Agenda

In-Public Meeting

Date: 15 April 2024
Timings: 09:30 – 12:45
Meeting details: Meeting Room Kestrel 1& 2, Highpoint

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Board Requirement
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive**	Chair	To receive
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
			Register of Interests & Declaration of Interests	Chair	To receive
2	09:35	30mins	**Patient Story**	Chief of Nursing and AHPs	To receive
3	10:05	30mins	**Staff Story**	Chief People Officer	To receive
4	10:35	10mins	**Reflection on Patient and Staff Stories**	Chief of Nursing and AHPs Chief People Officer	To discuss
5	10:45	5mins	**Minutes of the meeting held 4 February 2024**	Chair	To approve
6			**Action Tracker**	Chair	To receive
Quality and safety					
7	10:50	10mins	**Safety and Quality – contemporary matters including:** • **Board to Floor Visits Feedback 6 month report** • **Freedom to Speak Up** - *verbal update*	Chief of Nursing and AHPs	To receive
10-minute break					

Items to receive					
8	11:10	10mins	**Chief Executive's Report**	CEO	To receive
9	11:20	10mins	**Clinical Professional Engagement and Leadership Report (inc. professional strategic framework and nurse revalidation) (Nursing, AHPs and medical workforce)**	Chief of Nursing & AHPs	To receive
10	11:30	10mins	**Board Assurance Framework Compliance**	CEO	To receive
11	11:40	20mins	**Integrated Performance Report** *Including:* • *Safe* • *Caring* • *Effective* • *Responsive* • *People* • *Finance* • *Research and Improvement* • *System Oversight Framework*	Executive Leads	To receive
12	12:00	5mins	**NHS Provider Licence Report**	Governance Programme Lead	To receive
13	12:05	10mins	**Patient Safety Incident Response Plan**	Associate Director of Quality, Safety, Governance and Risk	To approve
14	12:15	10mins	**Equality Delivery System (EDS)**	Chief People Officer	To approve
Governance					
Reporting Committees and Governance matters					
15	12:25	15mins	**People Committee –** *Exception Report of meeting held 8 February 2024 and 21 March 2024*	Committee Chair & Acting CPO	To receive
15			**Mental Health Act Scrutiny Committee-** *No meeting held to report*	Committee chair	To receive
16			**Audit & Risk Committee –** *Exception Report of meeting held 9 February 2024*	Committee chair	To receive

17			**Quality Assurance Committee-** *Exception Report of meeting held 21 March 2024*	Committee chair	To receive
18			**Non-Confidential update from Finance & Infrastructure Committee** – *Meeting 25 March 2024*	Committee chair	Verbal update
19			**Charitable Funds Committee –** *Exception Report from meeting held 23 February 2024*	Committee chair	To receive
20			**Remuneration and Nominations Committee –** *Non-Confidential verbal update from meeting held 14 March 2024*	Committee chair	To receive
Any other business					
21	12:40	5mins	**Any other business and reflections including:**	Chair	-
22			• ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***	Chair	
23	12:45	---	**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	-

Item 5

Minutes

Solent NHS Trust In Public Board Meeting

Date: Monday 5 February 2024
Timings: 09:30
Meeting details: Highpoint

Chair: **Mike Watts,** Acting Trust Chair (MW)	
Members: **Andrew Strevens,** CEO (AS) **Angela Anderson,** Chief of Nursing and Allied Health Professionals (AA) *(virtually)* **Nikki Burnett**, Chief Finance Officer (NB) **Debbie James**, Chief Strategy & Transformation Officer (DJ) **Alasdair Snell,** Chief Operating Officer (ASn) **Sorrelle Ford**, Acting Chief People Officer (SF) **Vanessa Avlonitis,** Non-Executive Director (VA) **Stephanie Elsy,** Non-Executive Director (SE) **David Kelham,** Non-Executive Director (DK)	**Attendees** **Sam Stirling**, Corporate Affairs Administrator **Dominic Ford**, Governance Programme Lead (DF) **Apologies** **Gaurav Kumar**, Non-Executive Director (GK) **Dan Baylis**, Deputy CEO & Chief Medical Officer (DB) **In Public Observers** **Paul Lewzey**, Governor- Southern Health (PL) **Adrian Thorne**, Governor- Southern Health (AT) **Michael North**, Governor- Southern Health (MN)
Patient Story (item 2) **Sky**, Service User **Ophelia Watson**, Head of Experience of Care (OW)	**Staff Story (item 3)** **Hayden Kirk**, Clinical Director (HK) **Anna Walker**, Head of Quality & Professions (AW) **Ruth Flanders**, Deputy Head Integrated Services (RF) Sara Dennin

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. The Board welcomed public observers to the meeting.
1.2	The meeting was confirmed as quorate. The declarations of interest form was circulated and there were no updates to note.
2	**Patient Story**
2.1	*OW & Sky joined the meeting.* Skys journey was shared with the Board and OW thanked for the opportunity to highlight experiences. An overview of Skys experience and key challenges was noted, including lack of understanding and clarity in processes. OW commented on work together as part of the Alongside Communities workstream and the importance of considerations in changing the narrative to ensuring better experiences for trans and young people. The Board were briefed on continued work within the Community Engagement Team, including Gender Working Groups, to ensure learning and feedback.
2.2	MW thanked Sky for sharing experiences and reflected on wider learning for the Board and NHS as a whole. Potential areas for further support throughout the transitioning journey and how to improve advocation was queried. Sky emphasised the importance of ensuring regular communications, offering potential alternatives during waiting list times and a greater number of gender clinics.
2.3	SF thanked Sky for strong advocacy across the community and understanding that people may not always get it right, however commented on subsequent opportunities to educate further.

	AS reflected on reverse mentoring programmes and usefulness in this area to ensure further learning.
2.4	AS asked about potential areas of work that could be enhanced and Sky suggested strengthening feedback from young people to ensure greater listening across all levels of the organisation. AA agreed importance and the need to work together to design service delivery. Further work required to understand advocacy, access and understanding was emphasised.
2.5	DK queried how to ensure correct terminology and language. Sky highlighted education and listening as key and noted importance of understanding intention behind interactions. MW thanked Sky and OW for attending the meeting. *Sky and OW left the meeting.*
3	**Staff Story**
3.1	*HK, AW, RF & SD joined the meeting.* The Board were briefed on the Futures Project- Advanced Training Programme. • Background and reason for development was shared. An overview of the purpose and aim of the programme was explained. • Challenge regarding requirements and current situation was highlighted. • The importance of bespoke skills, training requirements and key specialist leadership was noted. The need for functional changes were acknowledged. • The Board were informed of the 4 (6) pillars of practice, defining skills required. • RF shared the leadership structure and requirement for operational and clinical challenge to make the correct balanced decisions. Review of staff development pipeline was confirmed. • An overview of the programme journey was provided and SD explained development, including service redesign, review of how frameworks were developed, Learning Needs Analysis (LNA) development and training matrix development. • Progress to date was reported, with intention to fully embed by April 2024. Considerations of scale across services was highlighted. • Aims for the coming year and impacts were shared. • HK provided an overview of risks and recognised culture change and support required at Board/Executive level.
3.2	VA commended work to date and commented on considerations for measuring impact of success. It was confirmed that measures would be evident via the staff survey/appraisals and work was taking place with the Research Academy to consider further. .
3.3	SE queried frameworks across the NHS, including Southern Health. DJ noted various QI methodologies and NHS impact approach advocated for a systemic structure. The importance of being cognisant of this work as the Trust transitions to the new organisation and ensure a common approach to learning and development was acknowledged. SF commented on usefulness across the whole NHS/wider ICS level and considerations as part of the Fusion programme.
3.4	DJ highlighted skills matrix developed within the commercial team and queried alignment/consistency. HK informed of discussions held with commercial and finance teams in relation to in-house training and the matrix and explained review together with this piece of work. DJ emphasised key workforce and financial planning considerations required. HK agreed and commented on broad categories and commonality of language required. It was noted that all work was contempory, with continued live conversations.
3.5	AA commended work undertaken and the need for considerations of links to competencies within the matrons handbook and mutual learning across all areas. AA also commented on further review into wider system areas and higher education institutes when scaling up programmes.

	AW informed of alignment to the matrons handbook as well as finance and performance elements. The Board were also informed of careful terminology to ensure inclusive of Allied Health Professional (AHP) groups.
3.6	The Board reflected on the importance of ensuring triangulation with other programmes. MW thanked the attendees for presenting to the Board. *HK, AW, RF & SD left the meeting.*
4	**Reflection on Patient and Staff Stories**
4.1	The Board reflected on the patient and staff stories presented. VA commented on the learning elements from both, particularly regarding pivotal training areas and ensuring these are carried into the new organisation. Challenges were raised regarding isolated delivery of such programmes across services, time taken from clinicians and the role of the learning and development team. The Board discussed forensic review required together with Project Fusion in relation to training programmes and ensuring not lost in leadership changes.
4.2	MW summarised key outcomes/actions from both stories: • Patient story- to understand learning and developing advocacy • Staff story- building on strong work across all areas (with Fusion in mind) and considering culture for programmes
5	**Previous minutes, matters arising and action tracker**
5.1	The minutes of the previous meeting held on Monday 4 December 2023 were agreed as an accurate record. DK reflected on the importance of ensuring actions were clearly specified to ensure appropriate action.
5.2	The following actions were confirmed as complete: AC005068, AC005069 & AC005070 It was agreed that action AC005067 remain open on the tracker for appropriate follow up.
6	**Safety and Quality – contemporary matters**
6.1	The Board were briefed on increased cases of viral and gastro infections. It was confirmed that there were no significant impacts identified in terms of staff sickness levels and guidance and communications in relation to Infection Prevention restrictions were ongoing.
6.2	<u>Board to Floor</u> AA informed the Board that a final summary report would be presented to the final meeting to ensure closure elements were clearly outlined. MW commented on the importance of ensuring successful transition of key elements to the new organisation. SE suggested usefulness of inviting the Southern Health Board to attend Board to Floor visits as part of the transition process. **Action- AA.**
6.3	<u>Freedom to Speak Up</u> There were no specific concerns to escalate to the Board. Rise in cases due to change in leadership was noted, however AA confirmed that no impacts had been identified.
7	**Chief Executive Report**
7.1	AS presented the report. • The Board were informed of apprenticeship awards taking place. • An overview of work taking place within Special Care Dental Services was provided, with key elements of learning being considered as part of the new organisation.

	• Ongoing industrial action and continued GP negotiations was noted. • AS informed of significant issues within the system and critical incidents declared across Trusts.
7.2	The Board were briefed on active work taking place within community services to open additional bed capacity. Activity to establish new unit at Sheer Water was shared and ongoing discussion with NHSE and the ICS confirmed. Importance from a patient safety perspective requirement for short term investment was emphasised. The need for CQC approval was highlighted and further considerations in terms of resource and partner support was confirmed. SE acknowledged vast pressures and importance from a patient safety perspective. SE highlighted the importance of ensuring effective audit trail of decisions made throughout the process. MW agreed and commented on transparent ownership of risk when switching between organisations and ensuring stand down criteria was clearly documented. VA queried considerations aligned to the winter planning process. AS explained challenges and requirement to ensure reactive working. Considerations into planning for 2024/25 was noted. ASn briefed on patient cohort and collaborative work with Southern Health. Ongoing discussions regarding staffing, managing risks and effective planning was highlighted. ASn assured the Board that guidelines were being followed and continued review to ensure balance of risks. NB provided an overview of financial risks and requirement for system work and clear narrative. NB commended the work of the estates and facilities service for their prompt work to date.
7.3	AS noted demand and capacity issues highlighted within the BAF section and continued reactive work/discussions. DK queried risk target dates and AS commented on contempory/fluid review of risks based on priority areas and confirmed target scoring set to the end of the organisation.
8	**Clinical Professional Engagement and Leadership Report (inc. professional strategic framework and nurse revalidation) (Nursing, AHPs and medical workforce)**
8.1	AA provided an overview of current activity and explained that a further report will be brought to a future Board meeting to summarise/close out ahead of Project Fusion. • It was confirmed that the inaugural system Advanced Clinical Practice conference was being planned as per guidelines. • AA informed of apprenticeship awards taking place, with awards being given within the university sector. • Continuation of the matron forum and professional advisory group was highlighted and AA briefed on engagement events held.
9	**Draft Annual Plan**
9.1	DJ presented the report. • The Board were briefed on current business planning process and QIA planning for additional posts being undertaken. • Continued joint working with Southern Health and Isle of Wight NHS Foundation Trusts was highlighted. • Challenge in terms of 2024/25 planning timescales for the Isle of Wight segmentation piece was noted. • Positive work to build on the Clinical Transformation Groups was reported. • DJ informed of standard year 1 plan templates for Post Transaction Implementation Plans (PTIPs) within corporate services being established. • Progress and positive partnership working was acknowledged.

9.2	MW queried planning across each individual organisation. DJ confirmed that each organisation was completing a workforce and activity plan, to be brought forward into a single submission for a single operational plan. The Board were informed of narrative produced based on work taking place within the Clinical Transformation Groups.
9.3	AS informed that national guidance had not yet been received and ongoing discussions were taking place in consideration of timetables. It was noted that further discussions would be held within Confidential Board.
10	**System Financial Recovery Plan Update**
10.1	NB provided a contempory update. • Current position in terms of timetables was highlighted. • Challenges regarding financial position agreement with the national team was shared. Miscommunication in terms of number agreed for forecast out-turn was explained and ongoing discussions with the ICB were shared. It was confirmed that there was currently no agreed number for month 10 and NB assured of full discussions at the Finance & Infrastructure Committee, with agreement subject to credit note. • The Board were informed of escalation meeting in place for discussions in relation to 2024/25 planning. • NB briefed on critical position in relation to acute services. Changes to the BAF to reflect the contemporary position was highlighted. • Pressures were acknowledged and challenges changing financial trajectory at this time recognised.
11	**Integrated Performance Report**
11.1	An overview of key escalations were shared. Challenges within the Special Care Dental Service were shared and it was confirmed that the Trust was awaiting final confirmation before restricting referral criteria. Considerations of solutions, including potentially minimising domiciliary visits, was confirmed.
11.2	The Board were informed of deep dive completed in relation to the proportion of OPMH patients in wards longer than 60 days. Assurance that performance was safe and appropriate was noted.
11.3	It was confirmed that a co-ordinated deep dive of incidents had been completed via performance review and QIR. Strong discussions were highlighted and it was confirmed that further assurance would be provided via governance routes.
11.4	VA commented on improvements shared across areas, including assurance in terms of VTE. Regarding urgent community response, VA queried data accuracy and ASn explained current position.
11.5	The Board formally acknowledged hard work of all staff over the last few months, recognising high performance despite pressures.
11.6	MW reflected on the usefulness of high-level understanding of consequences included within the executive summary of this report.
11.7	<u>People</u> • Maintained level of sickness absence was reported, with expected spike in January reporting due to community sickness. • Review of long term absence cases was confirmed and SF briefed on interventions being considered. • The Board were informed of positive uptake of the flu vaccination.

