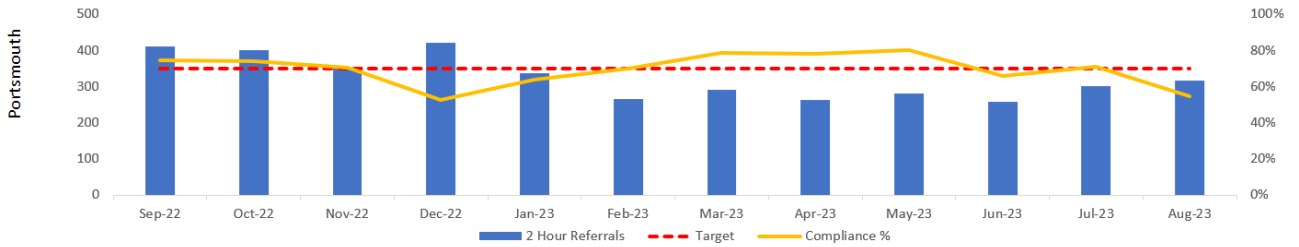


Figure 7: Portsmouth UCR 2-hour compliance, previous 12 months

Virtual Wards

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. We are seeing differences in the average length of stay between Portsmouth and Southampton teams and are challenging services to understand what is driving this.

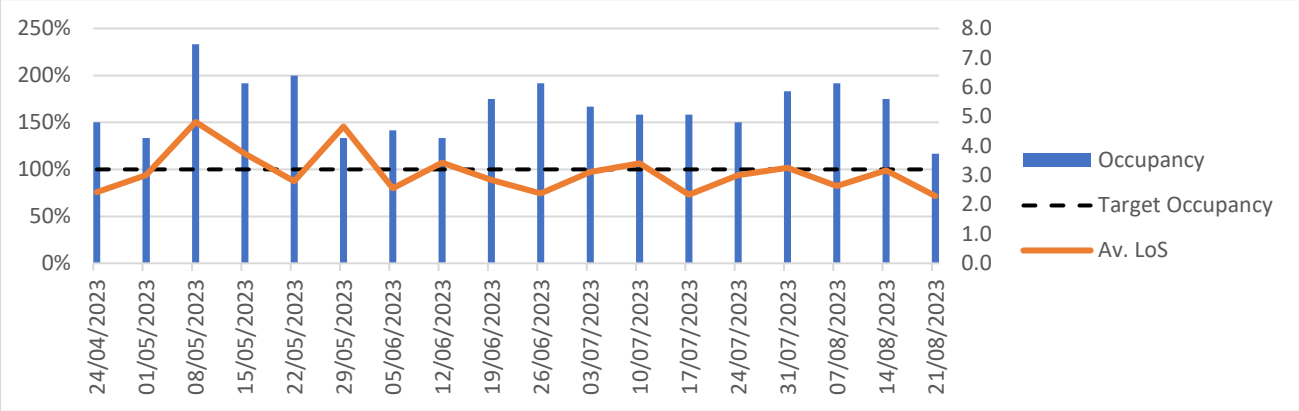


Figure 8: Southampton Virtual Ward Occupancy and average Length of Stay

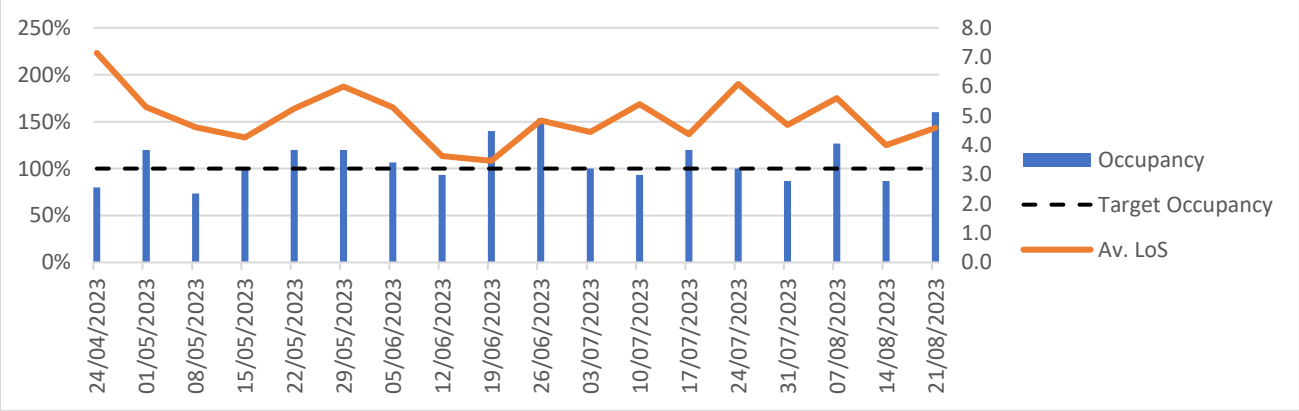


Figure 9: Portsmouth Virtual Ward Occupancy and average Length of Stay

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

Corporate Services reported slippage against a range of financial recovery actions as a result of the increased focus on Project Fusion and impact on capacity to deliver. More intensive support was also requested from the finance team in forecasting to enable corporate teams to keep control on their budgets. The majority of schemes will be reviewed as part of the new Financial Recovery Board, starting in October.

ICT reported that Solent have received secure email accreditation for @solent.nhs.uk accounts, meaning that the use of NHS Mail accounts can be ceased.

4. Responsive

a. Performance Summary

	Indicator Description	Internal /External	Target	Aug-23 Current Performance		Aug-23 Trending Performance	Aug-23 Variance	Jul-23 Current Performance		Jul-23 Trending Performance	Jul-23 Variance
Responsive	Patients waiting > 18 weeks	-	-	5500			H	5402			H
	Accepted Referrals	-	-	26908				27053			
	Formal complaints per 1000 WTE	-	-	3.7				5.4			
	Number of complaints	I	15	11	●	?		16	●	?	
	Number of complaint breaches	-	-	6			H	6			
	RTT incomplete pathways*	E	92.0%	76.6%	●	?	L	77.9%	●	?	
	Maximum 6-week wait for diagnostic procedures	E	99.0%	100.0%	●	?	H	100.0%	●	?	
	Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0	●	?		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		67.0%	●	?	
	Talking Therapies - Proportion of people completing treatment moving to recovery	E	50.0%	51.0%	●	P	L	51.0%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 6 weeks	E	75.0%	94.0%	●	P		99.0%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 18 weeks	E	95.0%	100.0%	●	P		99.0%	●	?	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score*	E	95.0%	88.0%	●	?		87.2%	●	?	

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

b. Key Performance Exceptions

Patients waiting > 18 weeks

As previously reported, the number of patients waiting for a first contact for more than 18 weeks is likely to continue to rise as no significant interventions have been made to the management of waiting lists. Individual services continue to review and triage as appropriate, however without significant investment or change to service provision, the waiting list position will continue to deteriorate and flag a Special Cause Variation.

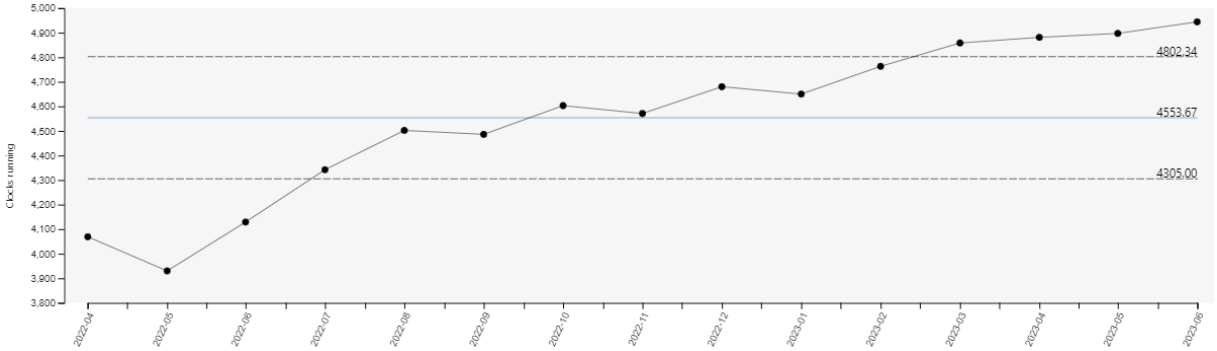


Figure 10: Monthly snapshot of the number of patients waiting for more than 18 weeks – Trust-wide (excluding Dental Services)

All Service Lines carried out a review of waiting lists where there are capacity and demand challenges, and assessed where harm may have incurred as a result. This was presented to the Quality Improvement and Risk Group in September and consideration is now being given on the safest way to manage these moving forward via Quality Assurance Committee.

For the first time since recovery from the initial COVID backlogs in 2021, the number of patients waiting for 52 weeks or more has exceeded 700.

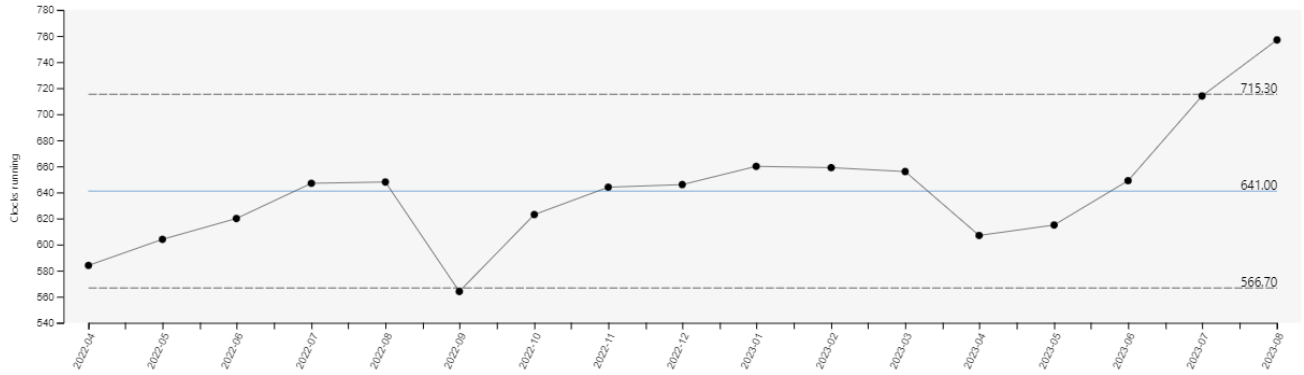


Figure 11: Monthly snapshot of the number of clocks running (>52 weeks) – Trust-wide (excluding Dental Services)

The increase in 52-week waiters is directly attributable to our Podiatry and Portsmouth MSK service. The recruitment challenges within the Podiatry service have been discussed at length in previous reports, and the increase in MSK is related to the Pelvic Health Service. The overall size of the waiting list for Portsmouth MSK has not grown, however 11.8% of patients have now been waiting for more than 26 weeks, compared to 6.9% a year ago (September 2022). The issues with the Pelvic Health service were discussed at Tripartite and the ICB have taken an action to resolve the issue.

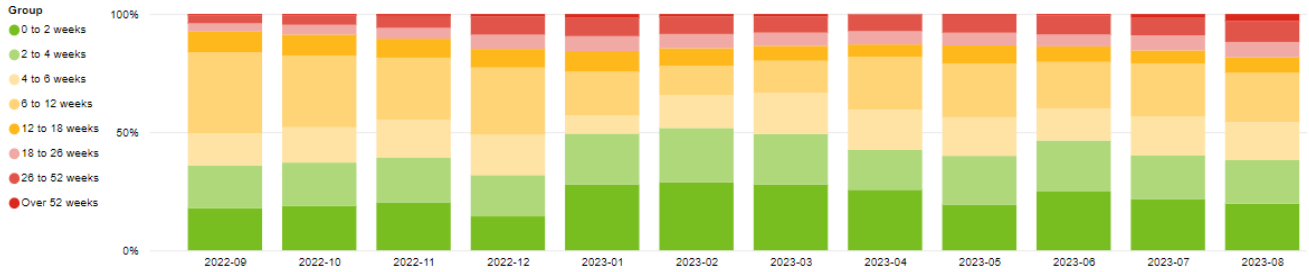


Figure 12: Proportion of patients waiting at month end for Portsmouth MSK service by wait group

Number of Complaint Breaches

An internal audit by PWC is going to undertake a review of Solent's complaints process, and the recommendations will hopefully identify any areas for improvement in our timeliness for responding to complaints. The audit is due to start late October 2023.

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. The breaches continue to be within the Community Paediatrics Medical Service (CPMS) due to challenges around doctor cover. Processes are in place to triage patients to ensure those with the greatest need are prioritised. This position is unlikely to change without significant intervention within the service.

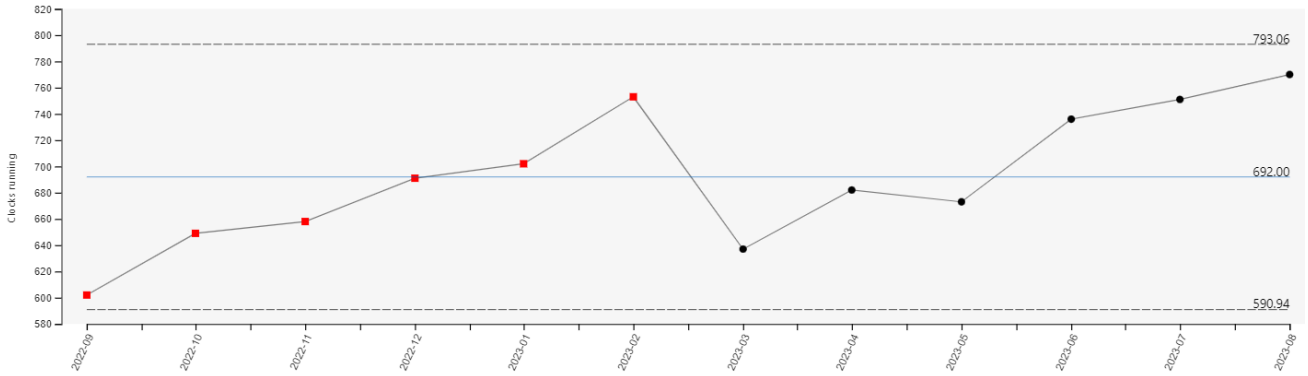


Figure 13: Number of patients waiting at month end for the Community Paediatrics Medical Service

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

Adults Community Services – Portsmouth

Speech and Language Therapy Waiting List Deep Dive

As previously reporting, the Speech and Language Therapy service has had consistently large waiting lists for some time, and the current waiting list is nearing 52 weeks in length, which is concerning. Analysis has shown that the number of patient contacts being delivered by the service appears to be decreasing, whilst the workforce (FTE) is increasing.

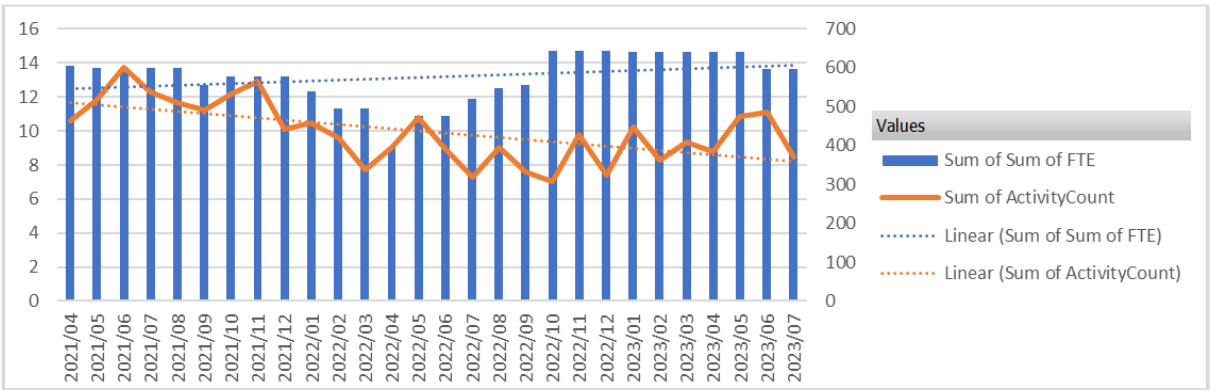


Figure 14: Substantive workforce (FTE) and patient contacts (activity) by month

This is partially due to improvements in data quality and the ceasing of inappropriate recording of non-patient contacts. The increased FTE and decrease in contacts are also as result of 2x new non-registrant staff supporting an advice and guidance offer at the point of triage, particularly within care homes, allowing care home staff to manage minor swallowing difficulties and reducing the volume of patient requiring specialist SLT support. This is proving to be very effective.

The newly introduced prioritisation of patients at triage is ensuring the service are seeing those patients most at risk in a timely way, however those patients deemed low risk (P3) are waiting a significant amount of time and receiving an inequitable service. An action plan has been put in place to reduce the large waiting lists and long waiting times, considering ways to redistribute resource to the most common conditions (dysphagia, progressive neurological conditions), and reduce follow up ratios of patients where appropriate.

An improvement trajectory has been developed, however in order to free up capacity to make the necessary pathway changes 25 new patient appointments need to be released from December onwards. The service has been asked to monitor progress and bring an update back to PRM in the new year.

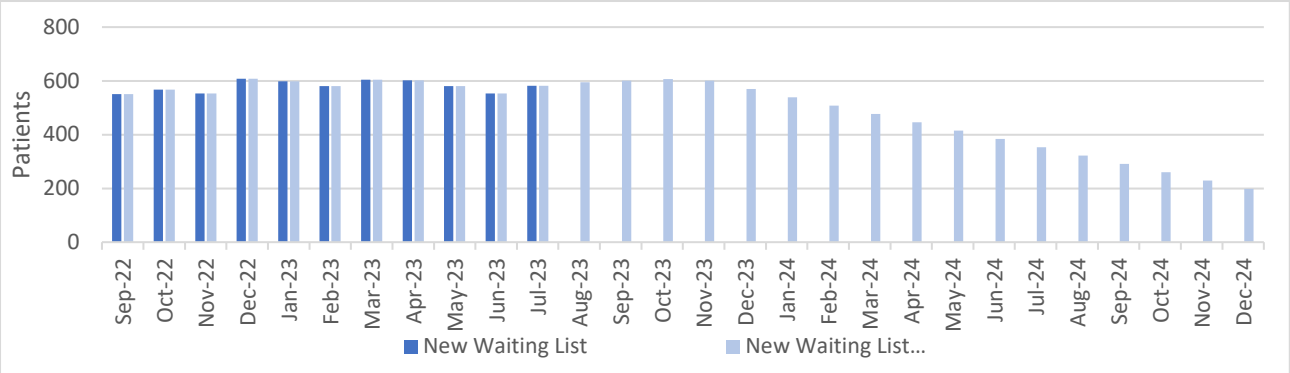


Figure 15: Number of patients on, and predicted to be added to, the waiting list

Medically Optimised for Discharge (MOFD) patients at PHU

The Transfer of Care Hub (ToCH) team, who facilitate the rapid discharge of patients from PHU into community services, has recently seen some changes within the workforce which have indirectly resulted in an increase of around 40 MOFD patients in PHU. The timing of this issue is unfortunate given the pressures on the system and the need to increase flow. The Service Line, supported by the Trust are working on solutions to bring the number of MOFD patients back down both in the short and long-term.

Sexual Health Services

Monkeypox Vaccination Programme

The Monkeypox vaccination programme was completed in July 2023 and the team have received a plaudit from NHS England, recognising the 'hard work, dedication, professionalism and patience of your service managers, clinical leads and teams. The service has delivered more than 2500 doses of the vaccine since the start of the programme in May 2022, accounting for 50% of the doses delivered in the Hampshire Thames Valley region.

ICB Commissioned Services

Solent have given notice of our intention to withdraw from the provision of Termination of Pregnancy and Vasectomy services from April 2024 due to the lack of financial sustainability within the contract. The trust is working with commissioners to identify a safe delivery model for future. There is a risk to the local system if there is no service provision for these services and GPs have already expressed concerns about the withdrawal of this provision locally.

AMH Inpatients

There have been challenges with the number of Responsible Clinicians on the Orchards. During August, 5 beds were closed whilst the Responsible Clinician model was reviewed and stabilised to ensure compliance with the legal obligations of the Mental Health Act. All demand was met during this period, and no patients were placed out of area, although our ongoing mutual aid offer to Southern Health was reduced. There are currently 3 staff undergoing the process of gaining their Responsible Clinicians status which will provide robust cover in future.

A2i

There has been an increase in the A2i caseload, with consistently more referrals than discharges over the last 12 months (caseload has increased by 138). This is being actively managed with weekly reviews of both the caseload and waiting list to ensure patients are on the most appropriate pathway.

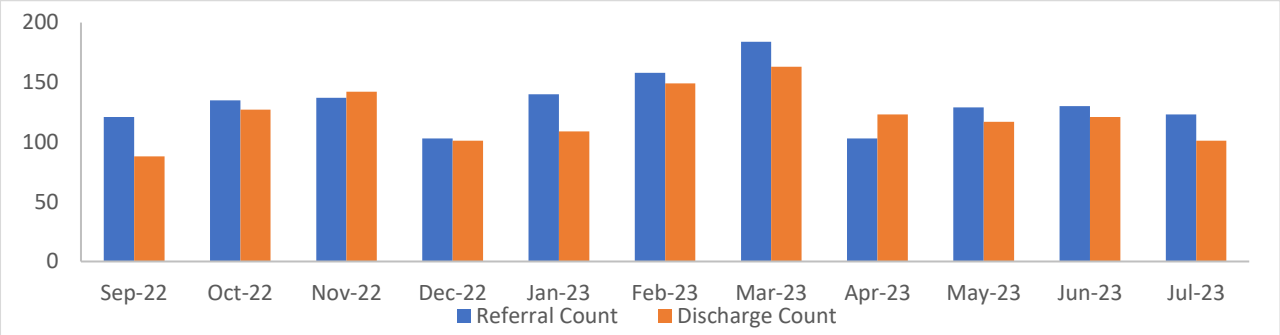


Figure 16: Number of referrals and discharges into the A2i service

Waiting times have remained consistently above the 5-week target, with latest data showing an average wait of 11.5 weeks in July 2023. There is an action plan in place to reduce waiting times focussing on caseload management, staffing and waiting list management.

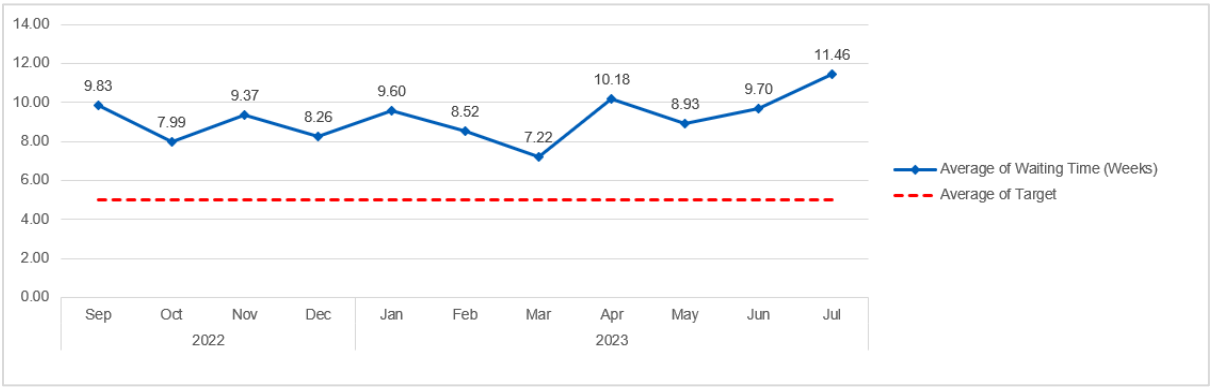


Figure 17: Average A2i waiting time compared to target.

There have been ongoing recruitment challenges to practitioner posts with one successful applicant due to start in October, however there are still two further posts out to advert.

Special Care Dental Service

Recruitment Challenges

There is a significant vacancy issue within the Special Care Dental Service, which is replicated nationally, and within Solent there is also an added challenge around retaining Dentists once in post.

Figure 18: WTE staff in post since January 2020

Recruitment is ongoing and roadshows are being organised within each of the localities, as well as consideration being given to the use of incentive schemes. These challenges are impacting multiple areas across the service, compounded with staff feeling pressured, resulting in high sickness levels. There were 54 clinics cancelled in July due to staffing challenges, which impacts on the already long clinic waits and ability to deliver the activity required by our contract. NHS England have acknowledged the efforts of the service and have provided assurance that they will not seek to penalise Solent for underachievement of the contract.

	Aldershot	Andover	Basingstoke	Bitterne	Cowes	Eastleigh	Gosport	Havant	Hythe	Millbrook	Petersfield	Poswillo	RSH	Somerstown
Surgeries	3	2	3	2	4	3	4	3	2	3	2	1	3	4
Dentist WTE	2.8	1.9	2.4	2.4	3.2	2.8	2.5	0.95	1.8	1.6	1.0	0.1	2.8	1.85
Therapist WTE	0.8			0.4	0.6	0.4	0.7	0.6	0.6	0.4	0.3		0.8	0.4
Dentist Vacancy FTE			0.6	0.4	1.0			1.4	0.4	0.6	0.6		0.6	0.6
Referrals Received	385	122	489	582	296	266	546	528	360	553	131	29	462	686
Waiting Time: Aug22	12	9	12	25	9	18	12	12	15	17	4	2	17	17
Waiting Time: Aug23	14	10	20	29	10	12	23	18	25	26	16	10	24	24

Figure 19: WTE staff in post/vacancies, volume of referrals waiting, and maximum waiting time in months

Referrals into the service are at a significantly higher rate than the number of new patient assessment slots available, so the waiting list is growing rapidly, month on month. Patients are offered the opportunity to attend clinic locations with shorter waiting times, however this is not often taken up. This position is not likely to improve in the near future.

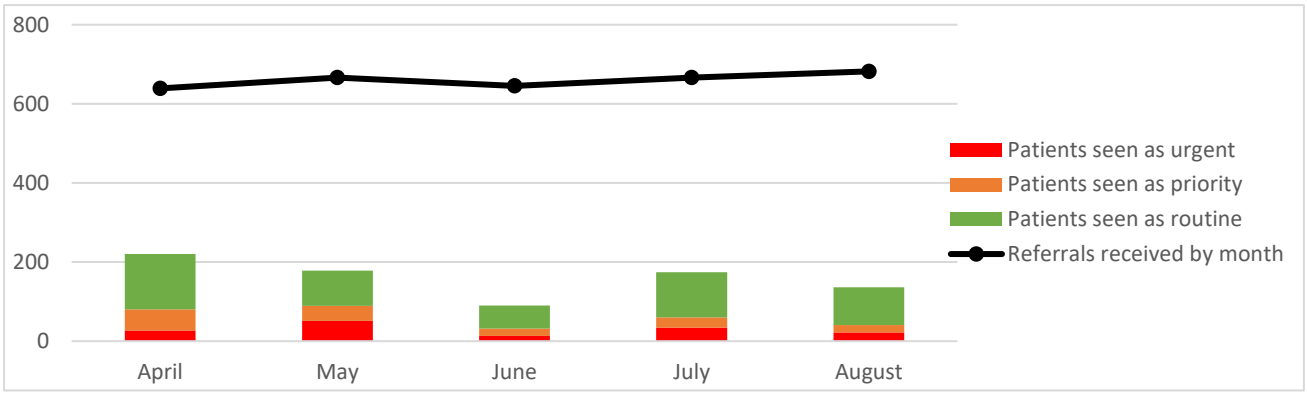


Figure 20: Referrals received compared to new patient assessments by month

Primary Care Services

GP Patient Survey Results

Both the Solent GP Surgery and Homeless Healthcare team have received positive feedback across a number of areas within the GP Patient Survey. Whilst there is room for improvement across some metrics which scored lower than the ICB or national average, feedback on a number of areas has been well received. The practice will be employing the use of a feedback tool, Working Feedback, and it is hoped that this will provide a broader scope of feedback and allow us to be more responsive.

The service has to date focussed on offering patients an appointment on the same day, however this is not always an appropriate time based on their need. This was implemented during COVID when patients were being triaged, however it no longer reflects best practice and ensuring patients are seen by the right person, at the right time.

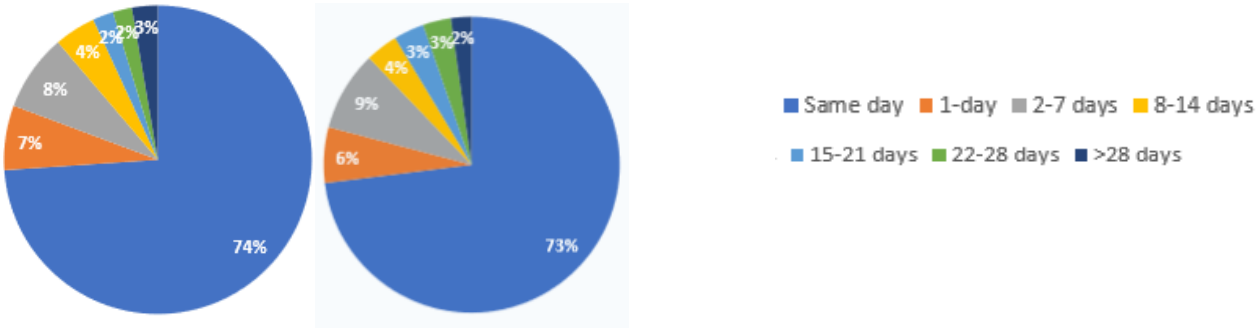


Figure 21: GP appointment booking times, June and July 2023

The proportion of patients being seen over 28 days from booking has maintained at between 2-3%, this is consistent with the averages seen across HIOW ICB and nationally.

Patients have reported an improvement in how easy it is to get through the surgery on the phone (40%), and this is higher than our peer practices within the PCN (31% St Mary's Surgery, 39% Alma Road Surgery). This is an improving position year-on-year since pre-COVID.

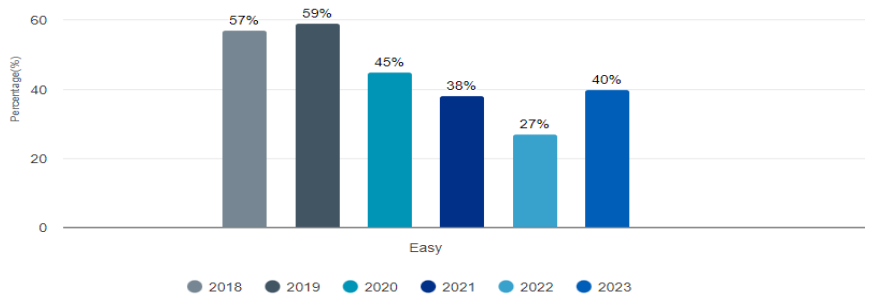


Figure 22: Patients reporting it was 'easy' to get through on the phone at Solent GP Surgery

Patients also reported being happy with the appointment times offered to them (64%), which is the highest percentage achievement on this metric for the past 6 years.