	• SF commended work of the temporary staffing team, particularly in relation to negotiation of agency rates. • Focus on rostering optimisation was highlighted. • SF briefed on current position in relation to the workforce plan and challenges in relation to financial targets. Discussions were held regarding the current financial position and challenges demonstrated.
11.8	Finance • NB briefed the Board on the financial position in terms of recovery, with reduced gap to 300k off plan. Significant challenge in relation to Sheerwater and financial forecasting was shared. • The Board were informed of reduction in cash balance. • An update was provided in relation to cohort of invoicing. • NB provided an overview of run rate and non-recurring position. Planning to deliver break even plans for next year were highlighted.
11.9	The Board noted the Research and improvement and SOF update.
Exception Reports	
12	**People Committee**
12.1	There was no meeting held to report. The January meeting has been rearranged to 8 February 2024.
13	**Mental Health Act Scrutiny Committee**
13.1	There was no meeting held to report.
14	**Audit & Risk Committee**
14.1	There was no meeting held to report. DK provided an update in relation to ongoing proactive work regarding auditor fees and associated process.
15	**Quality Assurance Committee**
15.1	VA presented the report and highlighted key escalations raised. It was confirmed that further discussions were required in Confidential Board regarding strategic objectives.
16	**Non-Confidential update from Finance & Infrastructure Committee**
16.1	There was no update to share In Public.
17	**Charitable Funds Committee**
17.1	There was no meeting held to report.
Any other business	
18	**Any other business and reflections including:** • ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***

18.1	AA briefed the Board on work taking place in terms of Board risk appetite across organisations and alignment to Southern Health.
18.2	AS reflected on the quality of conversations held and inclusion of closure elements expected within the next meeting.
18.3	Reflections were provided from the Southern Health Governor observers: • AT commented on easy-to-follow discussions and positive atmosphere. Positivity of integrated discussions and strong Non-Executive Director challenge, as well as clear evidence of patient focus, was emphasised. The importance of ensuring wider system working was noted. • PL shared thoughts on the similarities between Southern and Solent Boards and potential opportunities for development. • MN reflected on vision focused discussions and intrinsic links between the patient and staff story. Key elements for joint considerations required, including education, listening, building trust and communication was emphasised.
18.4	No other business was discussed and the meeting was closed.
19	**Close and move to Confidential meeting**

Action Tracker

Overall Status	Source Of Action	Date Action Generated	Minute Ref	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
Open	In Public Board	05/02/2024	6.2	AC005071	Safety & Quality- Contemporary Matters	SE suggested usefulness of inviting the Southern Health Board to attend Board to Floor visits as part of the transition process. **Action- AA.**	Angela Anderson	

Board and Committee Summary Report

Title of Paper	**Board to Floor 6 monthly update**				
Date of paper					
Presentation to	Trust Board Meeting – In Public				
Item No.					
Author(s)	Kirsty Smith – Quality and Safety Officer Pauline Jeffrey – Head of Quality and Safety				
Executive Sponsor	Angela Anderson – Chief of Nursing and Allied Health Professions				
Executive Summary	The purpose of this paper is to provide a brief overview of the 'Board to Floor' sessions held in the period October 2023 – March 2024				
Action Required	For decision?	N	For assurance?	Y	
Summary of Recommendations	The Trust Board is asked to note this report.				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Positive / negative inequalities	No impact				
Previously considered at	Not applicable				

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	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					

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.						
Executive Sponsor Signature							

Key messages /findings

Purpose:

The purpose of this paper is to provide a brief overview of the 'Board to Floor' sessions held during the period, October 2023 – March 2024.

Background:

Board to Floor visits continue to provide an opportunity for staff to speak directly with Board members. These sessions have been established within Solent NHS Trust for over three years and have always presented a great opportunity for staff to discuss the area in which they work face to face with the Board members.

While it is acknowledged that the investment of time in completing these sessions is significant, the positive reaction has been worthwhile. The current 'Board to Floor' process is continually reviewed by the Quality & Safety Team, Associate Director of Quality, Safety, Governance and Risk and the Chief of Nursing and Allied Health Professions.

Sessions:

During the Q3/Q4 2023/24 (October 2023 – March 2024), Trust Board members completed six visits across five of the seven clinical service lines (See Appendix 1)

It is disappointing to have only facilitated 6 visits across 7 service lines in a period of 6 months however it has been really challenging securing NED availability due to additional Project Fusion commitments.

Of the visits that were booked for Q3 & Q4 x 6 were cancelled after being arranged, 3 x by service, 3 by NED.

Themes as raised by staff:

The following were noted to be the main themes both, as positive highlights and as issues that managers might wish to explore further. None were recorded as actions but shared with relevant service senior managers for awareness.

Top five positive themes highlighted by staff were:

- Enjoy working in team/pride.
- Project Fusion
- Staff development / Succession planning
- Supportive team (inc. SLT)
- Good working relationships with External Partners

Concerns highlighted for further discussion were primarily focused on the following:

- Concerns regarding formation of new Trust
- Patient acuity
- Required resources not available.
- Recruitment & Staffing
- Waiting Lists

Conclusion:

These visits continue to provide welcome opportunities for Solent NHS Trust staff and Trust Board members to have open and honest conversations. Staff can celebrate innovation and good practice as well as discuss the challenges that services face.

As part of this process, we provide notes which are emailed to the relevant service manager and Head of Quality and Professions (HQP) post visit.

The future of board to floor visits in the new organisation is being discussed with colleagues across the organisations under Project Fusion. Cross organisational visits are in the process of being discussed in the meantime.

The Trust Board is asked to receive and note the report.

Appendix 1.

The following is a list of all the sessions completed and those booked until the end of March 2024.

Service Line	Date	Location and Team
Adults Mental Health	20/03/2024	Hawthorn Ward.
Adults Portsmouth	25/10/2023	Transfer of Care Hub (ToCH).
	20/12/2023	Summerlee Unit.
Adults Southampton	29/11/2023	Lower Brambles Ward.
Child and Family	28/02/2024	Southampton Paediatric Liaison.
Corporate	No visits completed this period	
Specialist Dental	31/01/2024	Royal South Hants.
Primary Care	No visits completed this period	
Sexual Health	No visits completed this period	

Item 8

CEO Report – In Public Board

Date: 5 April 2024

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

Solent NHS Trust scores strongly in 2023 NHS Staff Survey

We formally recognised the publication of the 2023 NHS Staff Survey results, revealing that Solent NHS Trust has come top in its class for its compassionate and inclusive culture.
66.8% of employees at Solent completed the survey, with the organisation achieving improved results on 4 out of nine key themes of the People Promise whilst the remaining 5 themes have remained the same.

We produced a suite of multimedia comms messages and materials to support the announcement to all staff as well as the media, service users and wider Solent stakeholders.

Solent NHS Trust scores slam drunk with young citizens

We recognised how Solent's Experience of Care Team has introduced a groundbreaking approach to engaging with young people that's proving to be a slam dunk success. The initiative addresses the feedback gap among men under 25s and those from black and Asian backgrounds with NHS services, with the team introducing a dynamic blend of basketball and slam poetry as a way of engaging with these groups. We shared this positive update via a press release and social media posts.

Girl Guides extend their heartfelt thanks to Solent's leaders

Members of a Girl Guides group in Southampton took time to thank Solent's Executive Team for their support on the young people's work on the wellbeing gardens in the grounds of the Western Community Hospital. Chief Executive, Andrew Strevens, Chief of Nursing and Allied Health Professionals, Angela Anderson, and Nikki Burnett, Chief Finance Officer, have been champions of the green initiative since it started in 2020. Since that time, the community relationship has blossomed. We prepared a press release which was covered by the Daily Echo, and we publicised the happy news across our staff and public channels.

Solent receives national recognition for work with newly qualified nurses

We marked how the preceptorship team at Solent has recently been awarded the 'National Preceptorship Interim Quality Mark' in recognition of providing a high standard preceptorship for newly qualified nurses. Since 2023, Solent's team have offered preceptorships to 125 clinical Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC) registrants, representing five cohorts during this period. Each programme lasts 12 months and includes structured support, education, and pastoral care by experts from across the Trust.

Celebrating Solent's amazing apprentices

During Apprenticeship Week in February we showcased the stories of two Solent apprentices – Ellie and Stephanie. Ellie Peplinski is currently in the final year of her Registered Mental Health Nursing apprenticeship after starting it in 2021 whilst Stephanie Carpenter works at Solent as a Manual Handling Trainer and has recently completed her level 6 Chartered Managers degree.

Applauding colleagues who inspire

We have some truly inspirational members of staff, and we shared two such stories recently. The first centres on Rachael Blake, AHP Team Lead and Physiotherapist.
With an undergraduate education and early career, Rachael found her calling within Medicine for Older People. However, it wasn't until she ventured into Older People's Mental Health (OPMH) that she truly found her niche.
In her role, Rachael has launched numerous initiatives aimed at revolutionising physiotherapy within mental health settings. These include standardising outcome measures to highlight the importance of maintaining mobility among OPMH inpatients, establishing a national peer support network for mental health physiotherapists, and significantly increasing physiotherapy services within Adult Mental Health (AMH) wards.
Most recently, Rachael (pictured below) won The AHP Leadership Award at the NHS Hampshire and Isle of Wight AHP Awards.

For Overseas NHS Workers Day, we invited Ahmad Al Jammal, Senior Heart Failure Nurse at Solent, to reflect on his time in the NHS since joining in January 2023. Ahmad explains: "My journey into healthcare has been one filled with heart, dedication, and a genuine passion for making a difference in people's lives. Fast forward through a Bachelor's Degree in Nursing from the Lebanese American University (LAU), I found myself pursuing a Master's in Adult Gerontology at the American University of Beirut (AUB).
"In my current position, my daily responsibilities encompass coordinating the treatment plans for heart failure patients, conducting initial assessments, and actively collaborating with patients and their families. In this role, I can shape clinical decisions and ensure the seamless execution of discharge plans. It's a position that calls upon my leadership skills and diagnostic reasoning expertise to contribute to the wellbeing of those under my care." Read more of Ahmad's account (pictured below).

Championing inclusion for all

With this year's chosen theme for International Women's Day focusing on 'Inspiring Inclusion', we sat down with Joanne Bertelsen to find out what inclusion means to her.

Joanne has worked in the NHS since 2007 and currently works in our Estates & Facilities Department as a Senior Project Manager. Prior to this, she worked in Administrative and Executive PA roles before joining Solent as a Project Officer in 2015.

Speaking about her career to date, Joanne said: "I am very proud of my career route, the variation in my roles has allowed me to undertake new challenges that have helped with my own personal development.

"Being a woman in quite a male-dominated field and working with senior colleagues whilst in a junior role, has shown its challenges. However, by maintaining a respectful and professional approach, demonstrating my knowledge, and delivering on my commitments, any early issues were conquered." Read more from Joanne.

Industrial action

We played our part in supporting our staff and service users through the most recent period of industrial action – this time by junior doctor members of the British Medical Association (BMA) in February. We worked in an agile and responsive way to particularly reinforce messaging internally and externally for the benefit of acute Trust partners across Hampshire and Isle of Wight who had higher numbers of staff absent during the action.

Section 2 – Internal matters (not reported elsewhere)

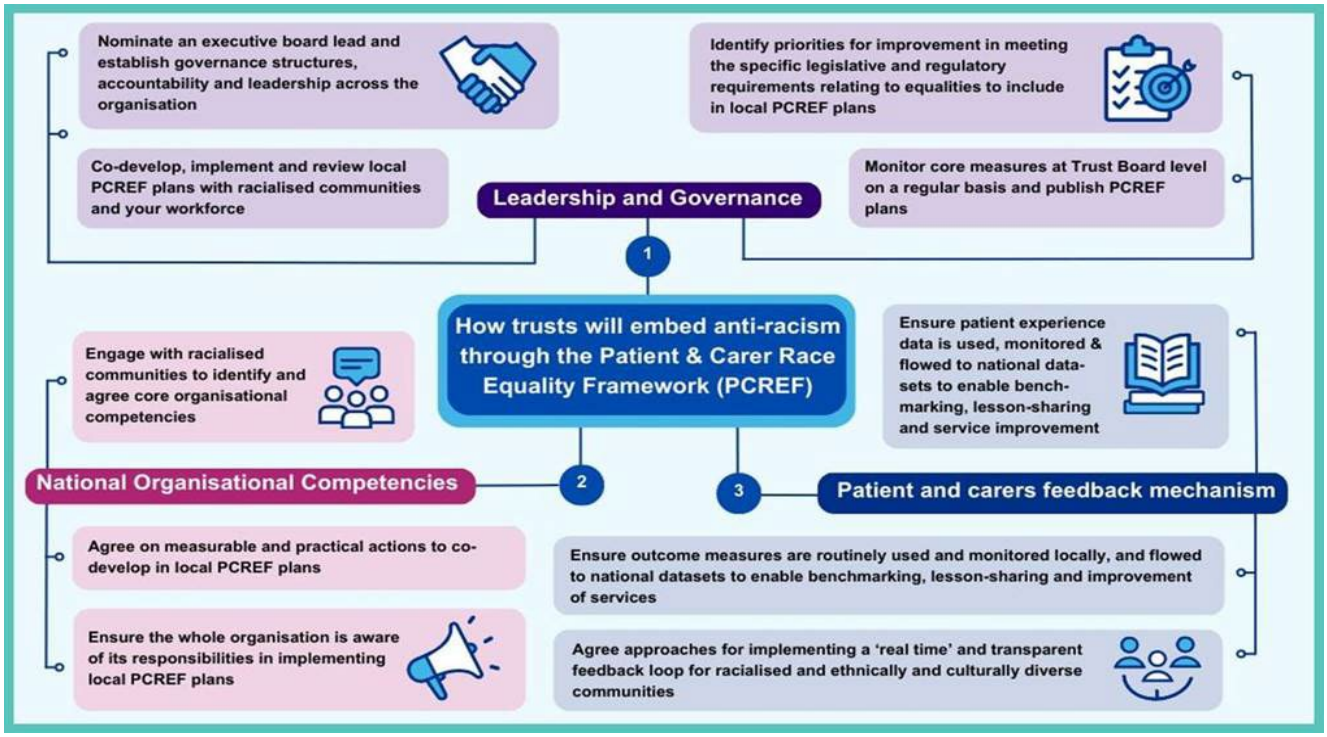
Patient and Carer Race Equality Framework (PCREF)

The PCREF sets out the legislative and regulatory context for advancing mental health equalities and will assist mental health trusts and other mental health providers to comply with their obligations. It aims to elevate the voices of service users, carers and communities to inform the service improvements we want to see through the collaborative participatory approach of the PCREF and renew the social contract between citizens and the public sector is at the centre of the framework – its emphasis upon working transparently with constituents is critical to its success.