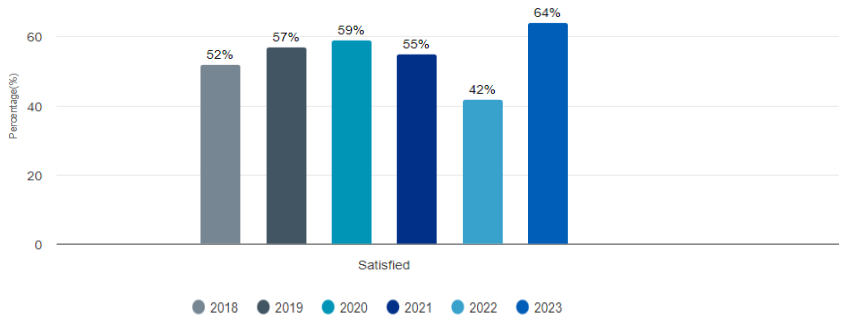


Figure 23: Patients happy with the appointment time offered to them at Solent GP Surgery

The Homeless Healthcare Team scored 100% on several metrics, which no other Practice achieved in any other category. Whilst there were only 12 respondents, this is a hard to reach and engage with group of patients, so this feedback is extremely valuable. Detail of the metrics where the team scored 100% are below:

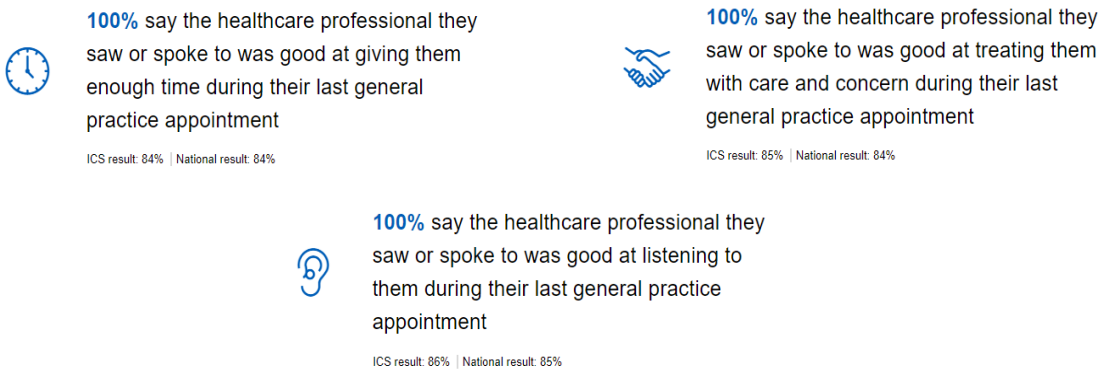


Figure 24: Feedback from GP Patient Survey for Homeless Healthcare service

5. People

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Aug-23 Current Performance		Aug-23 Trending Performance	Aug-23 Variance	Jul-23 Current Performance		Jul-23 Trending Performance	Jul-23 Variance
People	Sickness (annual)*	I	4.5%	5.3%				5.3%			
	Sickness (in month)	I	4.5%	5.1%				4.8%			
	Turnover (annual)*	I	14.0%	13.5%				13.9%			
	Turnover (in month)	I	1.2%	1.6%				0.9%			
	New starters (FTE)	-	-	42.24				44.7			
	Proportion of Temporary Staff (in month)	I	3.6%	4.9%				4.6%			

b. Key Performance Exceptions

Sickness Absence

The Trust continues to see a high proportion of absence related to mental health which continues to increase, currently at 1.63% of total absence (HIOW ICS average = 1.1%). There is exploratory work ongoing with Occupational Health & Wellbeing and system wide programmes to consider how best to support staff with the pressures of work and home life. The Trust is signed up to the 'Good Breaks' project, a national scheme to encourage staff to take a proper respite during working hours. As the Trust is an outlier, the People Services team have been asked to undertake an evaluation of our wellbeing offer and the impact this has on reducing sickness because of stress, anxiety and depression.

To support improved reporting of sickness the Trust has removed S98/99 reporting codes from ESR (other and not known). This will encourage a better understanding of the reasons why our staff are absent due to sickness so that we can support them more appropriately. We are expecting it to increase absence related to mental health further in the short-term but will continue to monitor this.

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 delve further into our sickness absence data, identifying more granular trends in episodes and reasons and correlating with turnover, protected characteristics and service lines.

Temporary Staffing

Focus continues on reducing our reliance on temporary staffing, particularly agency use. There has been significant progress in some service lines, notably Adults Portsmouth and Adults Southampton in reducing agency bookings following a concentrated effort on improved rostering. The safer staffing establishment reviews led by the Chief Nursing Directorate have supported this, whilst ensuring that inpatient and community teams understand the ratio of registered and unregistered staff required on shift to meet patient demand.

The Trust is not an outlier in regard to temporary staffing use as a proportion of overall workforce at 4.9%, but due to ongoing financial challenges it is imperative this high-cost use is reduced and utilised only in specific, authorised clinical need. The Trust has had success in converting Locum GPs to substantive contracts and bank, which will support this position. The South East Temporary Staffing Collaborative (which all HIOW Providers are now signed up to) will be joining the Trust for a workshop in September to consider further opportunities.

People Metrics Review

Over the coming months, the targets used to monitor compliance within the People domain will be reviewed in line with national and local benchmarks and will consider internal aspirations of where we would like to be as a Trust. This will ensure we are sufficiently challenging ourselves to support our People and the Trust effectively.

c. Spotlight On: Vacancy Levels

Turnover is a particular area of focus for the People & OD Teams in regard to understanding the reasons behind staff leaving the Trust. Several initiatives are being implemented with a view to improving recruitment and retention:

- With the Project Fusion timeline fast approaching, a change management support package has been prepared to ensure staff are well informed about the key dates and consultations regarding TUPE.
- There has been positive progress on filling a number of Health Care Support Worker positions, with over 20 applicants currently going through employment checks.
- The Trust will be attending a number of University Career Fairs in the Autumn, and there are four dedicated Dentistry Roadshows planned in September.
- The Trust is piloting a marketing AI strategy with a recruitment partner for Consultant Inpatient Psychiatrists.
- A workshop was held recently to make improvements to the Trusts 'Onboarding and Induction' offer, resulting in an action plan with a timeline for completion by December 2023. Within this there will be improved welcome materials for new staff, and an induction opportunity where IT kit, ID badges and other essential starter assets will be provided. This is linked into the Chief Nurse Directorate with clinical inductions.

6. Finance

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Aug-23 Current Performance		Aug-23 Trending Performance	Aug-23 Variance	Jul-23 Current Performance		Jul-23 Trending Performance	Jul-23 Variance
Finance	Year to date surplus/(deficit) Actual v budget	-	-	-1.7%				-2%			
	Agency spend % pay	I	3.5%	3.9%				3.4%			
	Cash balance	-	-	£8.0				£10.0			
	Aged debt (over 90 days)	-	-	839.6				504.1			
	Use of Resources Score	-	-	3				3			

b. Spotlight On: Month 5 Results

The plan for 2023/24 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 £349k, £384k 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).

Cost Improvement Plans (CIP)

The trust has an efficiency programme of £23.9m, made up of 27 schemes. M5 CIPs underperformed by £475k and are £1.7m under year to date. Further work has been done in M5 for the accurate recording and reporting of CIPs. In M5 £1.6m of CIP schemes held centrally were distributed to services for ownership. Most of the high value schemes are phased to gain impact, the CIP target increases by £500k a month in M6.

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 5 capital spend was £17k, £487k underspent against plan. YTD spend is £2,759k, £222k underspent to plan. There was less spend than expected in M4, actuals to date have started to re-align with plan and it is expected the overall capital programme will match the Trust's capital allocation.

Cash

The cash balance was £8m as at 31 August 2023, £2m less than July. The decrease in cash is due to £1.3m being due by Southampton City Council not paid. There are currently no known issues with invoices raised and continued to be chased.

Aged Debt

The Trust's total debt was £4.9m at the end of August, a decrease of £800k from July, due to high value invoices being paid in the 0-60 bracket. 91+ days overdue debt at the end of August was £0.8m, £0.6m increase from July due to invoices becoming 91+ days overdue. SBS continue their normal procedures to chase, along with finance assistance.

Aged Creditors

The Trust aims to pay its creditors on receipt of undisputed, valid invoices within 30 days or payment terms, whichever is later. Performance against this metric is monitored nationally by NHS England against a target of 95% achievement. For August 2023, the Trust paid 91.9% of volume of invoices within target and 92.6% of value.

Scan date to payment date of 28.2 should result in 100% BPPC compliance, however the invoice date to Scan date is 20.1 meaning a lengthy delay on invoices getting onto the system. Investigation is underway with other local organisations to understand if it is an issue for Solent, or across all Hampshire SBS clients. The issue will then be escalated with SBS to improve the performance.

7. Research & Improvement

a. Performance Summary

Since April 2023, we have recruited 159 participants in 21 studies, comparable with similar size Trusts across the Wessex region. A further six are due to open in the in next few weeks.

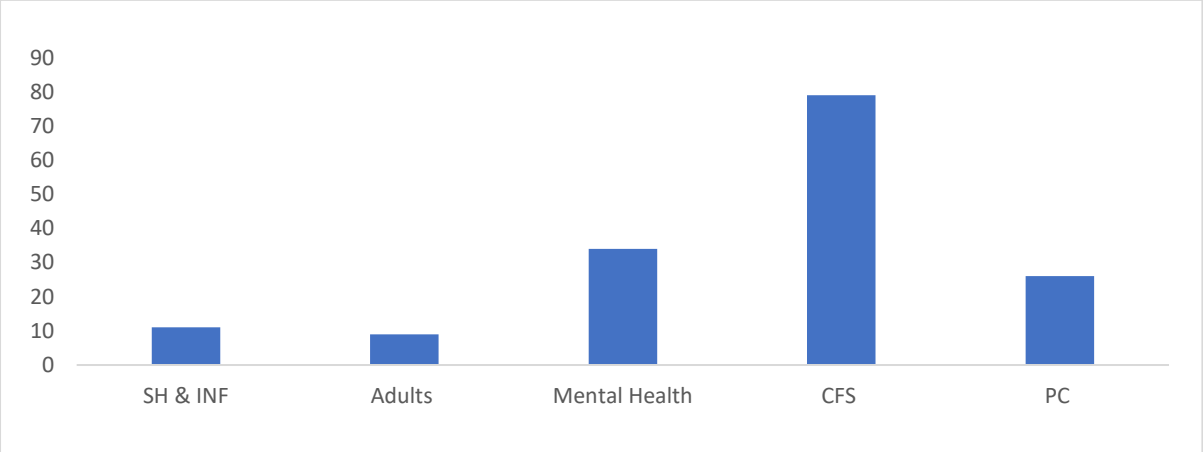


Figure 25: Research recruitment by Service Line since April 2023

b. Spotlight on: MSK Research

Studies currently in set-up

- The RADICAL study is evaluating the clinical and cost-effectiveness of radiofrequency denervation (RFD) treatment for low back pain. We are currently the top recruiter in the country for this study.
- The Immune-mediated inflammatory diseases (IMID) study is recruiting patients with psoriasis, rheumatoid arthritis, systemic lupus and axial spondylarthritis, and is contributing to a national bioresource which will help future research and improve targeted treatments. 26 participants have been recruited against a target of 10.
- POISE – predictors of outcome in sciatica patients following an epidural steroid injection: a prospective observational cohort study. 23 participants have been recruited against a target of 10.

Studies in the pipeline:

- REPPORT – recurrent patella dislocation – personalised therapy or operative treatment? This study will require collaboration with Portsmouth Hospitals University Trust as it is comparing physiotherapy with surgery.
- PANDA – Maximising outcome for patients with shoulder pain: Using optimal diagnostic and prognostic information to target treatment.

Annex A: Making Data Count Icon Crib Sheet

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

Solent NHS Trust - System Oversight Framework

The NHS System Oversight Framework is aligned with the ambitions set out in the NHS Long Term Plan and the 2023/24 NHS operational planning and contracting guidance. The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

A set of oversight metrics are used to support the implementation of the framework at a system level. The Hampshire and Isle of Wight Integrated Care System (HIOW ICS), that Solent is part of, has been moved into System Oversight Level 4, highlighting the additional support being received from NHS England with regards to managing the financial deficit of the ICS through a Recovery Support Programme. An updated set of metrics and supporting technical guidance has been released on 29 August 2023. The report will be updated for the next period to reflect the new measures.

The metrics listed below are those which Solent contribute towards. It is worth noting that nationally a number of these metrics are linked to the provision of additional funding to support performance improvement, however, as a Community and Mental Health provider, Solent is not always eligible for these funding streams. Metrics which have incentive funding for other providers are highlighted in blue below. We continue to monitor our contribution towards these targets, as a member of the local system, but acknowledge we are not given financial support to invest in additional improvements for this activity.

				Aug-23				Jul-23			
Indicator Description		Internal /External Target	Target	Current Performance		Trending Performance	Variance	Current Performance		Trending Performance	Variance
Quality, Access & Outcomes	S038a: Potential under-reporting of patient safety incidents	E	100.0%	100.0%				100.0%			
	S039a: National Patient Safety Alerts not completed by deadline	E	0	0				0			
	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	490				521			
	S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (3 months rolling)	E	0	0				6			
	S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	-	-	100.0%				100.0%			
	S101a. Outpatient follow-up activity levels compared with 2019/20 baseline	E	75.0%	105.5%				108.4%			
	S105a. Proportion of patients discharged to usual place of residence	-	-	68.4%				70.1%			
	S107a. Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	E	70.0%	63.3%				66.0%			
	S009a: Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	E	0	5				7			
	S013a: Diagnostic activity levels - Imaging	E	545	552				463			
	S013b: Diagnostic activity levels - Physiological measurement	E	77	74				61			
Preventing Ill Health	S117a: Proportion of patients who have had a first consultation in a post-covid service more than 15 weeks after referral	-	-	0.0%				11.8%			
Looking after our people	S071a: Proportion of staff in senior leadership roles who are from a BME background	I	12.0%	8.0%				8.0%			
	S071b: Proportion of staff in senior leadership roles who are women	I	62.0%	71.3%				71.3%			
	S071c: Proportion of staff in senior leadership roles who are disabled	I	3.2%	5.7%				5.7%			
	S067a: Leaver rate	I	14.0%	13.5%				13.9%			
	S068a: Sickness absence (working days lost to sickness)	I	5.0%	5.1%				4.8%			
Finance and Use of Resources	S119a: Financial Efficiency	E	-	1.3%				1.4%			

Solent NHS Trust - System Oversight Framework

Performance Summary:

The majority of metrics showing a negative trend or variance have been covered within this months, or previous iterations of the Trust Board Integrated Performance Report . Other areas of exception worth noting are as follows:

Outpatient Follow-Up Activity

Numbers of follow-up contacts continue to be a higher proportion of all contacts than desired by NHS E/I. Discussions are underway with the ICB to identify whether this metric is applicable to Solent. At present, no specific actions are being taken to actively reduce follow up volumes.

Key

In-month Performance Indicator

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

Trending Performance Indicator

Target has been consistently achieved, for more than 6 months

There is a variable and inconsistent performance against the target

Target has been consistently failed, for more than 6 months

Variance Indicator

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

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

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

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

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

Board and Committee Summary Report

Item 20

NHS Solent NHS Trust

Title of Paper	People Committee Exception Report September 2023, for October Board
Date of paper	21/09/2023
Presentation to	In Public Board Meeting Monday 3 October 2023
Item No.	20
Author(s)	Tina King, Business Manager, People Directorate
Executive Sponsor	Mike Watts, Trust Chair
Executive Summary	The Committee agenda is now more directed by the Board Assurance Framework (BAF) and has a 'Spotlight' item on the agenda to look deeper into risks identified. The spotlight this month was on sickness absence; in particular, the level of anxiety and stress related illnesses. Next committee the focus will be on temporary staffing. The Committee were agreed with the current BAF scoring but recognised the need to reflect on whether actions being taken would reduce gaps and achieve target scores. The new Workforce Intelligence dashboard led to useful discussion and insights including around the composition of the Bank workforce. An update on our Bank workforce will come to the next Committee meeting. The Committee noted that the National Staff Survey will be active in the consultation period for Fusion. It was agreed that regular "pulse checks" would give a more immediate source of information. The Committee also acknowledged there will be winter pressures at the time of consultation which could lead to increased sickness and therefore higher agency spend. The progress the Temporary Staffing Team had made on reducing agency costs were noted. There were also updates on international recruitment, Fusion, Employee Relations. The Committee were supportive of the new approach to Managing Employee Relations. It was reported that Southern staff will be joining the Solent Occupational Health provision from 4th January 2024.

Action Required	For decision?	N	For assurance?	Y
Summary of Recommendations	The Board is asked to note this report.			

Statement on impact on inequalities	Positive impact (inc. details below)	x	Negative Impact (inc. details below)		No impact (neutral)	
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	
2. Alongside Communities		9.Belonging to the NHS	x	13. A greener NHS	
3. Outcomes that matter		10. New ways of working	x	14. Supportive Environments	x
4. Life-course approach		11. Growing for the future	x	15. Partnership and added value	
5. One health and care team					
6. Research and innovation					
7. Clinical and professional leadership					

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

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

Board and Committee Summary Report

Item 21

NHS Solent NHS Trust

Title of Paper	Mental Health Act Scrutiny Committee Exception Report				
Date of paper	August 2023				
Presentation to	In Public Board				
Item No.	21				
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 10 August 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)*	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)							
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.
  - An increase in s2 cases during May and June 2023 was reported, with no cause/effect on care identified.
  - The Committee were assured that the use of s3 had remained stable during this reporting period.
  - An overview of DoLS assessments and review by the CQC was highlighted. The Committee were informed of fortnightly updates provided to local authorities to ensure appropriate oversight.
  - It was confirmed that there had been no s4 cases during this reporting period.

- Discussions were held regarding origin of s2 numbers and continued monitoring of all factors, including staffing, was highlighted.
- Review of s5(2) cases was held and it was confirmed that identified issues had been addressed.
- Extensive discussions were held in relation to monitoring of ethnic minority data and potential association to health inequalities/service accessibility.
- The Committee were briefed on work aligned to Project Fusion.
- Pressures in relation to manager hearings were shared.
- An overview of 136 breaches and assurance regarding criteria followed was noted.
- The Committee received an update on Associate Hospital Manager activity.

- Standard scrutiny of the **Restraint and Seclusion Assurance Report** took place.
  - An overview of the number and type of restraint was provided.
  - The Committee were assured that the number of incidents remains stable, with improvements noted following use of Inpatient Plan Of Care and PMVA Training.
  - Increase in incidents relating to acuity was highlighted and full assurance of review/scrutiny was emphasised.
  - An overview of cases of seclusion were shared and it was confirmed that all were in line with the policy and Mental Health Act Code.
  - The Committee were briefed on health and wellbeing packages in place to support staff dealing with challenging cases.

- The **Committee Annual Report** 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 22,1

NHS Solent NHS Trust

Title of Paper	Audit and Risk Committee Exception Report
Date of paper	August 2023
Presentation to	In Public Trust Board
Item No.	22.1
Executive Summary	The aim of this paper is to update the In Public Trust Board on key items discussed at the August 2023 Audit and Risk Committee meeting.

Action Required	For decision?		For assurance?	Y

Summary of Recommendations	The In Public Trust Board is asked to: • Receive the escalations from the Audit and Risk Committee meeting, including Freedom to Speak Up Annual Report (item 22.2) and Committee Terms of Reference (item 22.3)

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 Confidential Trust 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	Stephanie Elsy, Non-Executive Director (Chaired on behalf of David Kelham-Committee Chair)

Audit and Risk Exception report

Summary of business transacted:

Part 1 – Due Diligence Section

- The Committee reviewed the Legal Due Diligence Reports, with focus on consideration of gaining assurance from the and ensuring factual accuracy of key findings, risks and mitigations.

Part 2 - Standard A&R Meeting escalations

Below escalations for noting at the In-Public Trust Board

- The Chief Finance Officer presented a report outlining the **Losses and Special Payments** processed since the last meeting. Rational was provided, which was noted by the Committee.
- An overview of **Lessons Learned- Reflections on the 22/23 audit** was provided.
- The Committee received an **Internal Audit Update**, with the following reports presented.
    - Internal Audit Progress report (August 2023)
    - Final Annual Report 2022/23 (Noted- draft approved at June 23 meeting)
    - Final Risk Assessment and Plan for 2023/24 (Noted- draft approved at June 23 meeting)
- An **External Audit Update** was received and the Committee noted the following reports:
    - Auditor's Annual Report
    - Progress Report, review of external audit reports & recommendations
- The **Counter Fraud, Bribery and Corruption update- Progress Report & Self-Review Tool Outcome** was shared.
- There were no **external reviews/(un)announced visits** to report.
- The Committee received assurance from the **Q1 Risk Management Report.**
- The **Freedom to Speak Up Annual Report** was received. *(included as item 22.2)*
- Approval of the **Committee Terms of Reference** was recommended to Trust Board. *(included as item 22.3)*
- The **Audit and Risk Committee Annual Report** was received.

<table>
<tr><td>Title of Paper</td><td colspan="5">Freedom to Speak Up Report</td></tr>
<tr><td>Date of paper</td><td colspan="5">09 August 2023</td></tr>
<tr><td>Presentation to</td><td colspan="5">Board</td></tr>
<tr><td>Item No.</td><td colspan="5">22.2</td></tr>
<tr><td>Author(s)</td><td colspan="5">Bethany Carter, Lead Freedom to Speak Up Guardian</td></tr>
<tr><td>Executive Sponsor</td><td colspan="5">Angela Anderson, Chief of Nursing and Allied Health Professionals</td></tr>
<tr><td>Executive Summary</td><td colspan="5">This report will cover cases and themes reported between 01st April – 30th June 2023. Cases and reports prior to this date have been reported via the National Guardian Office data collection as numbers reported only.

During quarter four 30 staff contacted the Freedom to Speak Up Guardians to raise concerns, 29 of which were given full support and one was referred back to line manager support.
In addition, other engagement activities have been undertaken to raise awareness of Freedom to Speak Up and to further embed and improve the speaking up culture within Solent NHS Trust.

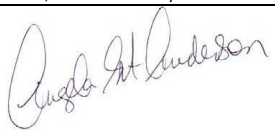
Of the 29 cases reported the themes attributed to cause are below:

<table>
<tr><th>Theme</th><th>Concerns raised</th></tr>
<tr><td>Concerns related to other inappropriate attitudes or behaviours</td><td>11</td></tr>
<tr><td>Worker safety or wellbeing concerns</td><td>5</td></tr>
<tr><td>Racism or Discrimination</td><td>4</td></tr>
<tr><td>Bullying and harassment concerns</td><td>7</td></tr>
<tr><td>Concerns related to the culture of the workforce</td><td>2</td></tr>
<tr><td>Grand Total</td><td>29</td></tr>
</table>

Respecting confidentiality, FTSU are unable to divulge any further reasoning, experiences, or subject matter.</td></tr>
<tr><td>Action Required</td><td>For decision?</td><td>N</td><td>For assurance?</td><td>Y</td><td></td></tr>
<tr><td>Summary of Recommendations</td><td colspan="5">The Board is asked to:
• Note the report</td></tr>
<tr><td>Statement on impact on inequalities</td><td>Positive impact (inc. details below)</td><td></td><td>Negative Impact (inc. details below)</td><td></td><td>No impact (neutral) X</td></tr>
<tr><td>Previously considered at</td><td colspan="5">Audit & Risk Committee</td></tr>
</table>

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

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

Level of Assurance *(tick one)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the [DN: insert name of Board/Committee] 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								

Freedom to Speak Up Annual Report 2022-23

1. Purpose

This paper provides an annual overview of data from 22-23 and information about FTSU activity for the period 1st April to 3oth June 2023. The format complies with the standards set out by the Nationals Guardians Office (NGO).

Annual Summary for year 2022-23

Section 1 - Assessment of FTSU cases quarter three

Section 2 - Themes

Section 3 - Learning and improvements

Section 4 - Actions taken to improve access to the FTSU Guardian route

Section 5 - Speaking up/listening up culture and actions taken to improve culture

Section 6 - National/regional activities and information

Section 7 - Future actions

Annual Summary for year 2022-23

- Table one below shows that 2022-23 saw the most concerns raised through FTSU guardians since 2019, an increase of 49 compared to 2021-22.
- This gives assurance that staff feel safe to raise concerns and provides us with opportunities to learn and make improvements.
- This increase has also been seen nationally and the circumstances are likely to be multifaceted including increases awareness of the FTSU service, improved communications

plan, development of FTSU strategy and workplan, development of champion network, attendance on various inductions and at away days and team meetings.

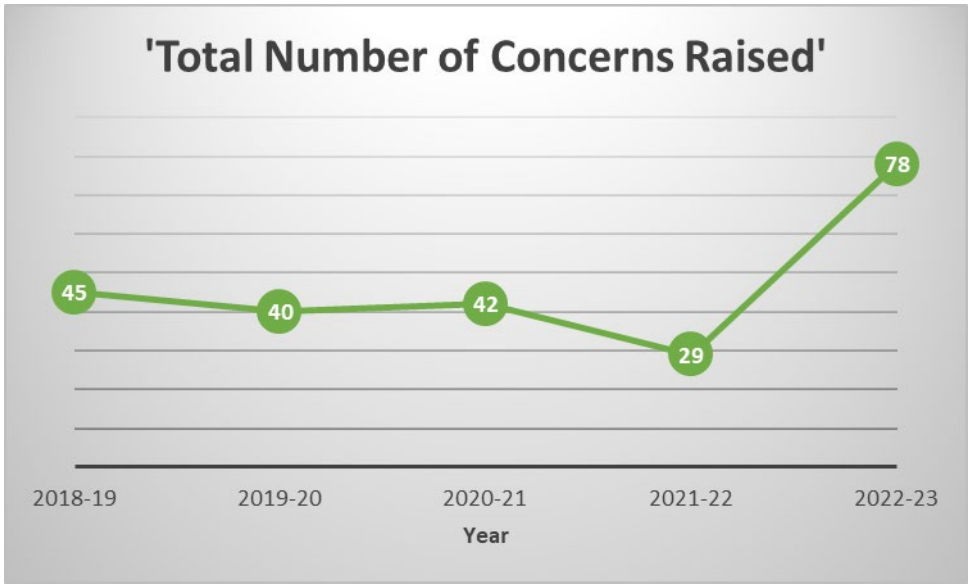


Table One

- Table two, below, shows the themes of concerns raised broken down by quarter. Although quarter four saw a decrease in concerns relating to behaviors this has increased again in quarter one 23/24.

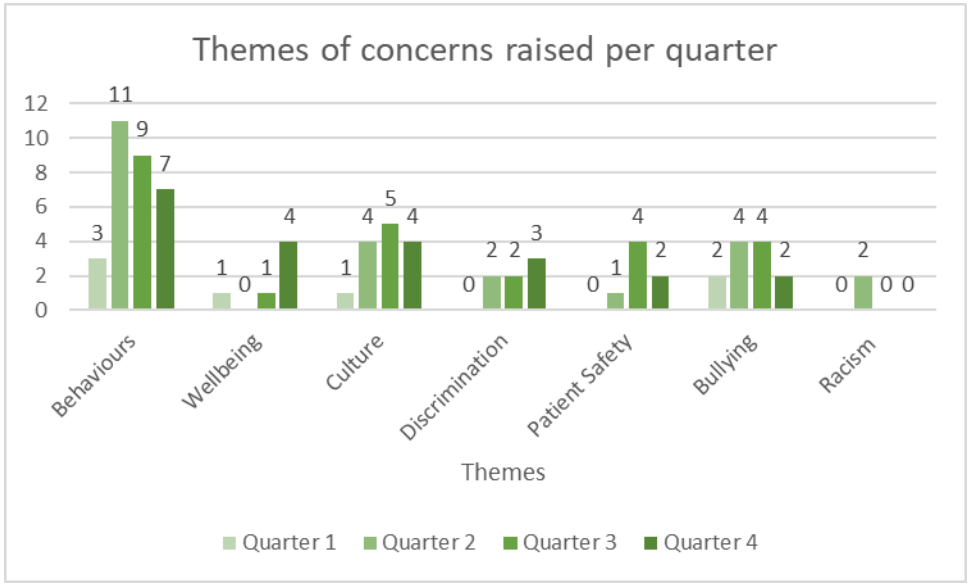


Table two

Section 1: Assessment of FTSU cases quarter one 23/24

Theme	Count of What is the concern relating to?
Concerns related to other inappropriate attitudes or behaviours	11
Bullying and harassment concerns	7
Worker safety or wellbeing concerns	5
Racism or Discrimination	4
Concerns related to the culture of the workforce	2
Contact made but referred back to manager	1

Grand Total	30

Table three

- 16 cases from quarter one remain open due to ongoing support / investigations or collaborative work and resolution still to be sought.
- 7 cases had been previously raised with no resolution gained, or resolution not sustained.
- 6 cases were raised through the anonymous reporting form

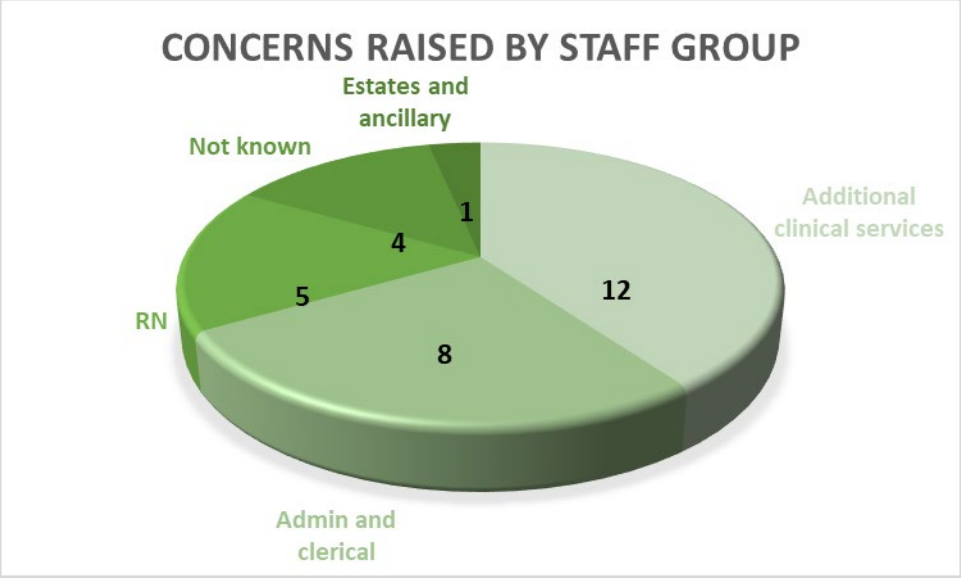


Table four

- In quarter one, staff from 'additional clinical services' raised the most concerns, closely followed by admin and clerical.