PCREF is split into three core components:

- Part 1 – Legislative and regulatory obligations (leadership and governance): Legislation has been identified that applies to all NHS mental health trusts and mental health providers in fulfilling their statutory duties, and leaders of the trusts and mental health providers will need to ensure these core pieces of legislation are complied with across their organisation.
- Part 2 – National organisational competencies: aligns with the vision in the Independent Review of the Mental Health Act 2018 (MHA). Through a co-production process, six organisational competencies have been identified working with racialised communities, patients and carers. Trusts and mental health providers should work with their communities and patients and carers to assess how they fair against the six organisational competencies (and any more identified as local priorities) and co-develop a plan of action to improve them.
- Part 3 – The patient and carers feedback mechanism: which seeks to embed patient and carer voice at the heart of the planning, implementation and learning cycles.

Mental health trusts are responsible for the delivery of the PCREF by the end of the financial year in 2024/25 and in collaboration with their partners, including local authorities, commissioners, communities, patients and carers from racialised and ethnically and culturally diverse communities; Solent's multi agency / multi trust group has tasked a working group to deliver PCREF aligned with national timelines.



Great Care

Safety matters

There are no matters to highlight.

Great Place to Work

Workforce matters

Medical Consultants in England have voted to accept the Government's latest pay offer. This is an important step in moving towards the conclusion of an unprecedented period of strike action by Senior Doctors.

The Trust is working through its workforce plan for 24/25 with a submitted position having gone to the ICB and National Teams. There will be a continued focus on the recruitment of Health Care Support Workers in the first half of the year, to support in reducing vacancies. Many service lines will be considering attrition and holding vacancies to support the financial position.

Focussed work is underway with our BAME and Disability Staff Networks to consider some of the declining indicators in the WRES and WDES results from 2023 NHS Staff Survey. The overall results and indicators for the Trust were positive, with improvements and best in class scores for a number of the People Priorities. Action planning with service lines is well underway and supported by the People Partnering Team.

The move to Salisbury NHS Foundation Trust Payroll Services has been successful. The transition has been smooth, without any incidents to staff being paid correctly.

Great Value for Money

Estates and infrastructure

Progress on the Western Hospital West Wing rebuild continues within the revised window of go live September 24. Legal delays surrounding the power supply have resulted in the need to install a temporary generator to ensure the work continue as planned. Risk to go live date remains whilst a resolution is found.
The site is now watertight with external cladding complete. Internal works are progressing well. On completion the system will have access to a state-of-the-art rehabilitation campus expanding the current provision in place across existing wards on the Royal Southampton Hospital Site.

Works have commenced at the Highclere site in Portsmouth for the reprovision of a GP premises following the closure of Cosham Health Centre. The site dynamics were known to be challenging due prior to commencement increasing the likelihood of site delays. Conversations with the GP practice are progressing well with go live anticipated early Autumn 24.

Results of the most recent Patient Led Assessments of the Care Environment (PLACE) scores have now been received with Solent placing top for the Region in combined food score, privacy & dignity, dementia and disability. Areas where Solent score mid-table are cleanliness and environmental condition, which are likely linked and a result of the prioritisation of the prioritisation of critical infrastructure over physical appearance in years past. An action plan is being produced to address where possible given financial constraints.

Our key risks

Operational Risk Register

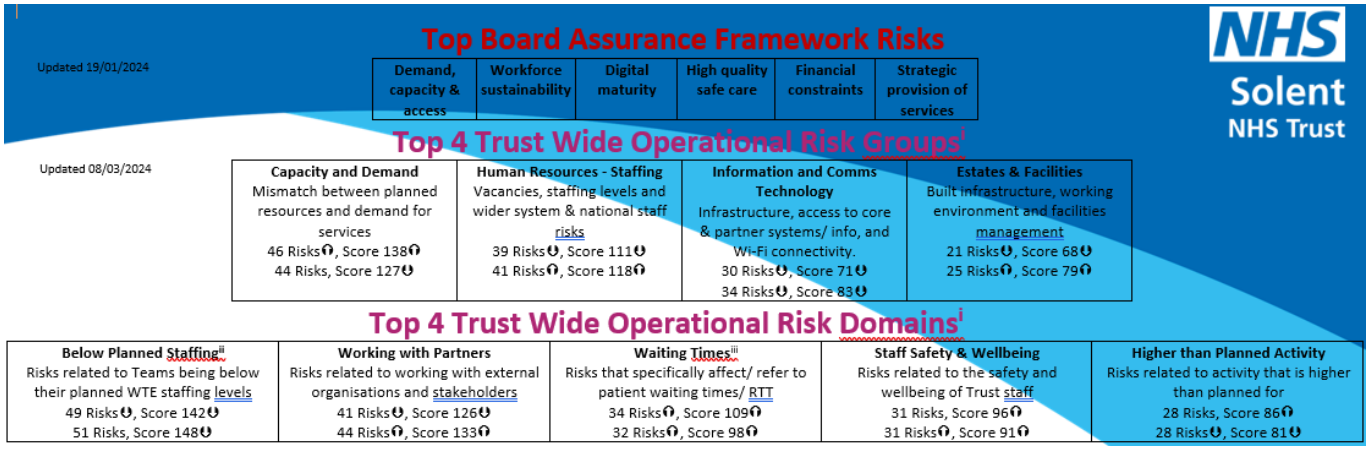
The risk pyramid summarises our key strategic and trust wide operational risks. Our top risk groups are:

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

The top Risk Domains are:

1. Below Planned Staffing
2. Working with Partners
3. Waiting Times
4. Staff Safety & Wellbeing
5. Higher than Planned Activity

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



Board Assurance Framework (BAF)

During March 2024, executive leads reviewed the detail within their respective BAF entries and provided relevant updates, including adjustments to target and residual scores and amendments to the supporting narrative, reflecting the current position. The Committees of the Board reflect on the BAF entries as part of their assurance process of managing associated risks. The latest summary of all BAF entries, as of March 2024, is as follows:

BAF Risk	Raw Score	Residual Score	Target and date
#7 -Demand, capa#7city and accessibility	L5 X S4 = 20	L4 X S4 = 16	L4 X S4 = 16 End Q4 2023/24
#4 - Workforce sustainability	L4 X S5 = 20	L3 X S4 = 12	L3 X S4 = 12 End Q4 2023/24
#1 -High quality safe care	L4 X S5 =20	L3 X S4 = 12	L3 X S4= 12 End Q4 2023/24
#5 -Financial Constraints	L4 X S5 = 20	L2 X S4 = 8	L2 X S4 = 8 March 2024
#8- Strategic provision of services	L5 X S5 =25	L5 X S4 = 20	L4 X S3 = 12 End Q1 2024/25
#6 -Digital maturity	L4 X S4 = 16	L3 X S3 = 9	L3 X S3 = 9 End Q4 2023/24

Section 3 –System and partnership working

Project Fusion

Significant progress continues to be made towards the creation for the new Trust for mental health, community and learning disability services for Hampshire and the Isle of Wight, including appointment of the designate Board. The new Trust – Hampshire and Isle of Wight Healthcare NHS Foundation Trust will provide a stronger, more joined-up platform from which to continue improving access and outcomes for patients and communities, and opportunities for our people.

Following discussions with NHS England colleagues, who are reviewing our plans, it was agreed in March that a little more time is needed to finalise preparations and ensure as smooth a transition as possible. The plan is that we will complete the integration in phases:

- Hampshire Child and Adolescent Mental Health Services successfully transferred into Southern Health, from Sussex Partnership on 1 February 2024.
- We are now aiming for the Isle of Wight community, mental health and learning disability services to transfer to Southern Health on 1 May 2024.

- We are aiming for the transfer of Solent NHS Trust services and the creation of the new Trust, Hampshire and Isle of Wight Healthcare NHS Foundation Trust to take place on 1 July 2024.

After completion of the three phases, our new Trust will encompass all services from Southern Health NHS Foundation Trust, Solent NHS Trust, and the community, mental health and learning disabilities services from Isle of Wight NHS Trust. We are progressing the work that needs to be done in partnership up to 1 July 2024. Undertaking the process in phases will ensure the best possible transition for the benefit of our patients, as well as given a greater assurance to NHS England colleagues.

Over the coming weeks it is also expected that we will move to closer alignment between boards and executive structures, to begin delivering the benefits as soon as possible.

HIOW ICS

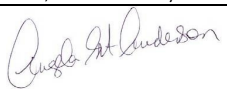
At the time of writing, the financial plans submitted by all organisations within the ICS, show a deficit for 2024/25 of £194m, significantly higher than the forecast out-turn for 2023/24. Meetings have been held with the national teams, who have made it clear that this is not an acceptable position, and that significant further work is needed.

Report Board and Committees

Title of Paper	Professional Leadership & Engagement Report May 2023 - March 2024 v0.1				
Date of paper	3 April 2024				
Presentation to	In-Public Board				
Item No.	9				
Author(s)					
Executive Sponsor	Angela Anderson, Chief of Nursing and Allied Health Professionals				
Executive Summary	The purpose of this paper is to provide an update on the current position with regards to professional leadership activity across the professions in Solent NHS Trust.				
Action Required	For decision?		For assurance?	x	
Summary of Recommendations	The In-Public Board is asked to note: • The nursing and AHP professions continue to contribute to the development of new and current workstreams across the Trust and system.				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) x
Previously considered at	Professional Advisory 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	x	10. New ways of working		14. Supportive Environments	x
4. Life-course approach	x	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				

Level of Assurance *(tick one)*	Significant		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	 Angela Anderson, Chief of Nursing and Allied Health Professionals							

Introduction

There are a range of professional activities across the Trust which impact on the delivery of care and the development of the workforce. The individual work streams continue to feed into their relevant sub-committee structures. This includes the activity reporting into the Project Fusion Clinical Steering group governance structure.

In addition, several developments at a regional and national level will have a significant impact on the future workforce and on how the Trust approaches training and recruitment to ensure a sustainable and adaptable workforce.

This paper provides an update on developments during the period May 2023 – March 2024.

There have been several episodes of industrial action that has impacted over this period specifically with regards to medical provision. The Chief Medical Officer and Chief Operating Officer leadership team have worked across the organisation with service lines, HR and system partners to maintain a safe clinical environment for patients and ensure appropriate staffing levels were present. Information regarding the industrial action was fed back through the National and ICB reporting systems. Lessons learnt from each period of action were shared to support organisational learning.

Conferences

International Nurses Day and Nursing Conference 2023

The Trust held another successful Annual Nursing conference on 12th May 2023 with the theme 'Our Nurses Our Future'. Under the leadership of Angela Anderson, Chief of Nursing and AHP's (CNO&AHP) we had an interactive day at Kings Community Church with 120 delegates who shared stories and listened to motivational presentations about the future shape of nursing. The conference was the culmination of events to celebrate International Nurses Day including the annual Florence Nightingale remembrance service at Wellow church on the 10th May and several events to highlight important issues as part of Dying matters week.

The Nursing conference saw impactful keynote speaker Paula McGowan OBE sharing Oliver's story, and Acosia Nyanin, Regional Chief Nurse with Nicole Lucy, ICB Chief Nurse, sharing the national, regional and ICB nursing priorities. Solent and external nursing speakers shared their nursing journeys from the undergraduate student experience through to experienced Support Workers and Consultant Nurses. We also celebrated those nurses and support workers who were nominated by their colleagues for Nurse and Support Worker of the year.

AHP Conference

The Trust held a successful AHP conference at the Ageas Bowl on Tuesday 17th October with inspirational guest speakers where Felix Barrow and his mum Vanessa told their story following a road traffic accident outlining the role of AHPs in the rehabilitation journey and highlighted Felix's Rode to Recovery and paralympic dreams. Over 120 delegates attended and were able to celebrate AHP achievements as part of team Solent and feedback after the event was extremely positive - "was a real celebration of the wonderful roles within the AHP Family" "very positive and uplifting: championing AHPs"

We celebrated those AHP's and AHP support workers who were nominated by their colleagues for AHP and Support Worker of the year.

Advanced and Consultant Practise Fusion Conference

The inaugural Advanced and Consultant Practice Fusion Conference held on 7th February 2024 at the Holiday Inn, Eastleigh, welcomed colleagues from the Isle of Wight, Solent and Southern NHS Trusts. With 96 attendees from across all organisations. It was a successful day with both internal and national external speakers. The feedback is shared in Appendix 1.

Other Awards and Nominations during the period

- Our ACP/Consultant pathway work has been nominated and was a finalist in the CAPHO awards – October 2023 receiving a Highly Commended recognition
- Dr Lindsay Cherry was awarded the Academic award in recognition of an outstanding contribution to academic knowledge by the Royal College of Podiatry
- Rachel Blake was a finalist in the AHP Leaders of the Year awards at the HIOW ICB conference which is held in March 2024 and won the AHP Leader of the Year Award.
- Patient Safety Team were finalists in the HSJ patient safety awards

Professional Leadership Forums

Professional leadership forums are delivered at both a service line and organisation level.