Section 2: Themes

For quarter one the main themes spoken up about were:

- Concerns related to other inappropriate attitudes or behaviours; staff continue to report unprofessional and unsupportive behaviours displayed by managers and colleagues. These behaviours include poor language, lack of support, attitudes towards admin staff, unfair treatment
- Bullying and harassment concerns; verbal and physical abuse, targeted behaviours, continually being criticised
- Worker safety or wellbeing concerns; concerns linked to removal of staff discount in restaurants, not being involved in decisions about changes to working processes and unfair allocation of flexible working opportunities within teams

Section 3: Learning and improvement

Purpose: In line with recommendations from the NGO the Speak Up eLearning module was made mandatory for all staff from 02nd May 2023.

Delivery: eLearning module accessible via LMS or FTSU G can be requested to attend team sessions

Outcome: As of 11th July 58.4% of staff had completed the training

Feedback about FTSU process (collected from evaluation forms)

- Once a case is closed, an anonymous evaluation form is sent to the person who raised a concern, asking questions about their experience of the FTSU process and if they would speak up again.
- Since implementation we have only received 17 responses from 45 sent out.
- Table 5 shows the response to the question "based on your experience would you speak up again?"

Table five

- The person who responded "no" felt they hadn't reached a suitable resolution, and those who responded "maybe" and "don't know" did not provide further details.

Quotes from feedback:

The service is wonderful as I have experienced it and the patience of being listened to and understood was brilliant. To enable open conversation with someone was really beneficial for me and to talk how a situation can be affecting and impacting one's health and wellbeing, taking home bad negative thoughts.

Beth was so lovely and supportive; I feel I could trust her, and she understood my concerns and took them seriously.

I managed to have a meeting so didn't require FTSU at the moment, but the response was supportive and timely, and I had every confidence in the service. I promote it all the time and am trying to enable FTSU to attend one of our meetings

I hope workplace bullying will end, and teams can work without any fear and enjoy their work. I understand managers have a difficult job to maintain and improve high performance of their teams. both managers and staff need to be

well supported to do their jobs and minimise conflict in the workplace. sometimes formal mediation required to resolve conflicts to prevent use to formal disciplinary processes.

Learning from feedback:

I would like to just add that your team need more power as you are limited to what you can do, and that further input would really be useful to HR and aid that open conversation and guidance to support an individual as I did not know where to go.

- All staff are informed of the level of involvement the guardian can have within the boundaries of their role and we continue to work with HR to try and improve the service we deliver.

Due to situation within the team the group session was very hard as it contained staff who were part of the situation or friends with the person.

- During group sessions and safety chats all staff are given the guardian contact details should they feel they need to speak separately and in confidence.

Section 4: Actions taken to improve access to the FTSU Guardian route

- Continual increasing Speak Up Champion Network
- FTSU pop up stands
- FTSU drop in clinics
- Mental health transition training programme
- International workers induction
- HCSW induction
- Improvement of Solnet site and different contact options available

Section 5: Speaking up/listening up culture and actions taken to improve culture

- All staff zoom with National Guardian
- Involved in a number of co-facilitated workstreams to improve behaviours and bullying within teams
- Respectful resolution roll out will aid managers in tacking issues with behaviours and bullying
- Good communications – repeating the message frequently but in different ways
- Training and awareness sessions
- Attendance at away days

- Safety Chats / Boards
- Speak Up for managers sessions
- Happier Working lives programme developed for speak up champions
- Staff engagement and recognition group
- Speak Up Champion training
- Collaborative working with service lines to identify areas for proactive work in response to speak up and staff survey data

Section 6: National / regional activities and information

- Lead Guardian presented Solent's story at the SE Region network meeting

Section 7: Future actions

- Policy has been updated to reflect the national policy produced by NHS England and the NGO and is awaiting ratification
- Triangulation of data report in progress
- Assistant Guardian recruited for 0.4 WTE to start 01st Sept. Joint position with 0.6WTE for Southern Health Foundation Trust
- Planning for Speak Up month.
    - Weekly webinars
    - Walk and talk Wednesday
    - Wear green Wednesday
    - Feedback Fridays
- Lead Guardian to host roundtable discussion at Queens Nurse Conference on 'speaking up for safety – a community perspective'.
- Lead Guardian Speaking at "A culture of candour" national conference
- Complete planning and improvement tool for submission to NGO January 2024

Audit & Risk Committee
Terms of Reference

1. Constitution

1.1 Solent NHS Trust Board hereby resolves to establish a committee of the Board to be known as the Audit & Risk Committee ('the Committee'). The Committee is a non executive Committee of the Board and has no executive powers, other than those specifically delegated by the Board in these Terms of Reference which are incorporated within the Trust's Standing Orders.

2. Purpose

2.1 The Committee is responsible for assuring the Board on matters concerning:

- **governance** - including financial governance, corporate governance and clinical and non-clinical audit
- **risk management,** and
- **internal control** - seeking assurance from internal and external audit and counter fraud.

3. Duties

3.1 Governance, Risk Management and Internal Control

The Committee will;

- seek assurance that the Trust's activities are efficient, effective and represent value for money – including **reviewing the establishment and maintenance of an effective system of internal control** that supports the achievement of the Trust's objectives
- receive and scrutinise the following **public disclosure statements**;
  - **Quality Account**
  - **Annual Report**
  - **Annual Governance Statement**

  seeking assurance that the Trust complies with regulation and information is triangulated with independent sources (for example, but not limited to, the Head of Internal Audit Opinion, External Auditors Opinions and Counter Fraud) prior to recommendation to the Board for approval.
- test the effectiveness of the use of the **Board Assurance Framework**
- seek assurance that **appropriate governance arrangements** have been implemented to support the organisation operating in the emerging **Integrated Care Systems and Integrated Care Partnerships**

3.2 Internal Audit

The Committee will

- ensure there is an **effective internal audit function** that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the Committee, Chief Executive and Board.

  This will be achieved by:
  - ensuring the periodic **re-tendering of the internal audit function**
  - review and approval of the **Internal Audit Plan** ensuring that this is consistent with the audit needs of the organisation

- consideration of the **provision of the internal audit service** - including the performance, cost, seeking assurance that the audit function remains independent, and of any questions of resignation and dismissal
- receive **Internal Audit Reports** and **progress updates** – consider the **major findings of internal audit work** (and management's response), seeking assurance that recommendations are being addressed and progressed, to ensure appropriate learning is taken and any gaps in internal controls mitigated.
- receive and review the **Head of Internal Audit Opinion**, prior to Board approval

3.3 External Audit

The Committee will:

- in accordance with the Local Audit and Accountability Act 2014, **establish an 'Auditor Panel' to advise on the appointment of external auditors** (membership of the panel will be approved by the Board). The Panel shall recommend the appointment of external auditors to the Board.
- review and monitor the **work and findings of the external auditor** and consider the implications and management's responses to their work.
  This will be achieved by:
  - consideration of **the provision of the external audit service** - including the performance, cost, seeking assurance that the audit function remains independent, and of any questions of resignation and dismissal
  - consider the scope of the **Annual Audit Plan** – be briefed by the auditors on their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
  - review the **Annual Audit Results Report**, for the prior financial year, including the report to those charged with governance
  - agree the **Letter of Representation** before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management response
  - agree any **non-audit services conducted** – agreeing acceptable thresholds and safeguards. Any such work will be disclosed within the Annual Report

3.4 Financial Reporting

The Committee will:

- receive assurances from management on **financial matters** – including changes to / notification of:
  - Single Tender Waivers
  - Losses and special payments
  - Write offs
  - Significant Financial issues/risks and any adjustments
  - Standing Financial Instruction (SFI) breaches
  - Changes to financial policies
  - Accounting standards update
- receive the **financial timetable associated with the audit of accounts**
- shall review the **Annual Accounts** and **summary financial statements** (within the Annual Report) before submission to the Board for approval, focusing particularly on:
  - changes in, and compliance with, accounting policies, practices and estimation techniques
  - unadjusted miss-statements in the financial statements
  - significant judgements in preparation of the financial statements
  - significant adjustments resulting from the audit
  - letters of representation
  - qualitative aspects of financial reporting
  - reported losses and compensation

- explanation of estimates or provisions having material effect
- any reservations and disagreements between the external auditor and management which have not been satisfactorily resolved

- monitor the **integrity of the financial statements** of the Trust and any formal announcements relating to the Trust's financial performance
- ensure that the **systems for financial reporting to the Board**, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board

3.5 Whistleblowing /Freedom to Speak Up

The Committee will, on an annual basis

- review the **effectiveness of the Trust's arrangements for its employees to raise concerns,** in confidence, about possible improprieties in financial, HR matters (including bullying), conflicts of interest, clinical or safety matters.
- ensure that **arrangements allow proportionate and independent investigation** of such matters and appropriate follow up action

3.6 Counter Fraud

The Committee will

- satisfy itself that the Trust has **adequate arrangements in place** for countering fraud, bribery and corruption
- review the **outcomes of counter fraud work and investigations**- seeking assurance that management are addressing any gaps in internal controls and are progressing actions to meet recommendations made
- ensure that the Trust has **appropriate policies and procedures** for all work related to fraud, bribery and corruption

3.7 Other Assurance Functions

The Committee will:

- review the **findings of other significant assurance reviews**, both internal and external to the Trust, and consider the implications for the governance of the Trust (e.g. from regulators /inspectors etc)
- receive updates on progress made towards the achievement of **clinical audits** and receive the **Annual Clinical Audit Report** and Annual Audit Plan
- scrutinise the **annual governance review of the Board Committees** conducted by the Governance & Nominations Committee, satisfying itself that committees are appropriately constituted and functioning in accordance with their Terms of Reference
- receive the Trust's **Charity Annual Accounts and Report**

4. Membership

4.1 Members of the Committee shall be appointed by the Board and shall comprise;

- Non-Executive Director Chair
- 1 Non-Executive Director

at least one of whom shall have recent and relevant financial experience.

4.2 The Chair of the Trust Board shall not be a member of the Committee.

4.3 In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum

5.1 The quorum necessary for the transaction of business shall be:

- 2 Non-Executive Directors (including the Chair or their designated deputy)

6. Attendees

6.1 The following officers will have an open invitation to each meeting, unless otherwise informed by the Committee Chair (or when the Committee meets privately):

- Chief Executive Officer
- Chief Finance Officer
- Chief of Nursing and AHP
- Representatives from Internal Audit, External Audit and Counter Fraud
- ~~Chief of Staff, Governance and Corporate Affairs~~
- Governance Programme Lead (For Solent) – Project Fusion
- Independent Freedom to Speak Up Guardian (FTSU)

6.2 The Head of Internal Audit, representative of external audit, Counter Fraud Specialist and FTSU Guardian have a right of direct access to the Chair of the Committee.

7. Frequency

7.1 The Committee shall meet

- at least on a quarterly basis at appropriate times in the reporting and audit cycle and otherwise as required
- In private with external and internal audit representatives without any member of the executives present on at least one occasion each year

7.2 The Chief Executive, external auditors or internal auditors may request an additional meeting if they consider that one is necessary.

8. Authority

8.1 The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information required from any employee of the Trust in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

9. Meeting administration

9.1 The Finance and Performance Business Support Manager shall act as the secretary of the Committee

9.2 Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members

10. Reporting

10.1 An exception report will be provided to the Board via the Committee chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

10.2 Following scrutiny, the Committee will recommend to the Board the approval of the Accounts, Annual Report, Annual Governance Statement, Letter of Representation, Quality Account and the Annual Clinical Audit report.

10.3 The Committee shall make necessary recommendations to the Board on areas relating to the appointment, re-appointment and removal of auditors and terms.

10.4 The Committee will conduct an annual review of its effectiveness

Version	25
Review date	August 2023

Board and Committee Summary Report

Item 23.1

NHS Solent NHS Trust

Title of Paper	Quality Assurance Committee Exception Report				
Date of paper	September 2023				
Presentation to	In Public Board				
Item No.	23.1				
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 21 September 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**

- **Urgent Matters of Safety-** increase in Covid-19 cases and impact/considerations aligned to winter planning was discussed.

- **Partnership Governance Arrangements**
  - An update regarding Junior Doctor and Consultants Industrial Action was provided.
  - The Committee were informed of issues within the Portsmouth system in relation to discharge and flow of patients. The current position was explained, and pressures highlighted. Extensive discussions were held and continued work noted.
  - The Chief Medical Officer presented escalations from the Clinical Executive Group regarding challenge/assurances required in relation to Project Fusion.

- **Briefing**
  - The **Patient Safety Incident Response Plan & Policy** was approved *(Board paper item 18.1 & 18.2)*
  - The Committee received an update briefing in response to the Lucy Letby conviction. Assurance and learning was confirmed. *(Board paper item 9)*

- The Committee **noted** the following reports presented:
  - **Experience of Care (including Patient Experience/Complaints & Community Engagement) - Q1 Insights Report & Year Three Delivery Plan**
  - **Patient Safety Quarterly Report including Learning from Deaths, Learning from Sis and Incidents Q1**
  - **Safe Staffing Q1 Report** *(item 23.2)*
  - **Health & Safety Annual Report & Q1 Report** *(Board paper item 17)*
  - **Infection Prevention & Control Q1 & IPC BAF**
  - **Proposal to batch close historical open incidents from 01/04/2020-31/03/2023**

- The Committee approved the Self-Declaration on Same Sex Accommodation Annual Report *(Board paper item 11)*

- **Performance & Quality Exception Report-** key escalations were presented, including increasing waiting lists and pressures within the Dentistry service. Extensive discussions and comments were shared.

- 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. An update regarding feedback from Mental Health Act Review Visit was shared.

- The **Committee Terms of Reference** *(item 23.3)* and **Quality Improvement & Risk Group Terms of Reference** were approved.

- The **Board Assurance Framework (BAF) consideration and oversight of risks Report** was reviewed and contempory update noted.

Item 23.2

Solent NHS Trust

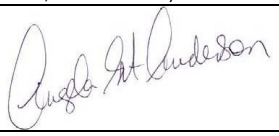
Board and Committee Summary Report

Title of Paper	Quarterly Safe Staffing Report- Quarter 1 April – June 2023			
Date of paper	September 2023			
Presentation to	Board			
Item No.	23.2			
Author(s)	Quality Governance Team			
Executive Sponsor	Angela Anderson, Chief of Nursing & AHPs			
Executive Summary	This report provides an overview of the Nursing & AHP safe staffing status for the period April – June 2023 and is set out in line with the National Quality Board (NQB) standards.			
Action Required	For decision?	(Y/N)	For assurance?	(Y/N)
Summary of Recommendations	The Quality Assurance Committee is asked to note: • There have been challenges to collate the workforce data within Q1 to be able to provide comparable data sets, however there has been robust discussions within Safe Staffing meetings including review of quality indicators, local workforce data 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. • Following feedback from the 2022/23 reports, the requested breakdown of temporary staff usage by registered and non-registered has not yet been achieved but will be included in future reports as we continue to develop the workforce intelligence data set with the Workforce Team. • The progress against implementation of the MHOST acuity and dependency tool in our mental health wards and the Community Nursing Safer Staffing tool in adults Portsmouth and adults Southampton and the planned implementation of the Safer Nursing Care Tool for the physical health inpatient units. • That following the business planning process, a review of inpatient clinical establishments has been requested by the Chief of Nursing & AHPs and will inform future establishment setting. • A safer staffing Assurance meeting has been implemented within the Quarter to provide oversight of all safer staffing activity.			
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Previously considered at	Quality Assurance Committee			

Strategic Priority this paper relates to

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

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

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

Executive Summary

This report provides the Trust Board with an overview of the Nursing & AHP safe staffing status for the quarter 1 period April – June 2023. It provides assurance that arrangements are in place to safely staff the services in line with the National Quality Board (NQB) (2016) safe staffing guidance.

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

The Board is asked to note the current reported position and to endorse the action being taken to maintain and monitor safe staffing levels across the organisation.

Quarter 1 continued to be challenging for all services. Safe staffing and patient safety were managed effectively by reviewing patient acuity and dependency, caseload, and flexible working. The impact of the outbreaks was monitored consistently and mitigations in place to manage effectively.

All historic Surge capacity was closed prior to April 2023.

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 current reports both at a trust wide and local unit level, this includes the Unify and CHPPD data that is shared externally.

Within Q1, the first data collection for the Community Nursing Safer Staffing Tool (CNSST) and the Mental Health Optimal Staffing Tool (MHOST) has been completed and analysis is ongoing.

There has been a change in the reporting of unavailability within this quarter which now shows the percentage against the trust agreed level of availability and the breakdown of reasons, this will support a forward view into Q2 of comparable data.

Community Nursing across both cities remains a concern and service lines continue to explore how recruitment strategies can be employed to generate interest and career development pathways. Within Q1, there has been successful recruitment across both cities and a reduction in vacancy rates within ADP from 27 to 21%, with hots spots still within the Band 6 RN workforce.

In Q1 the newly developed Safer Staffing Assurance meetings commenced. The Safer Staffing Assurance meeting is a formal forum for the Chief of Nursing & AHPs to seek oversight and assurance for the safe staffing position of the organisation in line with the National Quality Board and engage with service lines and People services together to consider and influence future developments, new and current guidance and to develop and deliver the safer staffing strategy.

The group will operate within the formal Trust governance framework as a formal subgroup of the Quality Improvement & Risk (QIR) Group and has no executive powers, other than those specifically delegated in these terms of reference.

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 Due to workforce data issues this report provides limited inpatient data includes the Care Hours Per Patient Day (CHPPD) data, for the adult inpatient wards. As with Q4 (2022 /23), there is a concern that the CHPPD data for the inpatient mental health wards is not correct and therefore has not been included until further investigation and analysis has been undertaken.

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

2. Overview of reporting period

Safe staffing meetings have continued during this reporting period. A number of services have daily huddles where concerns can be escalated via the service line and organisational assurance framework as deemed necessary.

Safe staffing meetings schedule has resumed the anticipated business-as-usual format throughout this quarter. This format has demonstrated the benefits of bringing commensurate teams together from across the trust; for example, a joint meeting across both cities held for adult inpatient teams, community nursing teams and long-term conditions community services. 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.

There were no national restrictions from an infection prevention perspective during Q1, however internal restrictions continued to be enacted in clinical environments if deemed appropriate and necessary in relation to IPC concerns.

During Q1 the IPC team undertook the below investigations:

- There were 0 SARS-CoV-2 outbreaks reported in quarter 1
- 1x SI investigation into potential staff to patient transmission of SARS-CoV-2 within PRRT.
- 3 Clostridium Difficile (C.Diff) investigations undertaken (2 x C.Diff toxin, 1x C.Diff GDH).

Further details regarding the above can be found within the Q1 Infection Prevention and Control Q1

Report. There were no MRSA BSI concerns raised in Q1.

The concerns raised that were 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 Q1 the Maples ward leader has provided 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. Hawthorne's is awaiting a new Band 7 team leader to onboard in October 2023.

Following introduction of Autoallocate within Health roster in Adults Portsmouth in Q3/4 2022/23 they have continued to embed this within this quarter starting to realise the benefits from the improved daily allocation support (matching skill set requirements and geographic "clustering" of caseloads), this has become part of daily BAU, positively impacting on releasing time to care. However, there are ongoing issues re the system and appropriate support from patient systems team required. Acknowledgement that this system needs clinical administration to ensure care plans and allocation is appropriate. Adults Southampton following 18 months of using the systems are taking learning from the ADP.

Within the Safer Staffing Assurance meeting in Q1, the Matron for Adults Portsmouth Inpatients presented the review that had been undertaken with regard to the safe staffing establishment and skill mix for the Jubilee Unit. Following the presentation and opportunity for discussion, the agreed safe staffing allocation was formally signed off by the Chief of Nursing & AHP. Within Q2, it is anticipated that all the other inpatient units will present their predicted establishment and skill mix.

3.0 Workforce

3.1 Due to recognised workforce data issues within the quarter, we have been unable to include a full workforce data set. Therefore, we have taken a decision to include the full year 2022/23 dataset to support a future comparator. The data in table 1 below showed a consistent picture across the year and shows that our substantive staff account for circa 90% of the total staffing.

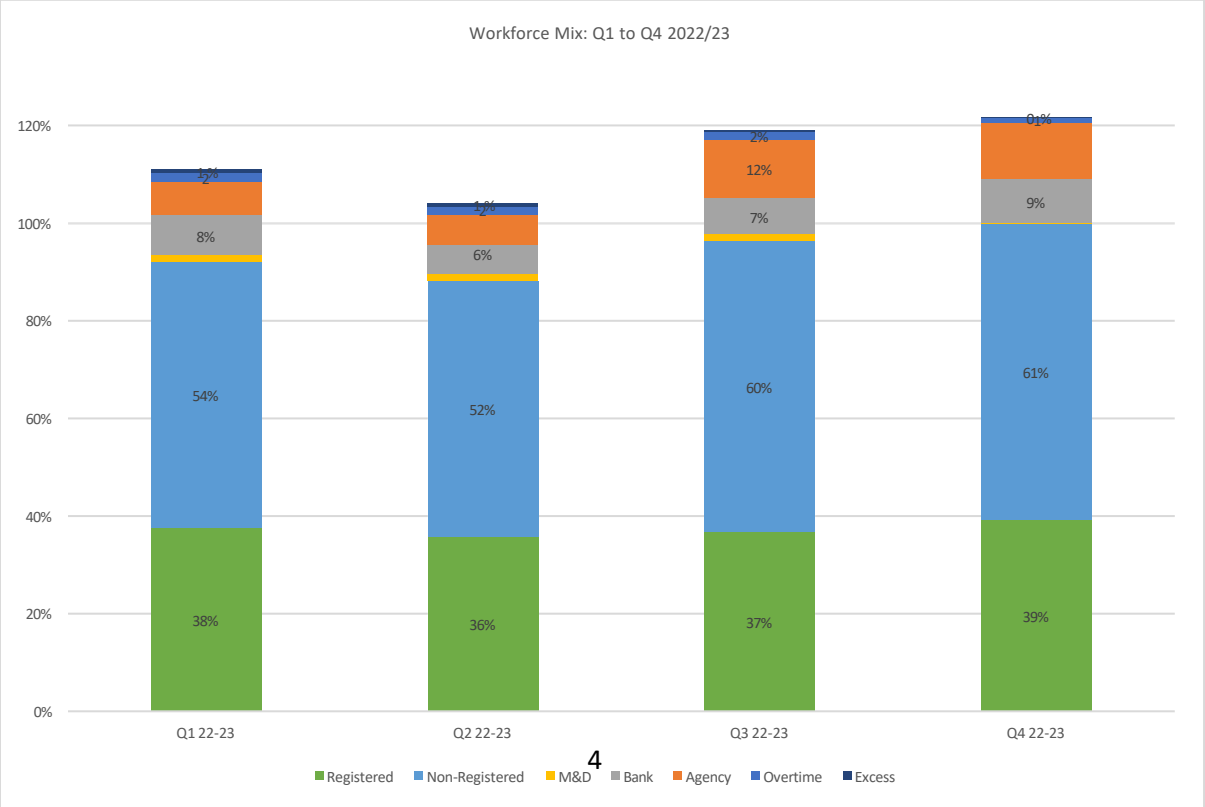


Table 1 Workforce by % Q1 – Q4 2022 / 23

3.2 It is noted from the Q1 safer staffing meetings for the physical health inpatient units, there has been a consistent reduction in use of temporary staffing particularly agency staff, with a proactive approach to management of use of temporary staffing and substantive recruitment. This will be reviewed once the accurate workforce data is available, and any interim escalations made through QIR or Safer staffing assurance meetings.

As part of the Jubilee establishment review and development of 2 clinical areas on the unit (Nelson and Cumberland), a workforce recruitment plan has been successfully enacted. However, the E- roster does not reflect the separation of the 2 units, making roster and workforce data more complex.

3.2.1 Across the organisation there continues to be a reliance on temporary staffing however due to the data issues it is not available at the time of writing.

4.0 Care Hours Per Patient Day (CHPPD)

4.1 CHPPD is calculated using the daily staffing numbers and the daily patient count at midnight and then aggregated for the month. Whilst this method does not represent the total and fluctuating daily activity, turnover, or the peak bed occupancy it provides reliable and consistent information and a common basis for comparisons to measure, review and reduce variation at ward level within organisations and within similar specialties across different trusts. CHPPD data should **not** be considered in isolation but should be viewed with additional data sources as changes in speciality, staffing levels and service moves occur. Reviewing it in isolation could demonstrate a misleading picture in terms of safe staffing levels. It is worthy to note that there is no option within CHPPD data to benchmark nationally or a best practice %. The comparison, alongside professional judgement occurs locally and with reference to previous individual wards data.

4.2 Within Q4 2022 / 23, there was concern that the CHPPD was incorrect and required further analysis. In Q1, an initial review of the CHPPD, establishment / E Rostering and Unify data has been undertaken. It was identified that further work is required, which will be undertaken within Q2. However, the adult inpatient units appear broadly consistent when comparisons are made with 2022/23 data.

For Q1, the CHPPD data for Adult Inpatient Units is shown in the table below, with the exclusion of the Jubilee units and mental health inpatients as noted above.

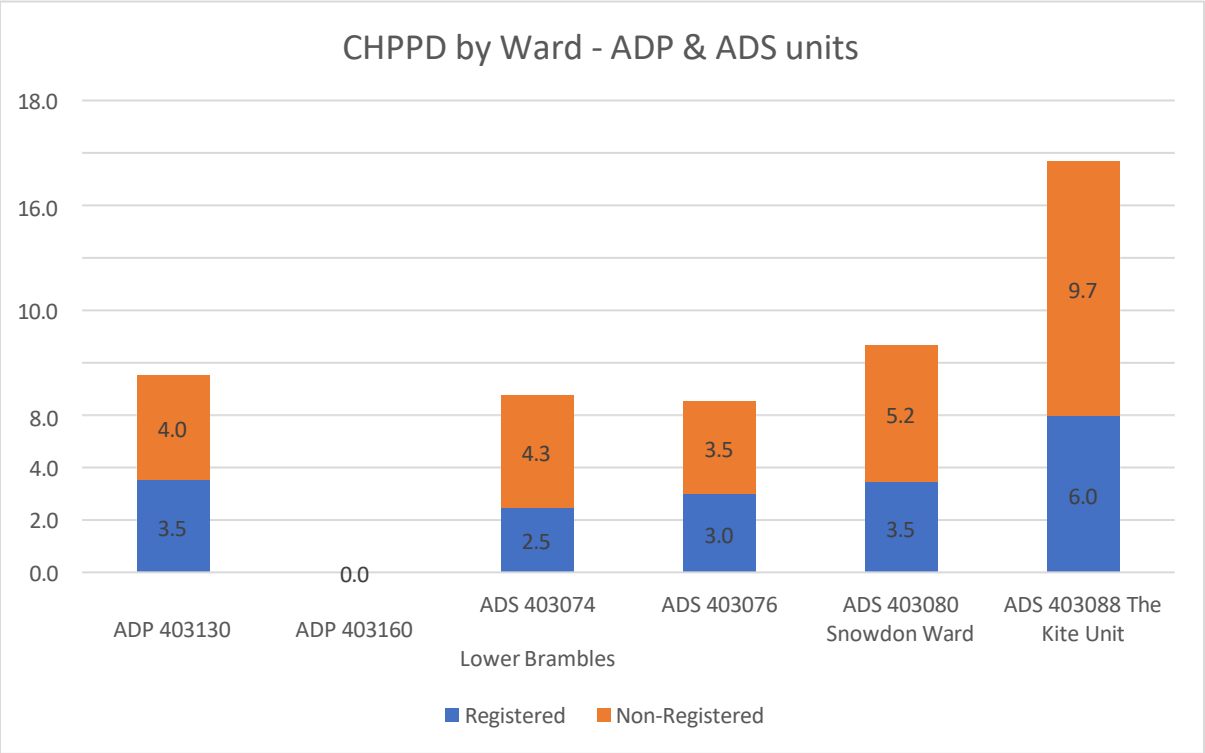


Table 2 Q1 2023 / 24 CHPPD Data Adult Inpatients excluding Jubilee and Mental Health Inpatients

5.0 Non-Productive / Unavailability

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

5.2 The data in tables 3 – 6 below show unavailability by theme across Q1. The trust target of 22%, 24% when including parenting, has been added to be table to demonstrate where teams have exceeded the target. It is noted that parenting leave has not traditionally been included within the non-productivity percentage for the trust however, for the purpose of this report it is included. This may need to be further discussion, to confirm parenting's inclusion or exclusion in future reports. The E Rostering Policy is due for review and therefore will need to be further discussed and whether there is an impact on the percentage total of unavailability.

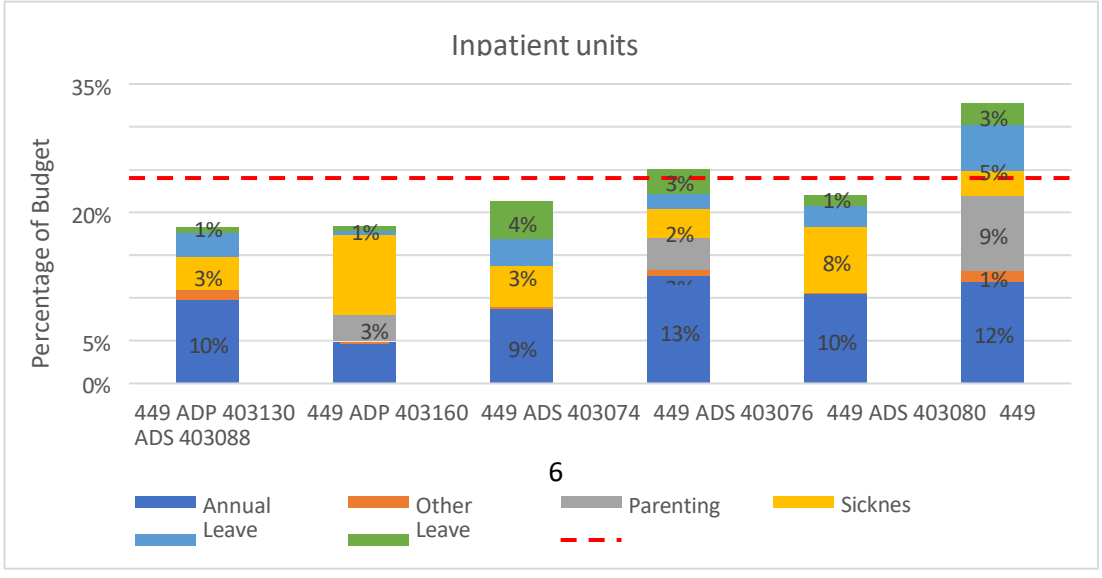


Table 3 Adult inpatient unavailability by theme

5.2.1 It is noted that the Kite Unit reported a higher level of parenting leave within the quarter and both Snowdon and Jubilee had a higher level of absence, when compared to their contemporises. In addition, it is worthy to note that whilst working day is included, this will account for staff who are in the ward environment but not included in the rostered allocation of staff but are "ready for action" should the need be required. The allocation of working day will relate to staff undertaking a supernumerary or supervisory role.