Professional Advisory Group (PAG)

These meetings occur on a bimonthly basis and there have been 3 meetings within this reporting period. The meetings have met quoracy and been well attended by clinical specialties and professional groups. The main areas discussed:

- Review of matters relating to multi-professional workforce and education including CPD and access and uptake of HEE/NHSE funding.
- Changes to HCPC Standards of proficiency (01/09/2023). With approval of the plan to support, raise awareness and compliance with those staff affected.
- Professional Nursing Advocate implementation and governance plan agreed as an escalation from PNA oversight group.
- Improvement to our pipeline offer for apprenticeships to registrant posts with a focused discussion to support improvement in the diversity within our professional groups and to fill those hard-to-recruit to posts. Including discussions on placing T level students in the trust.
- Formally reporting from the Advanced practice PAG subgroups
- International recruitment multi-professional discussions which formally feed into the International Recruitment Oversight group.
- Professional issues relating to new and emerging roles within the organisation.
- Initiation of a Task and finish group to support the overarching leadership and management of rotational Band 5 physiotherapists.
- Guidance document from NMC on combatting racial discrimination was circulated and discussed.
- Fusion updates where relevant to professional matters
- Joint working pilot between community nurses and primary care in Southampton shared.
- Updates received around changes to the Preceptorship Framework

Matrons Forum

The forum has a monthly schedule with a virtual format with x2 yearly face to face meetings planned.

In the reporting period the forum has delivered a range of activities focused around:

- Supporting the Matrons to develop and complete their competencies utilising the Matrons Handbook (2021)
- Supporting their visibility within the wider Trust, encouraging and promoting strategic engagement and to be the voice of nurse and AHP leadership, driving the quality agenda.
- Provided a mixture of education, information and training.
- Sharing best / evidence-based practice.
- Matron Walkarounds – this is now in place across all inpatient areas with Adults Southampton Team progressing to utilising Tendable quality audit reporting mechanism to capture the outcomes with an ambition to extend this across all inpatient areas.

Deliverables for next period

- Matrons Walkaround to introduce peer review element across the inpatient wards areas and extend into community settings
- As part of the Fusion plans to discuss harmonisation of existing Matrons Walkaround programmes.
- Working with Fusion partners to discuss the future of the Matrons Forum, how this can be sustained and developed further across the new footprint.

Head of Quality and Professions Forum

The forum has a monthly schedule with a mixed virtual, face to face format. These meetings cover contemporaneous issues alongside longer term workstream management from professional leadership, clinical, quality standards perspective. In this last period has additionally scheduled Fusion related activity including review of policies and programmes of work, working with a number of corporate quality teams.

Professional Leadership

Nursing Update

This review period has been building the foundations of safer staffing workforce planning and ensuring our clinical teams are developing their knowledge and skills relating to safe staffing, with a particular focus on our inpatient and community teams.

Key Updates

Tendable (digital quality audit platform)

The current contract has been extended for a further year to support Fusion harmonisation plans and to identify a suitable digital audit provider for the new organisation.

All inpatient units continue to perform monthly audits via the Tendable platform. Learning from audit findings have enabled us to take action on findings this includes access to scenario-based fire training, ligature cutter training and use which have been escalated through agreed quality governance routes.

Sexual Health Services commenced using Tendable in November (2023) work is ongoing to embed in practise in addition SARC is planning on adopting using to support gathering evidence towards achieving accreditation.

Professional Nurse Advocacy

An oversight group has been set up to support the ambitions to meet the organisational and national professional Nurse Advocate (PNA) roll out. Fusion partners have come together in a joint community or practise. A small cohort of nurses have completed the required PNA training. There is an organisational SOP to support implementation and a there is PNA activity growing across the organisation primarily with those PNA's applying practice directly within their teams.

Allied Health Professionals (AHPs)

Key Update

- Continued representation at meetings across system at HIOW ICB level including AHP Council, AHP Faculty, Profession specific task and finish groups, international recruitment.
- Commencement of support and training programme for our internationally educated OT's
- Implementation of HIOW AHP Support worker strategy. High levels of engagement from Solent at Community of Practice meetings across HIOW AHP community
- Joint project with CCIO – working with NHSE re E-med 3 certification usage within S1 module to commence - pilot commenced on time, to evaluate over next period
- AHP specific staff listening events held following feedback from exit interviews and action agreed with service lines where indicated
- Community of practice sessions commenced to support our HCPC unregistered Band 5 exercise professionals
- Funding to support level 5 podiatry apprentice and AHP support workers secured.

Deliverables for the next period

- Agree AHP Job planning action plan and complete business case to support development within Project Fusion
- Work with Preceptorship team to strengthen AHP content within the programme and benchmark against new National principles
- Identify and secure Apprentice posts for Physiotherapy and Speech and language therapy in partnership with local providers.
- Review AHP data and improve confidence in accuracy
- Streamline and improve staff experience for Band 5 physiotherapists on rotation
- To ensure robust clinical and professional supervision arrangements are in place for our art and drama therapists
- Develop offer of Higher Development Award participation for our AHP Support workers

Medical

Key Update

ROAG meets monthly, with NED and lay attendance. ROAG advises on all matters concerning doctors, including monitoring of current cases and other issues.

Industrial action has been a major theme of this reporting period. The Consultants and Junior Doctors have been on strike at the same time, producing new stresses. We have maintained safe clinical environments for patients and ensured appropriate staffing levels were present. Information regarding the industrial strikes were fed back centrally and to the ICB.

Cover for striking doctors is getting harder to arrange, despite the generous financial recompense.

So far, we have been able to agree cover for all essential shifts, but it has been a close-run thing at times.

We have commenced job plans for 24/25, ensuring that all doctors join Fusion with a valid, agreed job plan.

Implementing the use of Health Roster to link with pay for doctors ESR has been cleansed and is now reliably able to identify doctors. Service lines have begun moving doctors to doctors only cost codes. We hope to do a pilot service line in May 24.

Deliverables for next period

- We continue conversations around future structure (Fusion). All CMO policy documents have been discussed and shared with Southern Health and are being harmonised in Q4.
- Job plan data has been analysed, with some harmonisation, and new Job plans under discussion in Q4.
- Move to fully rostered medical staff (senior and junior) may happen prior to merge of Health Roster (SHFT also partly rostered, and keen to implement full roster)
- Streamlining industrial action process for doctors. Working closely with HR and Senior managers in each service line.

Workstreams

International Recruitment

Key achievements for the IEN education team

- Attainment of the Pastoral Care Quality Mark (PCQM). PCQM is a nationally approved award, acknowledging best practice regarding the recruitment process, clinical, career progression and pastoral support of our international colleagues.
- An international recruitment oversight group has been commenced to support assurance framework regarding the ongoing international recruitment within Solent.
- Within Q3, 4 international nurses were successfully recruited for the Adults Southampton Inpatient wards. The nurses have completed their initial induction, passed their OSCE exams and are now integrating into their permanent teams.
- Driving – throughout Q2 and Q3, 13 of our international community nurses have successfully passed their practical driving tests. There are currently further practical tests scheduled for Q4 2023 24 and Q1 2024 25. The IEN Education team/Estates continue to work to support IEN community nurses whilst they wait for their driving test in terms of voluntary drivers, driving assessments/lessons, increase access to pool cars or virtual car club for all our teams.
- Transition Programme for new IEN working on the inpatient wards in mental health continues with excellent feedback. This has led to the development of focus Friday for all new starters and students within MHS.
- Following a HIOW ICS Bid, and collaboration with the Florence Nightingale Foundation (FNF). 8 of our international nurses successfully completed the Accelerated B6 development programme, of which a number have secured B6 positions. We were also fortunate to host a visit by one of the FNF course lecturers, who spent time with 2 of our attendees, observing practice and applying leadership theory in practice.
- The Chief of Nursing and AHPs held forums within Southampton and Portsmouth, for our international colleagues. These were an informal opportunity for our nurses and AHPs to meet and discuss what has gone well and areas we could do better.

There was good attendance and sessions well received, some key issues were raised regarding the challenges to securing private rental properties including the impact of the cost of living, the challenges of settling into a new country, working in clinical environments and a healthcare system that they were unfamiliar with and the time it has taken to establish themselves and to feel confident in their role. It is agreed these forums will be held biannually.

- As a direct outcome of the forums, a further session was held for our international colleagues, supporting them to navigate national and local career development forums / opportunities.
- Occupational therapy colleagues have been able to join a trust wide ICS training programme to support development of clinical skills

Deliverables for next period

- Agreement of future international recruitment funding process and recruitment.
- Evaluate impact of accelerated B6 programme

Clinical Placement Capacity and Clinical apprenticeships

- Services continue to report difficulties expanding the numbers of undergraduate clinical placements due to requests from multiple HEIs and learner groups, e.g., T levels, IENs, ACP, SCPHN. However there has been success in increasing the number of AHP undergraduate placements.
- Adults Service Portsmouth have hosted the first Healthcare T level placements in the Trust. Guidance has been written to provide clarity on statutory and mandatory training required before placement and clinical activities that T level students are allowed to participate and observe.
- Solent are currently supporting 96 staff on clinical apprenticeships, 25 of these commenced their apprenticeship September 2023, in 9 different clinical apprenticeships (ACP, occupational therapy, nursing in adult, child and mental health, senior HCSW, trainee nurse associate and play specialist). Apprenticeship providers for SLT and Physiotherapy have been identified and applications are currently being processed – we have 2 candidates for SLT and 5 for physiotherapy.
- Additional clinical staff are undertaking leadership and service improvement apprenticeships.

Healthcare support worker recruit and retention Programme

- The healthcare support worker induction is now offered to all new to care support workers, and the programme has been evaluated following peer and subject matter expert review and from participant feedback. Changes are currently being made.
- Solent is participating in national and regional initiatives to recruit and retain HCSWs including
    - HCSW champion.
    - Successful grant application to support the training of staff in strengths-based recruitment. Including engagement with the Prince's Trust to assist in recruitment and support for those new to the NHS. The Recruitment and Attraction team will lead on strengths-based recruitment and princes Trust initiatives going forwards.
- Solent is working with ICB colleagues to implement the AHP Support worker strategy

Deliverables for next period

- Implementation of updated programme
- Setting up of HCSW forums and clinical update sessions

- Stay cafes scoping and proposal

Clinical Skill training

- Professional development activities have been assigned and procured for the investment received under the National CPD Funding Scheme - Extension Year (April 2023 to March 2024). Funding was awarded either through individual applications or from training needs analysis within services, which included Trust-wide training opportunities identified corporately. The necessary university modules for the upcoming academic year (2024-25) have also been identified and provisionally requested.
- The Internationally Educated Nurse (IEN) team have successfully trained 242 nurses since April 2022 to undertake the mental health nursing Test of Competence (TOC).
- New work-based learning has been added to the suite of clinical skills face to face learning in response to service requests. These include Glasgow Coma Scale assessment, Bladder scanning and ANTT training

Deliverables for next period

- Ensure that individuals and services have received funding and complete Q4 report for NHSE.
- Clinical development team to work with services to develop action plans to support assurance that staff are compliant with statutory training.

As part of Fusion, work has continued in creating a competency/capability framework document collaboratively with colleagues joining the new organisation. The aim is to finalise the document created at this time and identify an area in each Trust to pilot the document, to gain some honest feedback particularly around how user friendly it is.

Clinical supervision

Workstream in progress to review and progress the current clinical supervision framework being led on by the Mental Health Services HQP with the intention of developing a framework for supervision to support greater participation.

AHP job planning

Funding has been secured to allow AHP's and medical colleagues to continue using the Allocate software to record and monitor job plans until March 31st 2024. We are developing a paper/options appraisal with our Fusion colleagues to understand the opportunities and risks associated with the different approaches currently in place as we move into a new organization.

Development of CAMHs Academy

In recognition of the national and local recruitment and retention problems faced by provider organisations and the increasingly complex nature of child and adolescent mental health needs, Solent NHS Trust created a proposal for the development of a CAMHs Academy to address these issues. The proposal was supported internally and subsequently by the Hampshire and IoW Integrated Care System (HIOW ICS).

The proposed vision is to provide ***an integrated multi-disciplinary education, development and leadership system that will enable Children and Young People to have good mental health.***

To enable this concept to become a reality, partners operating in this area have been invited to participate in its development. This will occur through the establishment of a CAMHs Academy Steering Group. The group will work collaboratively, supporting the development of CYP MH workforce across the 4 NHS CYP MH providers

Advanced Clinical Practice (ACP) and Consultant Practice:

Significant progress has been made across the Trust in relation to supporting the development and governance of Advanced and Consultant practitioner roles.

- Consultation with staff recruited before the Advancing Practice policy and associated SOPs were ratified has been completed and all staff are on the correct Job description and ESR code.
- Received highly commended in the National Chief Allied Health Professional Officers award for AHP workforce transformation, in relation the Advancing practice work undertaken.
- Organized an Advanced Practice and Consultant Practice conference on the 7th February 2024 for 120 staff with the ACP leads from Southern Health and the IOW. The conference received excellent feedback from attendees and staff from the regional and national ACP faculties from NHSE, such as 'It has been a long time since I have attended such a positive, informative and inspirational event, everyone was so engaged and excited about the opportunities ahead.' Further information at Appendix 1 below.

- Two posters accepted at the project Fusion Advanced and Consultant practice conference
    - Upskilling in a Community NHS Trust to create the climate for Advanced Clinical Practice
    - Improving the support for trainee Advanced Clinical Practitioners
      What can we offer before they start their master's course?
- The later won a runner up price (independently judged by Lead for NHSE-SE ACP faculty, Solent's Head of patient participation and a service user).
- Two posters accepted for the Solent (HIOWH NHS FT) research conference at the end of Feb.
- Dragon's den evaluation report looking at an enhanced training program for trainee ACPs submitted with excellent feedback from Solent's Director of Research and Improvement.

Deliverables for next period

- Options paper for the Advanced and Consultant Practice leadership model in the new organisation to be circulated and presented to Chief Nurses in March.
- Transition from tACP to ACP process agreed with service line ACP leads but needs to go through PAG for sign off.
- Circulate the guidelines for staff that are wishing to express an interest in the supported ePortfolio route to gain The Centre for Advancing Practice recognition, after PAG.
- Workforce planning, recruitment and applications for tACP post and training programs and apprenticeship supervision money needs submitting by the 31st March 2024.
- Organizing the enhanced training offer again for cohort 2024 (from April to sept) and will offer any additional places to staff across the new organisation.

Integrated Care System Developments

Solent NHS have continued to work collaboratively, with local partners within the Hampshire and Isle of Wight (HIOW) Integrated Care Board (ICB).

The ongoing work to recruit AHP colleagues who have been internationally trained continued during this reporting period. The HIOW AHP community were recently successful in August, with an NHS England (NHSE) bid to financially support the recruitment `on-boarding' costs of AHP Occupational Therapists (OT), Radiographers and Podiatrist colleagues (£5K per candidate).

There have been challenges within this recruitment process. These include changes to establishment and vacancies impacting on reduction in posts available.

Solent AHP colleagues have had the opportunity to influence and shape AHP strategy at ICB level

with an ongoing secondment of the Community AHP Workforce Transformation Lead and OT workforce lead, providing us with the opportunity to strengthen the working relationship with colleagues across the ICB going forward.

We are key members of a number of regional meetings including

- Chief Nurse and AHP leadership forums
- SE Region Nurse supply
- End of Life
- PNA Community of Practice.

Conclusion and Recommendations

The nursing and AHP professions across the organisation continue to be very active in raising their profile, contributing both internally and externally to the development of the nursing and AHP professional workforce as well as supporting services to deliver the ambitions of the Trust Clinical Framework.

This report has provided a summary of the key activities undertaken since the last report.

The Board is therefore asked to note the progress being made.

Appendix 1

The inaugural Advanced and Consultant Practice Fusion Conference held on 7th February 2024 at the Holiday Inn, Eastleigh, welcomed colleagues from the Isle of Wight, Solent and Southern NHS Trusts.

Of the 115 registered for the event, 96 attended on the day while less than 20% were non-attendees, 5 of which sent apologies in advance whereas, 14 were no-shows.
The overall budget of £5038 was provided by the three trusts and incorporated venue hire (£3960 – SHFT £1650, Solent £1650, IoW £660), research poster printing (£288) and speaker thank you's (£290 + £500).

The programme included four keynote speakers;

- Professor Beverly Harden, Deputy Director for Allied Professions, NHS England.
- Vivian Zinyemba Nurse Consultant, Wiltshire Health and Care NHS@Home Service.
- Professor Robert Crouch, OBE, RN, PhD, FRCN, FRCEM (Hon) Consultant Nurse & Honorary Professor of Emergency Care, University Hospital Southampton/Southampton University
- Amanda Hensman-Crook, FCSP MSc DipPhys. MSK Consultant Physiotherapist.

In addition, there were nine breakout sessions delivered by trainee, advanced and consultant practice, research and professional service colleagues from across the three trusts.

To capture the impact of the conference, attendees were asked to complete a six-question survey. 50% of attendees responded with the following examples.

1. **What were you hoping to get out of attending today's conference?**
    - Networking opportunities with other tACPs/ACPs/CPs within the new organisation
    - Understand how ACPs are working across the trusts and gain shared good practice. Also, understand future career options and pathway.
    - Inspiration within the 4 pillars
    - Understanding of local challenges

2. **What was the highlight of attending the conference today?**
    - The overwhelming feeling that you are not alone in your struggles! And all the amazing resources that are available to us to help.
    - I enjoyed the breakout rooms. Choosing topics relevant to me.
    - Vivienne's talk about imposter syndrome, really touched me as felt in the same boat, also really liked the life of a Trainee ACP, showing how to survive the course and top tips on how to manage it.
    - Meeting such a positive group of practitioners, and exceptional leadership brought the advancing practice voice together at the start of Project Fusion.

3. **What would have worked better at the conference?**
    - I would have liked to have a chance to see more of the breakout sessions, maybe they could be recorded next time so we can catch up on the ones we miss?
    - Maybe some sort of networking board/s?
    - A separate room for poster presentations, a dedicated time when poster authors were stood by their posters to answer questions.
    - Registering for workshops beforehand - I could have planned with colleagues so that we covered them all.

4. **What impact will this conference have on your practice?**
    - I am coming away with so many ideas and inspiration for the future of ACP and consultant practitioner development. Also being aware of my privilege but also know that I deserve to make space for myself and step into it because I have worked hard.
    - Connecting with individuals to amplify their voice and the impact of their workforce transformation.
    - I feel it really helped clarify the advanced practice role and has given me direction in my portfolio route. It also gave me the confidence to proceed with my development in this area and worth!
    - Inspired me to undertake level 8 study.

5. **Would you like to attend a future Advanced and Consultant Practice Conference?**
    - Yes 100%

- Yes, yes, yes.
- Yes. Thanks very much for putting it together- a very valuable opportunity to share good practice.
- Yes, please. Enjoyed this more than our national conference probably because it was face-to-face tho!
- Only if sessions offer new info or updates.

6. **What would you like to incorporate in a future Advanced and Consultant Practice Conference?**
    - Guidance on supervision of tACP. what to expect from ACP supervision
    - Having medical colleagues supporting ACP and CP maybe having their opinion and a talk from a medical perspective. Also having the chief executive invited and maybe contributing to the conference.
    - Lived experiences…. Toni King with her PhD stuff was mind-blowing and not something I have heard elsewhere.
    - Learn more about different areas of advanced practice within our trust. Looking at the roles and what they involve and how they meet the 4! pillars of practice.
    - Dedicated time or activity for networking e.g. World café / round table ensuring trainees, ACP & CCPs are mixed.
    - An HEI to talk about their level 7 and level 8 courses and give advice.

As a result of staff sickness, several small issues were highlighted for future reference when coordinating a large-scale conference, primarily in relation to data collection for the following.

- Dietary/accessibility requirements
- Workshop selection
- Consent to share contact details

In summary, the conference received an overwhelming amount of positive feedback and content ideas for another Advanced and Consultant Clinical Practice Conference if the Trust Leads were to consider facilitating one again in future.

Isle of Wight NHS Trust

Solent NHS Trust

Southern Health NHS Foundation Trust

Board and Committee Summary Report

Title of Paper	Board Assurance Framework Compliance
Date of paper	03 April 2024
Presentation to	In-Public Trust Board
Item No.	10.1
Author(s)	Michelle Carstairs, Finance and Performance Business Support Manager
Executive Sponsor	Andrew Strevens, CEO

Executive Summary

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

The BAF is a live and dynamic document and is:

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

The latest summary of all BAF entries, as of March 2024, is as follows:

BAF Risk	Raw Score	Residual Score	Target and date
#7 -Demand, capacity and accessibility	L5 X S4 = 20	L4 X S4 = 16	L4 X S4 = 16 End Q4 2023/24
#4 - Workforce sustainability	L4 X S5 = 20	L3 X S4 = 12	L3 X S4 = 12 End Q4 2023/24
#1 -High quality safe care	L4 X S5 =20	L3 X S4 = 12	L3 X S4= 12 End Q4 2023/24
#5 -Financial Constraints	L4 X S5 = 20	L2 X S4 = 8	L2 X S4 = 8 March 2024
#8- Strategic provision of services	L5 X S5 =25	L5 X S4 = 20	L4 X S3 = 12 End Q1 2024/25
#6 -Digital maturity	L4 X S4 = 16	L3 X S3 = 9	L3 X S3 = 9 End Q4 2023/24

Action Required	For decision?	Y	For assurance?	N

Summary of Recommendations

The In-Public Trust Board is asked to

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

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

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

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

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

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

Role of the Board

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

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

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

Current position and matters to note

Contemporary Updates

The full BAF is included within Appendix 1, with amendments for March 2024 highlighted as indicated. Updates include amendments to residual/target scores, all agreed following an executive review in March 2024. A summary of BAF scoring and updates is also provided below.

BAF Risk	Raw Score	Residual Score	Target Score
Demand, capacity and accessibility #7	L5 X S4 = 20	L4 X S4 = 16	L4 X S4 = 16 - By End Q4 2023/24
Following the March 2024 review of BAF risk #7, demand, capacity and access to services, there were no amendments to the raw, residual or target scores, risk description, controls, assurances, gaps or mitigating actions.			
Workforce sustainability #4	L4 X S5 = 20	L3 X S4 = 12	L3 X S4 = 12 - By End Q4 2023/24
During the March 2024 review of BAF risk #4, workforce sustainability, the residual score reduced from 16 (L4xS4) to 12 (L3xS4) and amendments were made to the target score likelihood and severity figures, changing from L4xS3=12 to L3xS4=12. In relation to sickness, and visibility of sickness analysis, the BI Dashboards are in testing, aligned to G2 Occupational Health system and Health Roster. In addition, the further content has been created in the new workforce BI dashboard, supporting the alignment of workforce data and intelligence. In was also confirmed that the EDIB annual report was shared with People Committee in January 2024.			
Digital Maturity #6	L4 X S4 = 16	L3 X S3 = 9	L3 X S3 = 9 - By End Q4 2023/24
BAF risk #6, digital maturity, was reviewed in March 2024 and there were no updates to the raw, residual or target scores, risk description, controls, assurances, gaps or mitigating actions.			

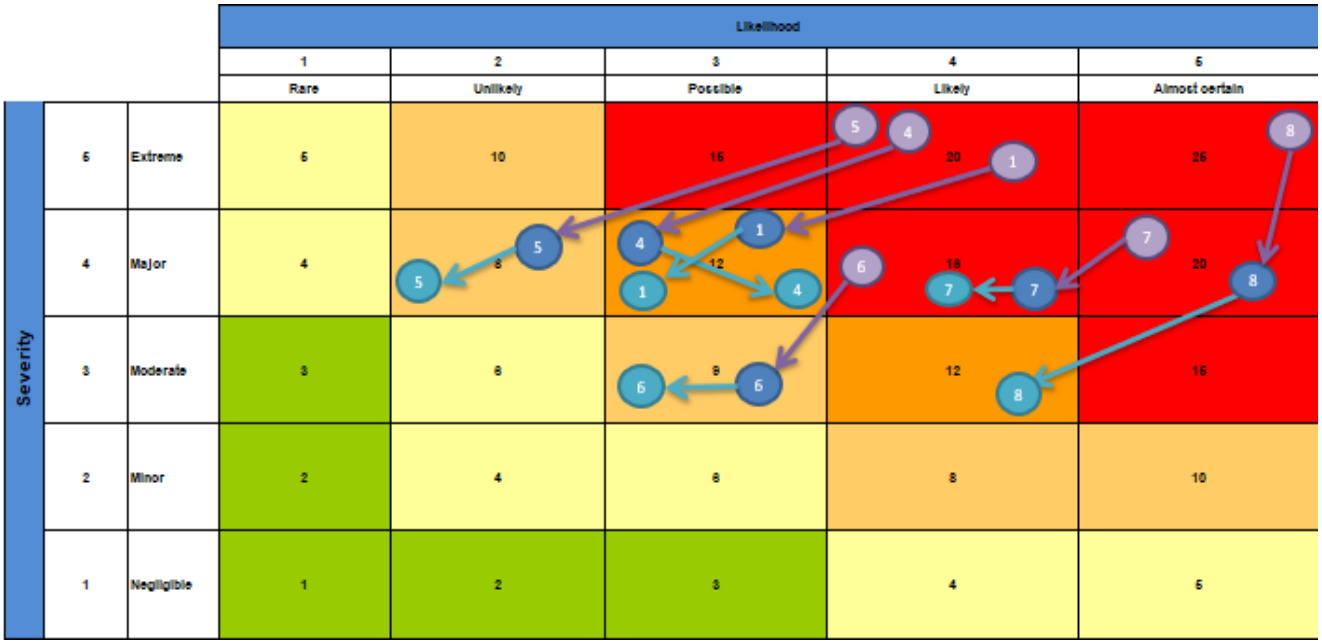
High quality safe care #1	L4 X S5 =20	L3 X S4 = 12	L3 X S4= 12 - By End Q4 2023/24
Although there were no changes to scores, there were several mitigating action updates reported following the review of BAF risk #1, high quality safe care, during March 2024. In relation to workforce planning, skills and competencies, assurance was provided that all inpatient units have had establishment reviews presented and agreed by the CNO and shared at the Safe Staffing Assurance meetings. In addition, the enhanced use of E-Rostering is now in progress and the monthly Safer Staffing Assurance meetings are fully established providing further assurances. Regarding the immaturity of information around acuity, the acuity scoring system, NEWS2, continues to be rolled out; with a supporting audit programme in place. Additionally, escalation routes, to support clinical staff, have been included in the Harm Tool rollout and service RAG rating. Actions updates relating to waiting list management were recorded, noting that the community nursing safer staffing tool has been used by services to support the 24/25 business planning process. Following the second Mental Health Optimal Staffing Tool (MHOST) data collection and analysis, some issues have been raised regarding MHOST, less applicable to OPMH.			
Financial sustainability #5	L4 X S5 = 20	L2 X S4 = 8	L2 X S4 = 8 - By March 2024
The March 2024 review of BAF risk #5, financial constraints, supported a reduction in the residual score from 12 (L3xS4) to 8 (L2xS4). It was agreed that both the raw and target scores were appropriately reflected and therefore no further amendments required. There were no updates or changes to the supporting narrative for the risk description, controls, assurances, gaps or mitigating actions.			
Strategic Provision of Services #8	L5 X S5 =25	L5 X S4 = 20	L4 X S3 = 12 - By End Q1 2024/25
The raw, residual and target scores remain unchanged following the March 2024 review of BAF risk #8, strategic provision of services, however, the supporting narrative for the risk description, controls, assurances and mitigating actions, all received updates to reflect the current position. The concerns raised by NHSE regarding the readiness of the creation of a single organisation, and the delay imposed of at least three months, have been reflected in the risk description; the subsequent extension of contracts for Board members has also been noted. Assurance will be measured through monthly meetings with ICB and NHSE, supported by surveys of the senior leadership team to assess the effectiveness of communication. Clarity is being sought from NSHE in relation to programme delivery and associated timetable, particularly in relation to the work to be completed, linked to the reasons for the delay. Referring to the loss of organisational memory and expertise, reports will be compiled from committees to hand over to the new organisation.			