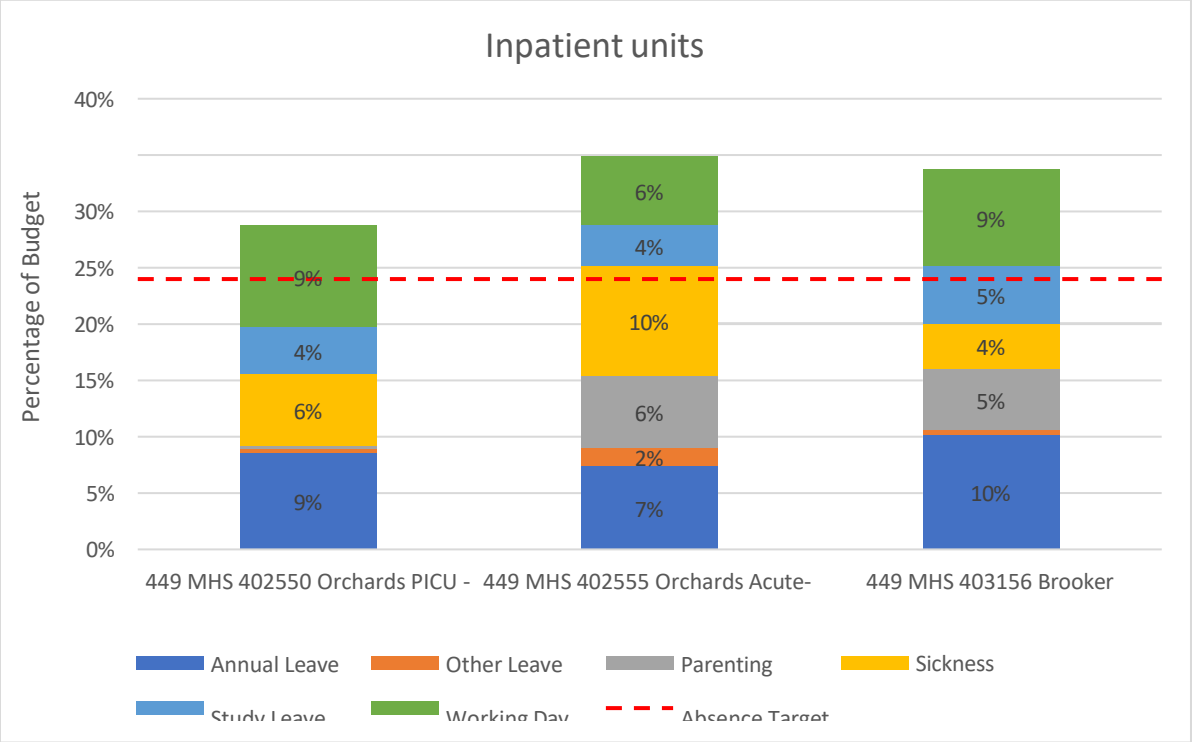


Table 4 Mental Health Inpatient Unavailability by theme

5.2.2 Within the Mental Health Inpatient areas, absence is noted to be high within Hawthorn at 10%, parenting features within both Hawthorn and Brooker, with working day significant at 9% in both Maples and Brooker. This will be explored further with the Matron and will support comparison within the Q2 report.

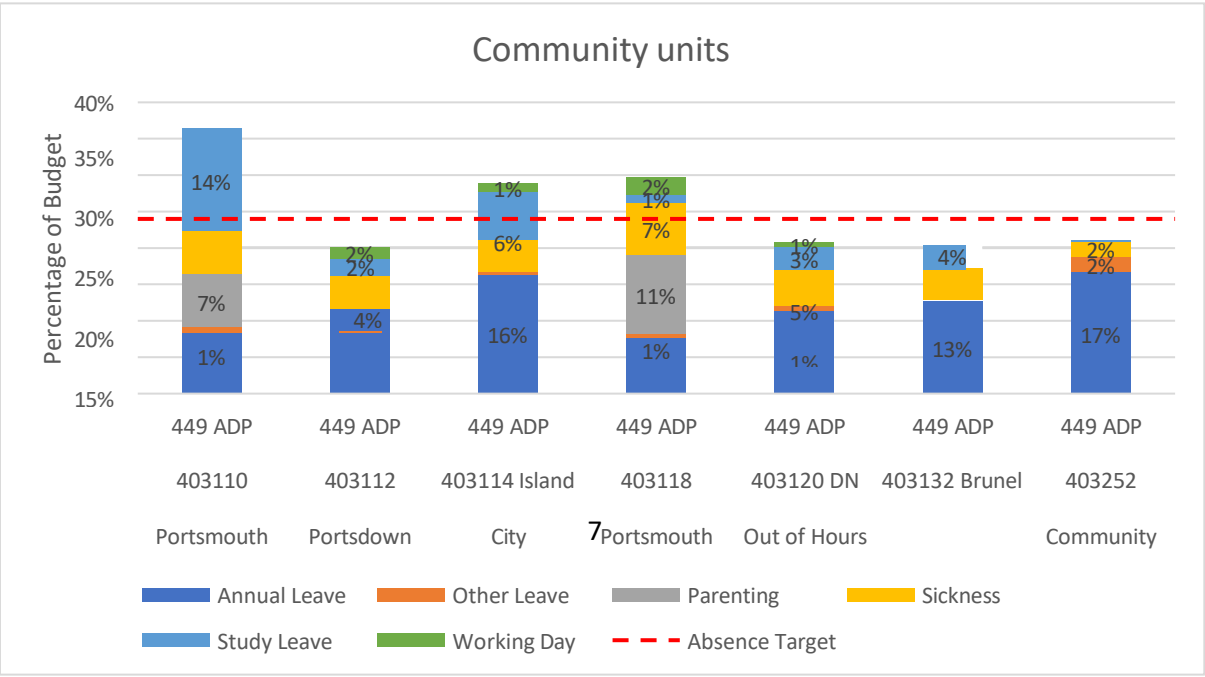


Table 5 Portsmouth Community Teams Unavailability by theme

5.2.3 It is noted that there is a variance of unavailability across Portsmouth team with the North reporting a higher level of study, the impact of releasing staff to CNSST training throughout the quarter may account for a component of this however this level of study is not reflected across all teams.

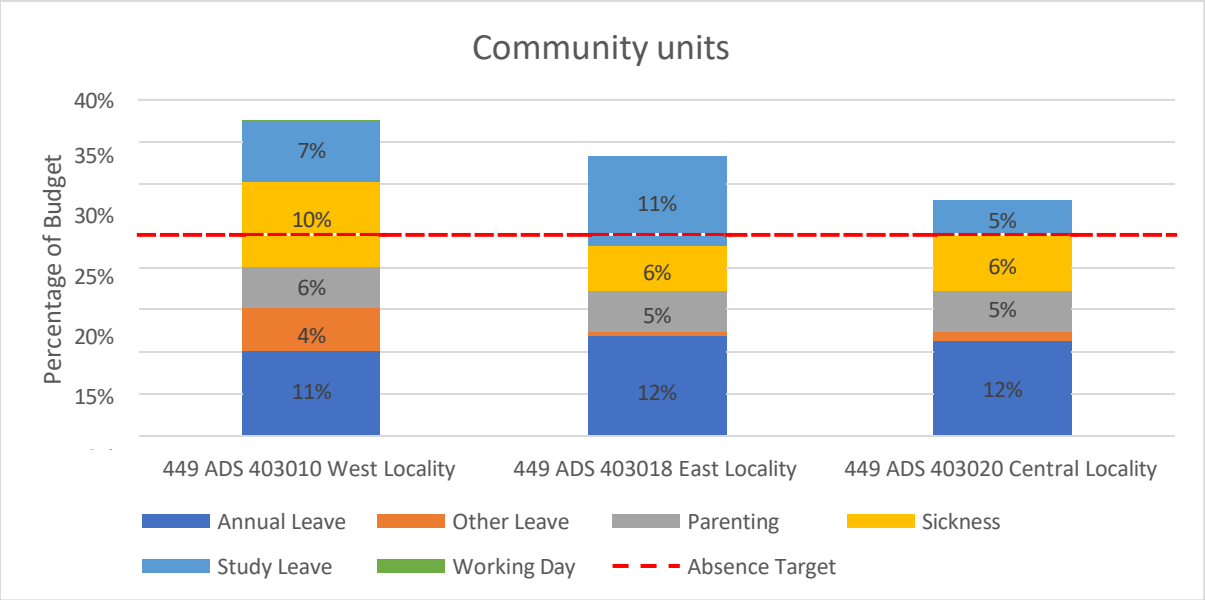


Table 6 Southampton Community Teams Unavailability by theme

5.2.4 Absence and study account for the highest unavailability with Southampton Community teams, especially within West Locality, the East localities higher level of study leave can be attributed to the DN post graduate trainee.

6.0 Recruitment and Vacancies

6.1 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 meeting have received monthly progress up-dates and escalations.

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

6.3 International Recruitment (IR) continues within 2023/24 with a planned recruitment of 3 inpatient RNs for the Southampton units.

6.4 There is ongoing work with the Mental Health and Adult service line Leadership Teams to progress the Mental Health & Community IENs transition programmes to enhance the clinical induction for any nurse who is new to a mental health or community role, the first programme is planned for September 2023.

7.0 Acuity & Dependency

7.1 Safer Nursing Care tools provide an evidenced based assessment that enables nurses to determine

patient acuity and dependency, incorporating a staffing multiplier to ensure nursing establishments reflect patient needs. Solent NHS Trust now holds the licenses to undertake the safer care nursing tools across mental health, adult inpatients, and community nursing.

7.2 Mental Health Optimal Staffing Tool (MHOST)

Following the pilot data collection in January, the Mental Health Inpatient wards have completed their first MHOST acuity and dependency data collection in May. Within the data collection period, the OPMH ward had a cohort of patients from the Acute Admissions ward however, this has been accounted for within the data collection.

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

7.3 Safer Care Nursing Tool (SCNT)
Whilst there is a pending national update of the acuity and dependency descriptors within the SCNT, it is unclear to the timescales therefore, it has been agreed within the Trust that we will move forward with an implementation plan to introduce SCNT to our adult inpatient wards. Once the initial training has been completed with the national team, timescales for the first data collection can be shared.

7.4 The Community Nurse Safe Staffing Tool (CNSST)
An intensive training schedule for CNSST was completed during Q1 for all clinical staff within the community teams. This was supported by the Community Educators in Practice, who also provided face to face support during the data collection week for ad hoc queries and additional training for temporary staff.

The data collection week was completed in Q1 and there follows a process to input the results and draw conclusions. As with the data collections for MHOST and SCNT, 2 data collections need to be completed prior to any amendments to establishment and / or skill mix.

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

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

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

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

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

8.2.1 Table 7 below shows the incident reporting trend across the inpatient areas relating to safe staffing issues. There has been a significant reduction in reporting of incident relating to safe staffing levels and most incidents are reported as near miss or low harm, none have been escalated to a Serious Incident.

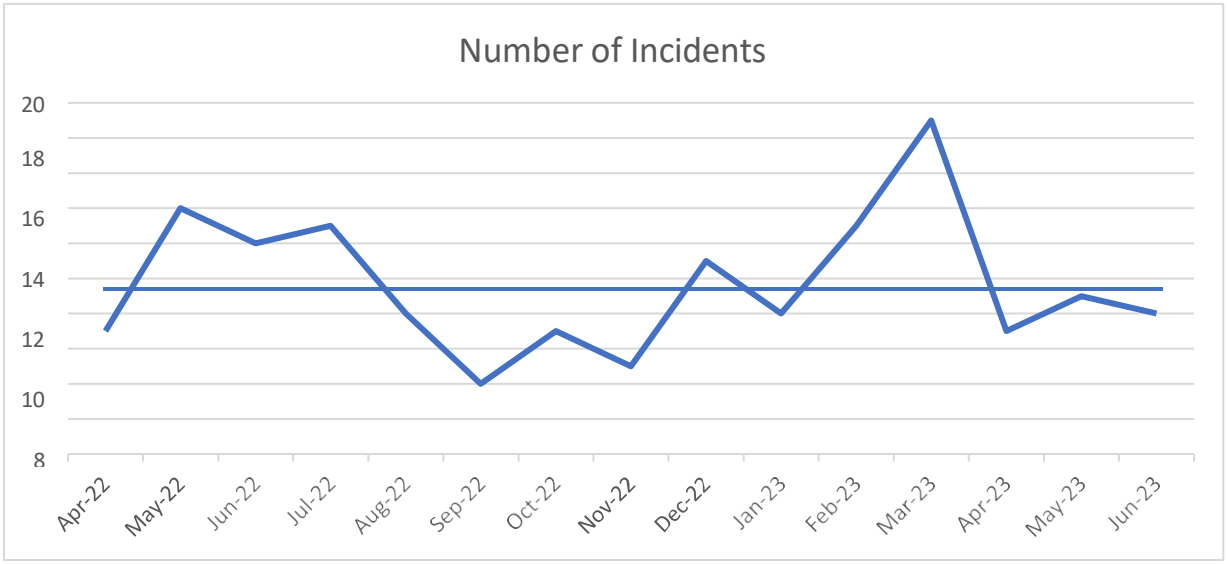


Table 7 Incidents trends staffing levels inpatient units Q1 2023 - 2024

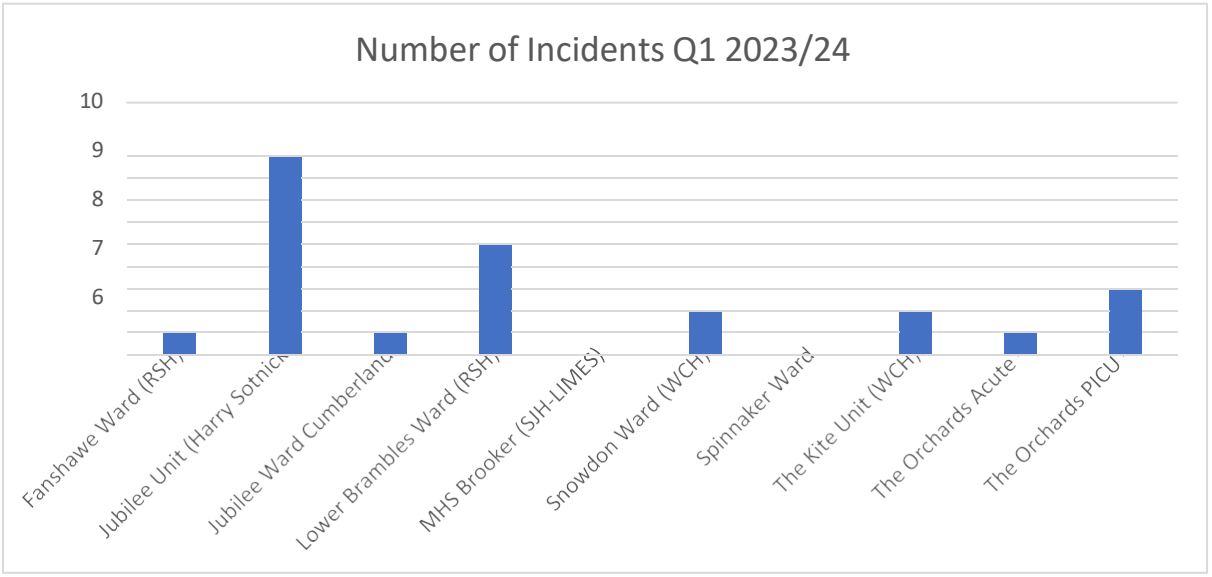


Table 8 Number of incidents for Q1 citing staffing affecting care & staff within inpatient services.