BAF Analysis (Residual Score spread)

Residual scores (of all BAF risks)

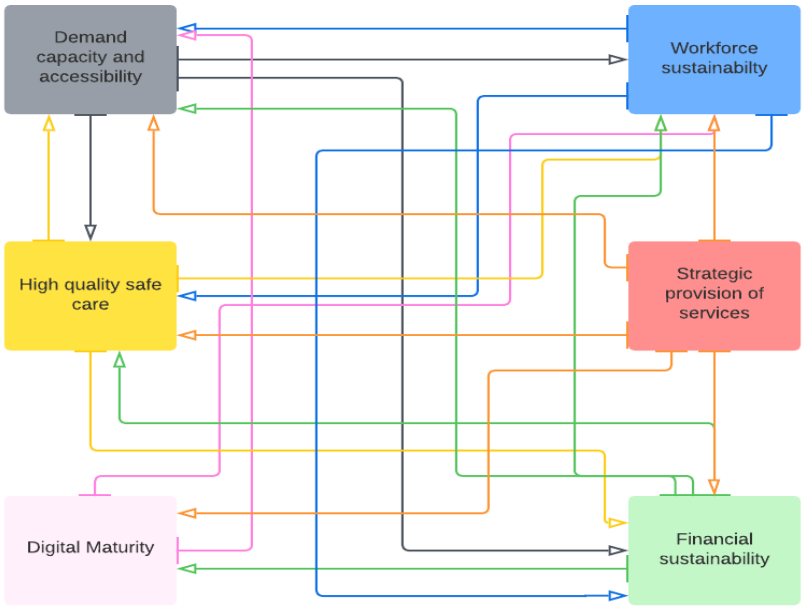
			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Severity	5	Extreme	5	10	15	20	25
	4	Major	4	8 5 - Financial sustainability	12 1 - Provision of consistently high quality, safe care etc. 4 - Workforce sustainability	16 7 - Demand, Capacity and Access to services	20 8 - Strategic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

Target Movement



Risk Map – Dependencies

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



Item No.		Presentation to	Trust Board – In Public
Date of paper	22 March 2024	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:			

Trust Board Integrated Performance Report (IPR)
January – February 2024

Our performance is summarised within this report using the following NHS England's '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

Executive Summary

The key points of note arising from the performance exceptions raised during the January and February reporting period are:

Diagnostics Waiting Lists

Achievement of the 6-week waiting list standard for diagnostics continues to be below 50%, and whilst the position is not deteriorating any further, the service is holding too much risk due to historic commissioning decisions and growth in demand. The Trust are actively outsourcing additional capacity to manage demand as quickly as possible, at financial risk to the trust. There is full executive oversight in ensuring the service returns to acceptable levels, and we are working with partners to determine the most optimal setting for this service provision in future.

Portsmouth and Southeast Hampshire (PSEH) System Pressures

There have been significant, sustained pressures across PSEH which Solent have continued to support in a number of ways. The most significant in this period is the standing up of the Shearwater Ward to temporarily increase the number of community beds available in Portsmouth, at cost to the Trust. This is a significant achievement for the Trust, and we are extremely proud of our staff for their continued dedication, commitment, and hard work to realise this. The Shearwater Ward was successfully demobilised by the end of March as planned, with minimal disruption to the system. Conversations with partners are critical to plan early for next winter so similar pressures are avoided as much as possible.

Portsmouth Neurodiversity Service

An innovative service change was shared at the Children's Performance Review Meeting this period, promoting the significant change to the way the Portsmouth Neurodiversity Service is delivered. The move from a diagnosis to treatment model has proved to be a beneficial solution to children and young people of Portsmouth, in an area which is a widely known national issue. Progress of the pathway change will continue to be reviewed and shared more widely across Solent and HIOW services if appropriate.

1. Safe

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance		Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance		Jan-24 Trending Performance	Jan-24 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%	92.0%				95.0%			
	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

Nothing of note.

Incident Reporting

The total number of incidents reported, and incidents reported per 1,000 contacts, have remain comfortably within the control limits during January and February, indicating no significant variation has occurred in this period.

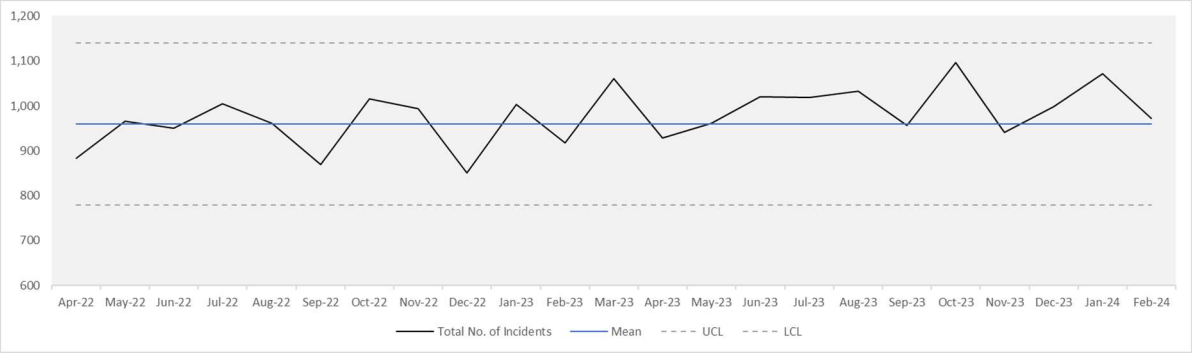


Figure 1: Total number of incidents reported by month

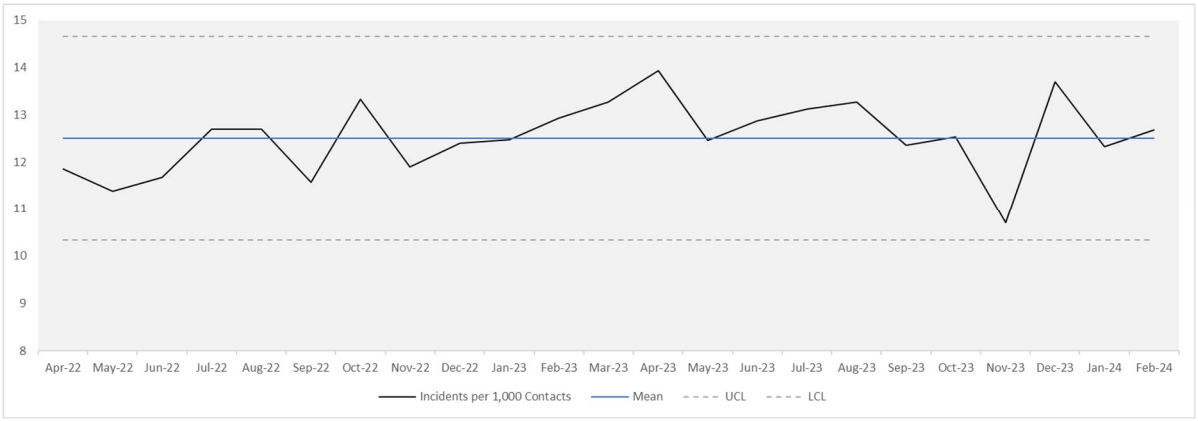


Figure 2: Number of incidents reported per 1,000 patient contacts

Whilst the overall number of incidents reported has increased slightly this financial year, there is wide variation between service lines, with Mental Health seeing the most significant increase (73.3% increase from Jan/Feb 2023 to Jan/Feb 2024), however this has not resulted in an increase in the level of harm being reported. This is concentrated within two distinct teams and relates to two specific cause groups:

The Brooker Unit has seen an increase in *Assault – Physical incidents* from 2 in 2022/23 to 111 to date within 2023/24. The increase is predominantly due to the high acuity of a small cohort of long-term patients, which has resulted in almost continuous use of seclusion in some cases. The service have improved their incident reporting following focussed training and this will also explain some of the reported increase. Recognising the challenges with this group of patients, the Quality Matron, supported by a second Trauma Risk Management (TRiM) Practitioner, are taking action to meet with staff involved and listen to their recent experiences with a view to formally agreeing a new approach towards the management and care of these patients.

Hawthorn Ward at The Orchards has seen an increase in *Self-Harming Behaviour incidents* which have increased from 4 in Jan/Feb 2023 to 46 in Jan/Feb 2024. The unit has a plan in place to utilise SWARM Huddle learning response methodology and has initiated work to review every incident when it occurs with the aim of identifying themes which can lead to changes and safety improvements.

2. Caring

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance		Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance		Jan-24 Trending Performance	Jan-24 Variance
Caring	Community FFT % positive*	E	95.0%	99.1%				99.1%			
	Mental Health FFT % positive*	E	95.0%	97.4%				96.3%			
	People Pulse Survey - Advocacy Theme (Recommended for Care & Employment)	E	0	-				-			
	Mixed Sex breaches*	E	0	0				0			
	Plaudits	I	-	78				123			

b. Key Performance Exceptions

Nothing of note.

c. Spotlight on: Trauma Risk Management (TRiM)

As part of the continuing development of the RIPPLE model of staff support, 8 Solent staff have received training as Practitioners in Trauma Risk Management (TRiM). TRiM aligns well with the overall RIPPLE model as it is a focused peer support intervention, evidenced based and NICE compliant, offering effective support for staff in the immediate aftermath of a traumatic, or potentially traumatic, event at work.

The training includes the early identification of signs of stress in those involved, along with the ability to complete assessments for staff and then onward referral or signposting. However, it should be noted that TRiM is not a treatment but a mechanism for monitoring the wellbeing of staff following a traumatic incident.

Following a presentation of the RIPPLE model at a recent Florence Nightingale event, Solent's Head of Patient Safety has been approached by two nursing journals to submit articles regarding the RIPPLE model, outlining an overview of the model, positive impact following implementation and learning throughout this process. Following the HSJ awards, this is a welcome opportunity and yet another example of the benefits of the RIPPLE model being acknowledged at a national level.

3. Effective

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance		Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance		Jan-24 Trending Performance	Jan-24 Variance
Effective	Bed Occupancy - Lower Brambles (Community)	I	92.0%	99.4%			H	96.5%			H
	Bed Occupancy - Fanshawe (Community)	I	92.0%	99.1%				92.0%			
	Bed Occupancy - Summerlee (Community)	I	92.0%	108.0%				104.6%			
	Bed Occupancy - Spinnaker (Community)	I	92.0%	108.5%				105.0%			
	Bed Occupancy - Brooker (OPMH)	I	85.0%	55.7%				55.7%			
	Bed Occupancy - Hawthorns (Adult MH)	I	85.0%	99.3%				92.9%			
	Bed Occupancy - Maples (Adult MH)	I	85.0%	97.1%				65.8%			
	Bed Occupancy - Kite (Acquired Brain Injury)	I	92.0%	95.7%				91.6%			
	Bed Occupancy - Snowdon (Neuro Rehab)	I	92.0%	104.2%				101.7%			
	Length of Stay - Lower Brambles (Community)	I	24.0	23.6				20.9			
	Length of Stay - Fanshawe (Community)	I	24.0	18.7				20.4			
	Length of Stay - Summerlee (Community)	I	18.0	46.7			H	32.6			
	Length of Stay - Spinnaker (Community)	I	24.0	25.3			H	19.6			
	Length of Stay - Brooker (OPMH)	I	78.5	58.5				28.5			
	Length of Stay - Hawthorns (Adult MH)	I	34.9	21.7				12.7			
	Length of Stay - Maples (Adult MH)	I	48.6	8.2				17.1			
	Length of Stay - Kite (Acquired Brain Injury)	-	-	87.0				0*			H
	Length of Stay - Snowdon (Neuro Rehab)	-	-	46.5				58.3			
	Non-Criteria to Reside (NCtR) [patient count]	-	-	19				20			
	% clients in settled accommodation	E	59.0%	38.7%			L	39.4%			L

*No patients were discharged during January

Length of Stay – Summerlee and Spinnaker

The average length of stay at discharge on Summerlee has risen above the upper control limit during February, reflecting the cohort of patients that have been admitted to our wards with a greater level of need than our standard admission criteria. It is likely this will continue whilst Solent work collaboratively with Portsmouth Hospitals University Trust until the pressures in the PSEH system subside.

b. Key Performance Exceptions

Elective Recovery Fund (ERF)

Solent's performance against the Elective Recovery Fund targets continues to be significantly above target by 21.7% at the end of February. This level of over performance continues to have been stable for the majority of the year and is therefore forecast to be the year end position. The final level of income will be dependant on the overall HIOW ICS achievement of the system ERF target, the value of which is not yet known.

TFC Desc	Activity Actual	Activity Plan	Activity Variance	Income Actual	Income Plan	Income Variance
Cardiology Service	1173	1132	41	£224,043	£216,212	£7,831
CPMS - CP/LAC	946	694	252	£182,578	£133,942	£48,636
CPMS - General Paediatrics	156	71	85	£38,532	£17,537	£20,995
CPMS - Neurodisability	1014	775	239	£195,702	£149,575	£46,127
Diabetes Service	55	109	-54	£7,865	£15,587	-£7,722
Pain Management Service	1040	835	205	£239,200	£192,050	£47,150
Physiotherapy Service	19096	16531	2565	£3,685,528	£3,190,483	£495,045
Trauma and Orthopaedic Service	11227	8348	2879	£2,020,860	£1,502,640	£518,220
Total	**34707**	**28495**	**6212**	**£6,594,308**	**£5,418,026**	**£1,176,282**

Figure 3: Cumulative ERF performance (local data) at M11 compared to baselines v9

Urgent Community Response (UCR) – 2-Hour Performance

Performance in the Southampton UCR team continues to achieve the 70% target despite pressures within the system resulting in the wider community workforce being flexed to support the areas of greatest need.

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
2 Hour Referrals	418	383	401	431	454	435	333	321	351	300	329	234	4390
Compliant	242	249	243	273	285	317	272	274	284	248	272	187	3146
Compliance %	58%	65%	61%	63%	63%	73%	82%	85%	81%	83%	83%	80%	72%

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

Whilst there are still some data quality issues with the information being reported for the Portsmouth UCR team, achievement of the target has reduced over the past few months as the team relaxed the 2-hour response target, to a same-day response in agreement with the ICS. This enabled the team to increase their UCR capacity to support the overall PSEH system response.

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
2 Hour Referrals	291	264	281	258	301	303	270	330	311	288	305	285	3487
Compliant	229	206	226	171	213	215	171	225	169	156	170	143	2294
Compliance %	79%	78%	80%	66%	71%	71%	63%	68%	54%	54%	56%	50%	66%

Figure 5: Portsmouth UCR 2-hour compliance, previous 12 months

Virtual Wards

The position on the virtual wards across both cities remains consistent, with workforce continuing to be flexed and stretched, utilising additional bank and agency staffing, in an effort to support the PSEH and Southampton systems, with no additional funding. There has been an impressive level of commitment from both cities at a time of significant pressure. Conversations are underway with the ICS regarding a proposal to double the virtual ward capacity in Southampton, if funding is available, as it is acknowledged the service have a lower number of beds per 100,000 population compared to other areas within Hampshire and the Isle of Wight.

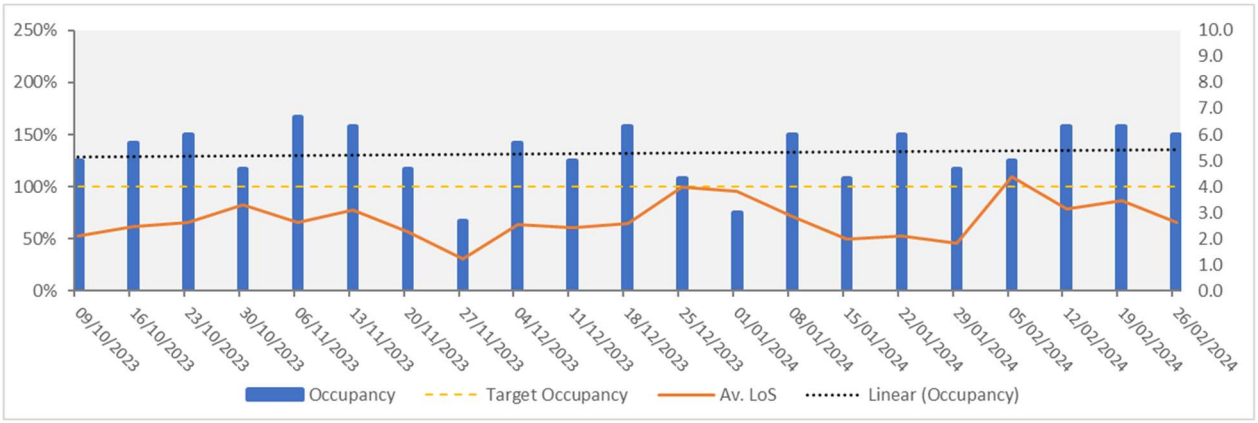


Figure 6: Southampton Virtual Ward Occupancy and average Length of Stay

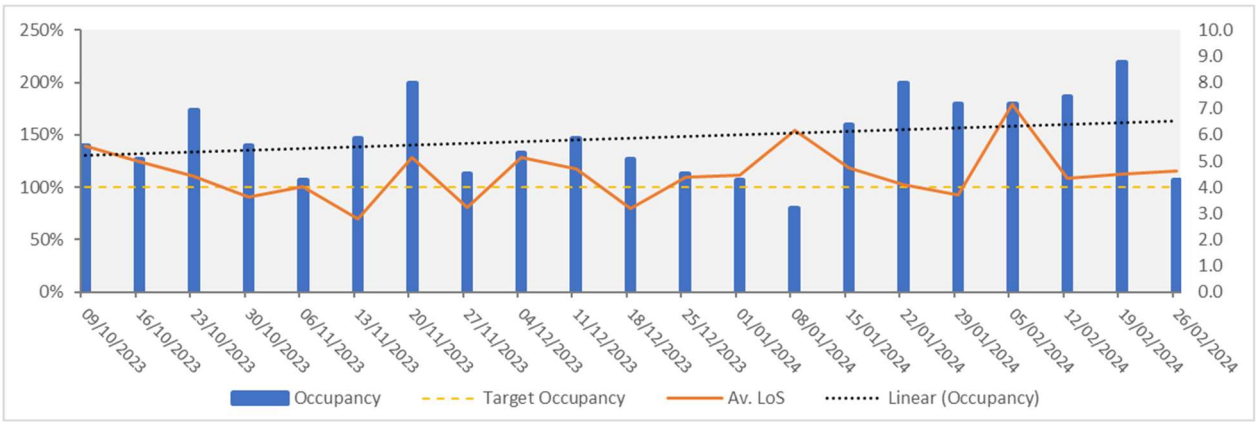


Figure 7: Portsmouth Virtual Ward Occupancy and average Length of Stay

4. Responsive

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance		Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance		Jan-24 Trending Performance	Jan-24 Variance
Responsive	Patients waiting > 18 weeks	-	-	6513			H	6650			H
	Accepted Referrals	-	-	25208				28946			
	Formal complaints per 1000 WTE	-	-	1.7				4.0			
	Number of complaints	I	15	5	●	?		12	●	?	
	Number of complaint breaches	-	-	2				4			
	RTT incomplete pathways*	E	92.0%	72.7%	●	?	L	74.0%	●	?	
	Maximum 6-week wait for diagnostic procedures	E	99.0%	40.0%	●	?	L	46.0%	●	?	
	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%	75.0%	●	?		67.0%	●	?	
	Talking Therapies - Proportion of people completing treatment moving to recovery	E	50.0%	55.9%	●	?		54.9%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 6 weeks	E	75.0%	94.0%	●	?		88.0%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 18 weeks	E	95.0%	100.0%	●	?		100.0%	●	?	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score*	E	95.0%	87.0%	●	?		87.0%	●	?	

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

b. Key Performance Exceptions

Patients waiting > 18 weeks

The position of our waiting lists continues to deteriorate, with the upper control limit now being breached for the past 8 months. Whilst work is underway to review the scope of individual, small, services to reduce demand, the overall waiting list position is unlikely to change significantly due to lack of investment.

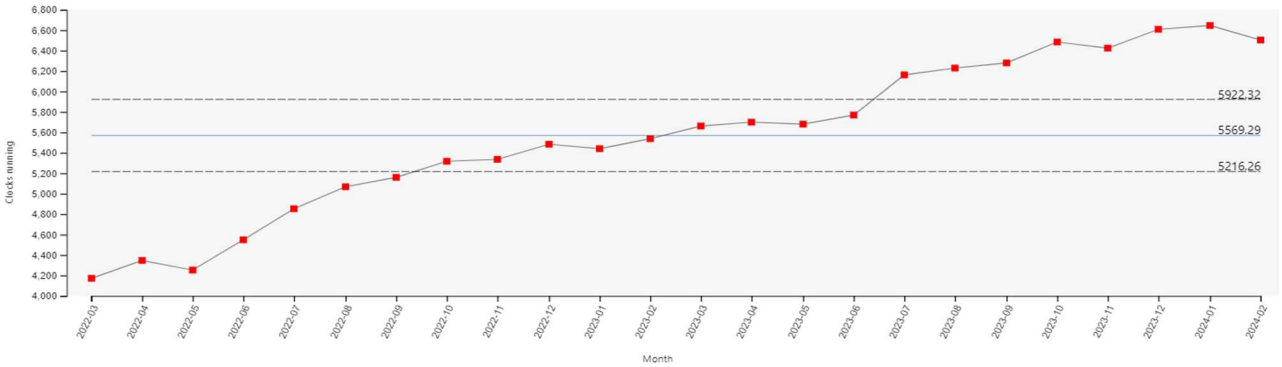


Figure 8: Monthly snapshot of the number of patients waiting for more than 18 weeks – Trust-wide (excluding Dental Services)

Waiting lists for a range of Community Services (as submitted within the Community Health Services Sitrep) are expected to demonstrate a 5% reduction across 2024/25 (target set by HIOW ICB as part of the planning process). For the reasons previously detailed, reducing waiting lists will not be without challenge, however we will begin to monitor these specific services and plan trajectories to achieve this within future IPRs for oversight.

RTT Incomplete Pathways

Performance against the national RTT Incomplete pathway standard continues to decline, with performance now having been below the 92% target for 19 consecutive months. The waiting times within the Community Paediatrics Medical Service (CPMS) continue to be a concern, with numerous initiatives being implemented in the past with little improvement in the position. A review is underway of the scope and pathways within the service. Performance is better within the East service as the model gives priority to new patients, however this results in long waiting times for second and subsequent appointments. The West model sees patients for first and follow up appointments more consistently spaced, which improves the throughput of patients in the service but sees patients waiting considerably longer for a first appointment.

Performance against the statutory Children Looked After standards has improved recently across both services, however this utilises the same resource as CPMS, so a focus to improve this performance has resulted in longer waiting times for patients on general paediatrics and neurodevelopmental pathways.
The review is hoped to find some significant options for improving performance, however even with new initiatives it will take many months to see a positive shift in performance.

Maximum 6-week Wait for Diagnostic Procedures

The 6-week wait for diagnostic procedures continues to be significantly below target as predicted due to the increasing demand for echocardiograms.

As previously reported, the demand on the Cardiology GPSI service is greater than capacity and this has resulted in a backlog of patients waiting for the service. An options appraisal has now been completed by the ICB, however work needs to continue to develop a sustainable model for this service at pace, otherwise the waiting list will continue to grow.

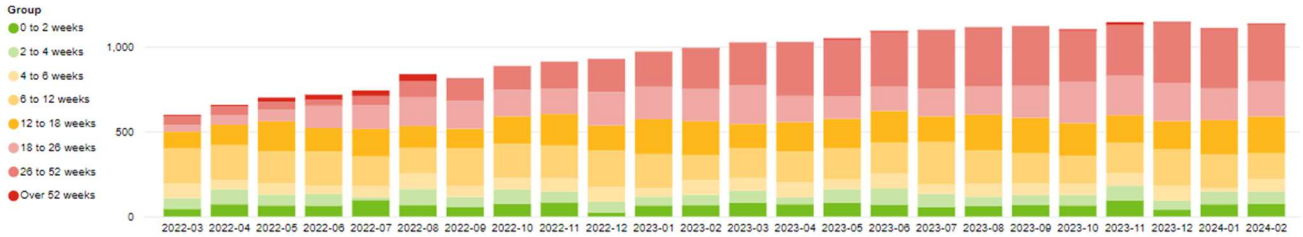


Figure 9: Patients Waiting for Cardiac GPSI service

There are also delays within the diagnostics element of the service due to increased demand, and Solent have commissioned support from UHS to support with the provision of echocardiograms, starting in March, to support the reduction of the current waiting list of 580 patients.

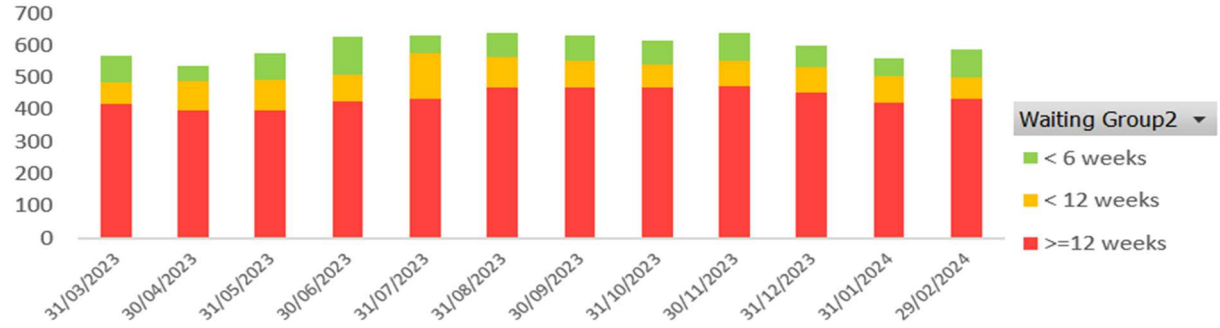


Figure 10: Number of patients waiting for an echocardiogram (weeks)

It is anticipated it will take 9 months to clear the backlog. Further support is also being sought from other third-party providers to help manage the risk. The ICB are not supporting the funding of this additional capacity, so it is an additional and unbudgeted cost to Solent. The monitor service is also an increasing concern, with capacity to report on monitors not meeting demand. A paper has been submitted to the ICB to explore possible solutions.

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

Adults Community Services – Portsmouth

Response to PSEH System Pressure

Over the past two months the PSEH system has been under immense pressure, with a significant focus being placed on moving people out of the acute hospital and managing their care in the community. Several 'firebreak' weeks have occurred, where all health and care organisations in the city came together to a focus on discharging patients and improving flow. The Adults Portsmouth community teams and inpatient units have supported this process in a number of ways. 3 surge beds were opened across Summerlee and Spinnaker wards, and a new 10-bedded inpatient ward was rapidly stood up in Shearwater.

Staff from Summerlee and Spinnaker were loaned to Shearwater, resulting in an increased use of bank and agency staffing on the existing wards. This has not only a financial implication, but it was also observed that the number of incidents on the wards increased during this period. Further analysis of this will be reported to QIR. The 10 beds on Shearwater were utilised, however the narrow criteria they were able to support meant they weren't fully utilised. Social care delays remain a significant challenge in discharging patients in a timely way.

The community teams have seen an increase in demand over the past 6 months, with an additional 150 referrals a month being received for complex nursing care and admissions to the PRRT caseload. This increased activity has supported an increase in avoided hospital admissions and an increased pull out of our community wards. This increase has also been facilitated by use of additional bank and agency staffing.