8.2.2 The Jubilee Unit has reported the highest number of incidents within the quarter.

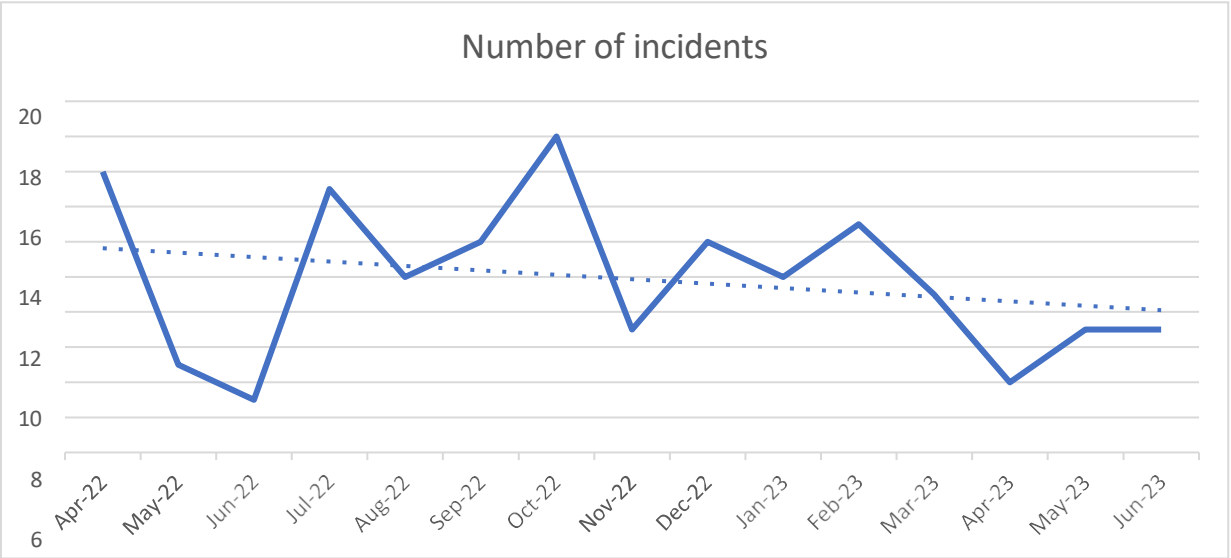


Table 9 Trend relating to safe staffing across Community Services 2022 / 2023

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

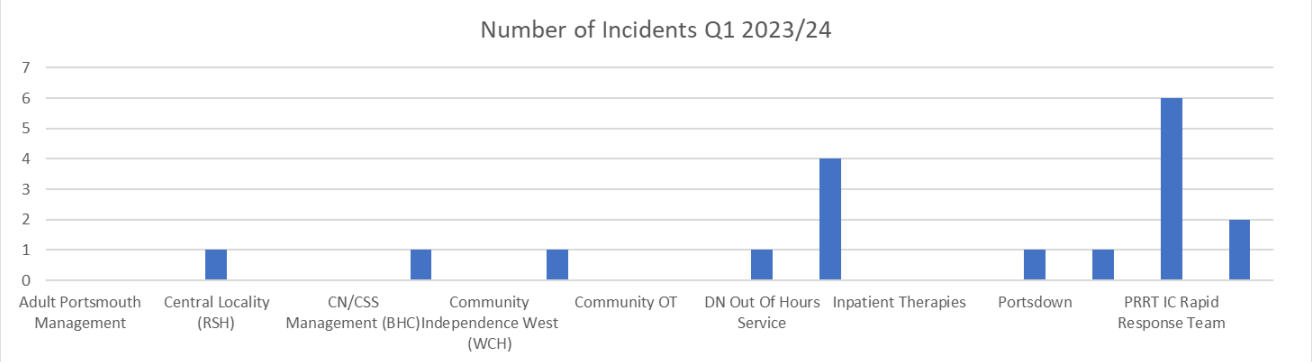


Table 10 Q1 incidents relating to safe staffing across Community Services

8.2.4 PRRT continues to record the highest number of incidents relating to safe staffing.

8.7 NSI – Nutrition

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

It has been established that all inpatients' wards within Solent NHS Trust offer protected mealtimes and all patients have a MUST risk assessment on admission and every 7 days during their stay. This is audited on a six-monthly basis, which identified our Solent NHS Trust inpatient wards were compliant. The next audit is due in Q1 23/24.

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.

9.0 Complaints and Service Concerns

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

- Communication
- Patient care
- Values and Behaviours of Staff

9.2 Within Q1, following analysis of the service concerns received in the reporting period there appears to be no service concerns directly relating to safe staffing levels. However, it is noted there were many concerns raised regarding inability to secure an appointment or delays in being seen, but not necessarily due to safe staffing levels.

9.3 There were 14 service concerns, 9 complaints and 2 professional feedback received within in Q1 relating to the values and behaviours of staff across the whole organisation. Within these, there was reference to staffing levels recorded as a theme.

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

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

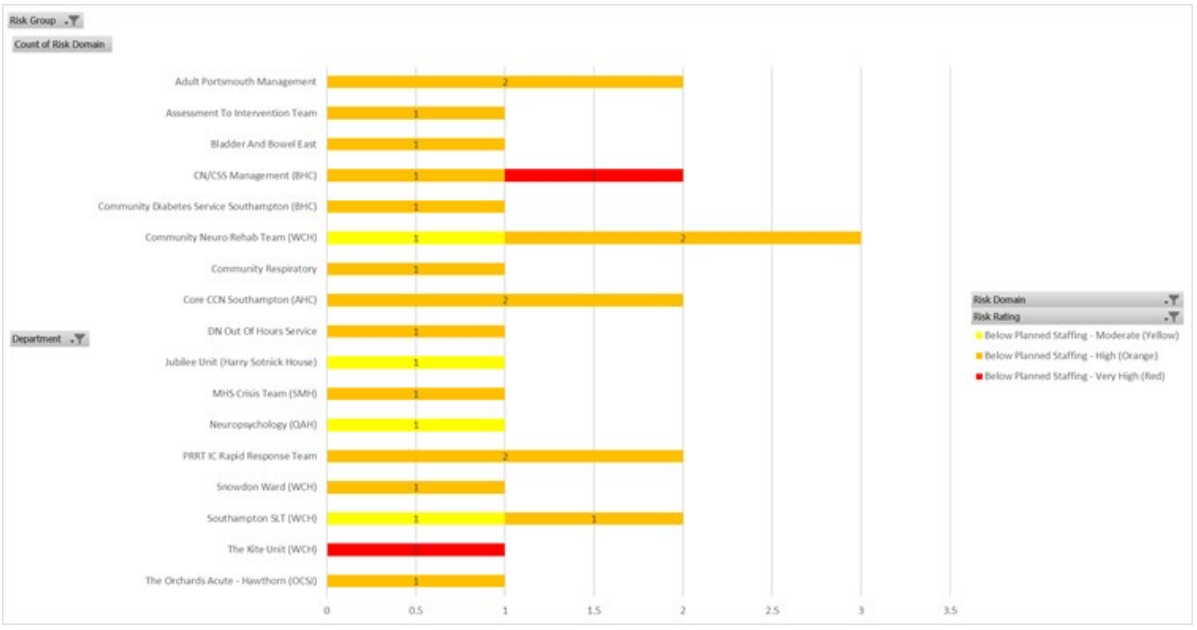


Table 11 Risks citing staffing levels within Q1 2023 / 24 impacting upon patient care / service delivery.

10.2 Within Q1 there has been a slight reduction in risks from 26 to 23 with 5 high risks being closed and 2 new high risks being opened. There is one risk where the rating has been reduced from very high to high.

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

There are two risks noted to be very high.

Very High Risks	
ADS - Community Nursing	Community nursing below planned staffing risk. Daily capacity reviews at morning meetings and RAG rating caseloads and staffing. Budget review completed with reduction in 29 WTE. 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.
ADS - The Kite Unit (WCH)	Inpatient below planned staffing risk. Ward doctor cover. Currently the ward Doctor cover on KITE is with Locum doctors including the consultant cover. Consultant post appointed to start in Oct 23, Speciality post appointed to await confirmation of start date.

Table 12 Very high risks relating to staffing affecting patient care / service delivery.

Previous High Risks closed
2030 URS Southampton
2105 URS Southampton
2160 Spinnaker
2186 Recovery Team North
2215 Parkinson's Nurse

Table 13 Previous high risks closed in Q1.

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

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

Within the reporting period high staffing related risks have been presented at CEG with Unscheduled Care response services and Mental Health inpatient both taken for a round table discussion.

11. Conclusion

In Q1 of 2023/24 workforce concerns relating to safe staffing is the top risk across the organisation.

During the reporting period the safe staffing meetings have sustained the planned monthly schedule. However, it was noted that should individual services be particularly challenged with regards to safe staffing and require additional support from the Chief Nurse Directorate, the HR Team and / or health roster team this would be supported.

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

Following the business planning process, a review of inpatient clinical establishments has been requested by the Chief of Nursing & AHPs and will inform future establishment setting. The Jubilee bedded capacity and establishment levels have been reviewed and agreed through the Safer Staffing Assurance group with associated successful recruitment and reduction in temporary staffing usage. The other inpatient units establishments will be brough to the Q2/3 meetings.

Services have continued to utilise temporary staff to mitigate gaps in the roster and therefore throughout the reporting period safe staffing levels were maintained.

Solent NHS Trust
Quality Assurance Committee - Terms of Reference

1 Constitution

1.1 Solent NHS Trust Board resolves to establish a Committee of the Board to be known as the Quality Assurance Committee (the Committee). As a Committee of the Board, the Standing Orders of the Trust shall apply to the conduct of the working of the Committee.

1.2 The Committee will work closely with the Audit & Risk Committee for those aspects of governance associated with assurance and internal control and will report to the Audit & Risk Committee on matters as requested by that Committee.

2 Purpose

2.1 The Committee is responsible for providing the Trust Board with assurance on all aspects of quality, clinical governance and regulatory compliance.

3 Duties

3.1 Objectives:

To seek assurance that

- processes are in place to assess and monitor clinical governance performance concerning all aspects of service quality
- effective processes are in place to achieve all areas of regulatory compliance including registration and recommendations of the CQC
- the development of all clinical governance activities within the service lines improve the quality of care throughout the Trust
- learning from relevant events is disseminated and embedded
- quality and safety matters within partnership governance arrangements are considered

3.2 The Committee will seek assurance on all aspects of quality via:

- Exception reports from
    - The Chief of Nursing and Allied Health Professionals (AHPs) and Chief Operating Officer Report which will highlight items to escalate to the Committee from the Quality Improvement and Risk (QIR) Group including key clinical service risks (providing assurance of the application of Trust risk appetite and tolerance, agreeing proposals to tolerate risks scoring 15 or above and assurance of the management and action plans of risks scoring 15 or above) and key escalations from sub-groups
- Scheduled reports from the various annual programmes including:
    - Regulatory Compliance and CQC oversight
    - Safe Staffing
    - Experience of Care, including community engagement and complaints
    - Research & Development including Clinical Audit & Effectiveness and Quality Improvement
    - Learning from Deaths, SIs and Incidents
    - Safeguarding
    - Learning Disabilities Strategy updates
    - Operational Risks and the BAF
    - Freedom to Speak Up
- Via the QIR Group, the Committee also seeks assurance regarding Medicines Management, Infection Prevention & Control and Safeguarding. The annual reports for these agendas are also noted at the Committee prior to presentation to Board.
- Quarterly reports on achievement against the Trust's Quality Priorities

3.3 The Committee will approve the QIR Group Terms of Reference

3.4 The Committee will also seek assurance from other functions concerning Trust business where there are regulatory compliance issues and will require the relevant management lead to provide regular assurance reports.

3.5 The Committee will conduct an annual appraisal of its effectiveness.

4 Membership

4.1 The Committee is appointed by the Trust Board and comprises:

- Non-Executive Director (Chair) or nominated deputy
- One other Non- Executive Director
- Executive Directors
    - Chief Executive Officer
    - Chief Operating Officer (accompanied by CDs as invited)
    - Chief of Nursing and AHPs
    - Deputy CEO & Chief Medical Officer
- Head of Compliance
- Associate Director of Quality and Governance

5 Attendees

5.1 If Executive Directors are unable to attend a meeting they should agree a deputy who is authorised to act on their behalf, with the CEO in consultation with the Committee Chair.

5.2 Agreed representatives from CQC and HIOW ICS have a standing invite to attend meetings and papers will be shared in advance of meetings.

6 Quorum

6.1 The quorum necessary for the transaction of business shall be

- The Chair or a nominated deputy being a Non-Executive Director
- a minimum of one other Non-Executive Director
- a minimum of two Executive Directors

7 Frequency

7.1 Meetings will be held six times a year, scheduled to support the business cycle of the Trust and additional meetings can be called by the Chair of the Committee if it is deemed necessary.

8 Secretary and administration

8.1 The Corporate Affairs Administrator shall act as the secretary of the committee. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated promptly to all members, following agreement by the Chair.

9 Authority

9.1 The Committee has no powers, other than those specifically delegated in these Terms of Reference. The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties
- to call any employee to be questioned at a meeting of the committee as and when required.

10 Reporting

10.1 An exception report will be provided to the Board via the Committee chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

Board and Committee Summary Report

Item 25

NHS Solent NHS Trust

Title of Paper	Charitable Funds Committee Exception Report
Date of paper	September 2023
Presentation to	In Public Board
Item No.	25
Author(s)	Belinda Brown, Executive Assistant to Chief Executive
Executive Sponsor	Gaurav Kumar, NED – Committee Chair Debbie James – Executive Sponsor
Summary of key issues/messages	The committee: - • Received the Quarter 1 (Q1) Finance Report covering the period 01 April 2023 to 30 June 2023. • was informed that the charity received public donations totalling £1,120.00 within Q1, including £750.00 from a charity bike ride, Havant to Paris, by Colin Edwards, the Trust's counter fraud lead. • Agreed to formally acknowledge Colin Edwards contribution to the charity. • was updated on the status the NHS Charities Covid 19 Appeal submission, which had been approved, pending receipt of further information on how the grant will be used (resource to grow the charity). The committee was informed that the grant worth £30,000.00 and the committee agreed to proceed with the application. • was informed that the NHS Charities Together stage 3 recovery grant submission, worth £88,000.00, had been submitted and that a decision would be made in October 2023. The funds for this grant, if successful, to be used to create a tranquil garden area at Falcon House. • Reviewed a bid for a staff values and behaviours initiative, but rejected as the bid did not fulfil criteria for the charity. The committee recognised that the bid initiative was worthwhile and suggested the bid be taken to the September Dragons Den forum. • Discussed the future of the charity in relation to Fusion and agreed for a link to be made with the Fusion workstream where conversations are progressing. • Received an update from Estates • Received an update from Communications • Agreed the objectives of the charity up to 01 April 2024.
Action Required	For decision? [ ] For assurance? Y
Summary of Recommendations	• The Board is asked to receive the above summary of business transacted.
Statement on impact on inequalities	Positive impact (inc. details below) [ ] Negative Impact (inc. details below) [ ] No impact (neutral) [ ]

Strategic Priority this paper relates to

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

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

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