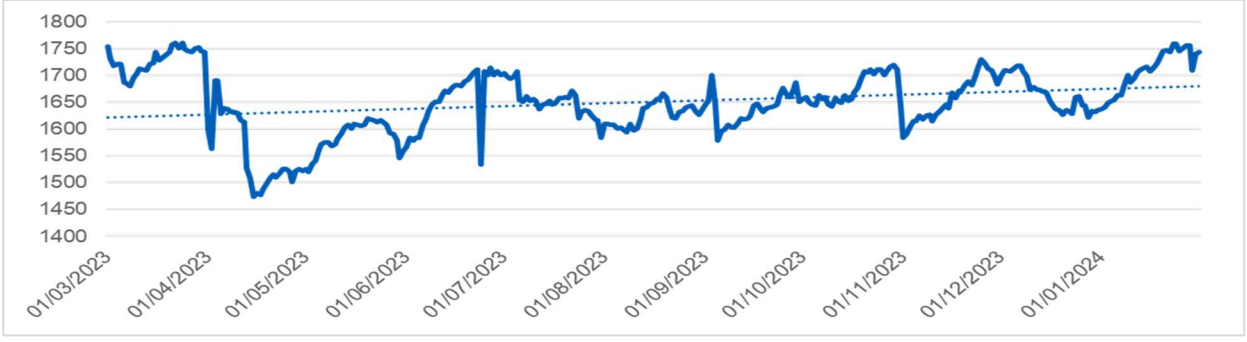


Figure 11: Number of patients on the community services caseload (Portsmouth)

The Transfer of Care Hub (TOCH) has continued to perform well, improving the speed of discharges from Portsmouth Hospitals University Trust.

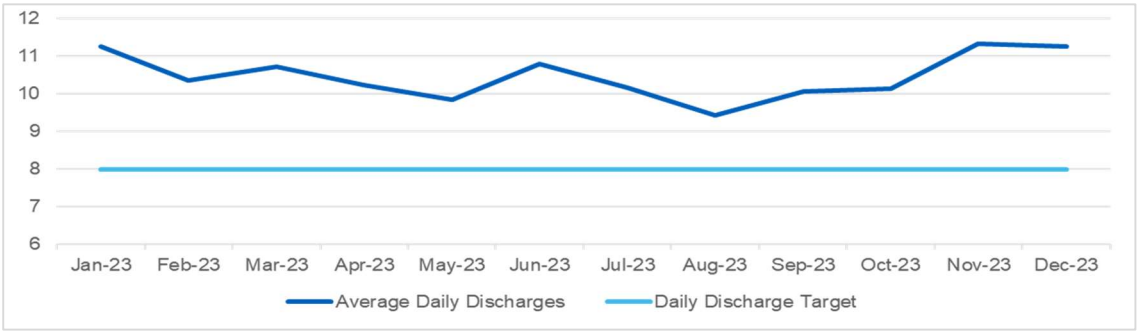


Figure 12: Average number of daily discharges – Transfers of Care Hub

Despite the significant pressures the teams have been working under, the use of off-framework agency remains at zero. Bank and agency usage has been at around 50 wte for the past few months, primarilyt to provide additional capacity to support the system pressures.

Adults Community Services – Southampton & Portsmouth

Increase in Insulin Demand

There has been a steady increase in the demand for patients requiring support with insulin across both Portsmouth and Southampton Community Nursing teams. There are currently 138 patients on the caseload in Southampton, which requires 10 wte per day to manage. This is stretching the weekend workforce particularly, impacting an already pressured workforce and resulting in other visits not being able to be completed in a timely way. A review is planned into the model of service delivery to fully understand the resource implications and consider long-term sustainability options.

Childrens Services

Portsmouth Neurodiversity (ND) Service

The introduction of a specific ND service in Portsmouth has had a positive impact on the waiting times for children requiring an ND diagnosis. The service provides and ND clinical and non-clinical offer based on profiling which is undertaken quickly after the need is identified, rather than children being automatically added to a long waiting list for diagnosis. The caseload has taken children out of the Core CAMHS and CPMS services, and since inception has seen the number of children waiting for assessment and diagnosis reduce from 702 (Dec 2022) to 493. It is expected that based on the current capacity of the service a waiting list of between 450-550 patients is sustainable.

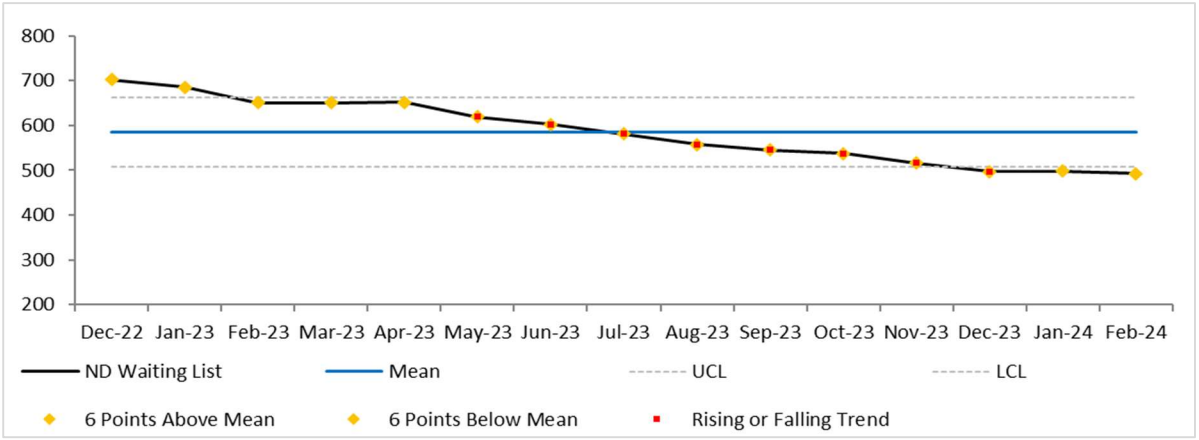


Figure 13: Number of patients on the Portsmouth Neurodiversity Waiting List

Mental Health Services

System Pressures

The past few months have seen an increased pressure across our mental health inpatient services with demand increasing and flow of patients through the service slowing. The number of patients waiting for an admission or mental health act assessment from acute hospitals and within the community has increased, resulting in the need to utilise some out of area beds to ease the pressure in March. The use of out of area beds is unusual for Solent, however this is common across other providers locally and nationally. This also coincides with the changeover of 2 consultants who are in a period of induction, which is impacting the flow of patients back into the community. The consultants are anticipated to be fully inducted by the end of quarter 1 2024/25.

There is additional pressure coming from the 136 Suite with damage requiring repair causing the suit to close for 2-3 weeks in March while the refurbishment takes place. The seclusion suite can be used as an alternative; however this does reduce the overall 136 Suite capacity across the county.

Despite pressures in the inpatient service, recent work undertaken within the Older Person's Mental Health (OPMH) service to redesign the management team and update working practices is progressing positively. The introduction of a consultant nurse post is planned, with the intention to support the lead consultant with additional clinical leadership and enhance the medical and non-medical leadership across the service, increasing the skill mix and improving the ability to treat patients in the community.

Musculoskeletal, Pain and Podiatry (MPP) Services

SMSK and Pain Service Decommissioning

Significant risks have been identified linked to the decommissioning of the South-East Hampshire and Fareham and Gosport Specialist Musculoskeletal (SMSK) and Pain services. The Pain service will stop accepting referrals from 1st April 2024 and SMSK from 1st May 2024, which poses a risk to patients as there is no alternative model defined at present. We are working in partnership with the ICB to develop a new service model which will reduce the risk of additional patients requiring referral to acute trauma and orthopaedic services, where they will experience long waiting times, and destabilising of local diagnostics provision. Discussions are ongoing.

Sexual Health Services

Demand for HIV Services

The HIV service caseload has been increasing consistently for a sustained period of time, predominantly due to the increase in patients joining the service from overseas. The impact of this growth is being investigated and capacity and demand is being reviewed.

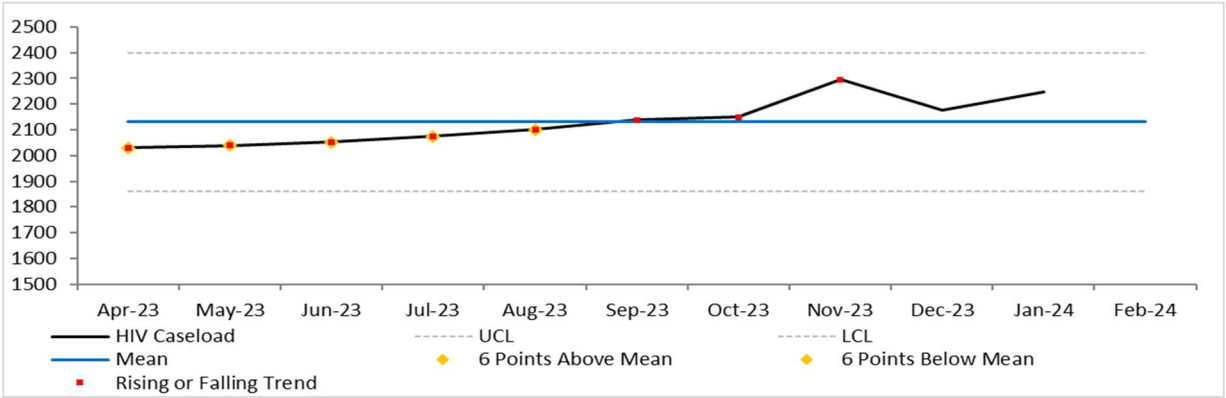


Figure 14: Number of patients on the HIV Caseload

Primary Care Services

Service Improvements

There has been a significant shift in the Primary Care service line over the past 12 months, with a number of successes and changes implemented. As previously reported, the recruitment of substantive GPs has provided stability to the service, reduced the spend on locums and has resulted in the service line being forecast to end the year within budget. This has enabled an increase in the number of available appointments from 7,912 in April 2023 to 11,455 in January 2024, a 45% increase.

Access to appointments, both with a GP and other staff, are now in line with national and HIOW averages, allowing patients to access appointments in a timescale appropriate to their need and to allow for routine care. There have also been significant improvements in the QOF standards, innovative community in-reach and outreach clinics, and improvements in the culture within the service line. Whilst the team recognise there is still further to go on their journey, particularly with staff culture as a continuous learning process, they are proud of their achievements and the impact this has on the outcomes for their patient population.

5. People

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance	Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance	Jan-24 Trending Performance	Jan-24 Variance
People	Sickness (annual)*	I	4.5%	5.4%			5.4%		
	Sickness (in month)	I	4.5%	5.1%			5.4%		
	Turnover (annual)*	I	14.0%	12.7%			12.6%		
	Turnover (in month)	I	1.2%	0.9%			1.3%		
	New starters (FTE)	-	-	31.13			55.01		
	Proportion of Temporary Staff (in month)	I	3.6%	5.6%			5.4%		

b. Key Performance Exceptions

Temporary Staffing

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

In February, the opening of Shearwater as an additional inpatient ward saw the utilisation of agency workers to fulfil staffing establishment, but more recently support has been offered from Portsmouth Hospitals University Trust Registrants using honorary contracts. There has not been a significant increase in agency usage to support this as was anticipated.

Focused work with the Mental Health service line is underway to support the reduction in temporary staffing, particularly agency use. (Approx. 600 shifts per month currently being used). This is being supported in two ways, rostering optimisation, and the offering of bank agreements to their substantive staff to enable a better fill rate, and flexibility for these staff to work additional shifts where feasible for them to do so.

Transformation programme resource is being allocated to support roster optimisation across the Trust in 2024/25, improving monitoring and delivery of roster management within the recommended timescales, reducing the utilisation of bank and agency staffing.

The temporary staffing team have significantly reduced off-framework usage, in which we saw net use in some weeks in February. This has been noted by the Southeast Temporary Staffing Collaborative as a positive benchmark for other Providers.

There are now only a handful of Medical Locum placements in operation, with none remaining off-framework.

6. Finance

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance		Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance		Jan-24 Trending Performance	Jan-24 Variance
Finance	Year to date surplus/(deficit) Actual v budget	-	-	-0.4%				0%			
	Agency spend % pay	I	3.5%	3.5%				1.3%			
	Cash balance (£m)	-	-	£5.40				£5.32			
	Aged debt (over 90 days) (£k)	-	-	£2,440				£2,473			
	Use of Resources Score	-	-	3				3			

b. Spotlight On: Month 9 Results

The plan for 2023/24 was a £2.2m deficit, however the system has been allocated more funding to help with the current financial positions. Solent are to receive £2.1m of this, to now report a forecasted deficit of £0.1m. The Trust is reporting an in month adjusted surplus of £1,907, £66k favourable to plan. Year to date the Trust is £162k adverse to plan.

The YTD deficit includes inflation on leasehold estates and underachievement of CIPs, offset with the release of non-recurrent benefits and additional funding from the ICB.

Cost Improvement Plans (CIP)

The Trust has an internal efficiency programme of £23.9m, made up of 27 schemes. M11 CIPs underperformed by £407k and are £5.8m under performing year to date, much of the underperformance is being driven by schemes developed post planning as part of the Trusts financial recovery plan.

Capital

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

Month 11 capital spend was £1.8m, £1.1m underspent against plan. YTD spend £11.6m, £7.9m underspent compared with plan. Forecast M12 Spend is anticipated to exceed M12 plan by £0.4m. The year end position is expected to be £6m underspent due to PDC spend on the WCH project and Highclere being deferred to next financial year; offset by additional CRL funding re-allocated from PHU to be utilised this financial year £0.5m.

Cash

The cash balance was £5.4m as at 29 February 2024, a £0.1m increase from January, primarily due to PDC received in month being higher than capital expenditure in month.

Aged Debt

The Trust's total debt was £10m at the end of February, an increase of £2.5m from January, due to £4.5m invoices raised in the month, half of these to SCC. 91+ days overdue debt at the end of February was £2.4m, £0.03 decrease in month due to payments paid.

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 February 2024 the Trust paid 95.2% of volume of invoices within target and 97.7% of value.

Scan date to payment date was 22.4 days, 1 days faster than January.

7. Research & Improvement

a. Performance Summary

Since April 2023, we have recruited 512 participants into 36 studies, comparable with similar size Trusts across the Wessex region. A further 2 are due to open in the in next couple of months. Recruitment has been slower than expected this year: two high recruiting studies that should have opened by now, have been delayed by the study teams. We are currently the 3rd highest research active Care Trust in the NIHR league tables.

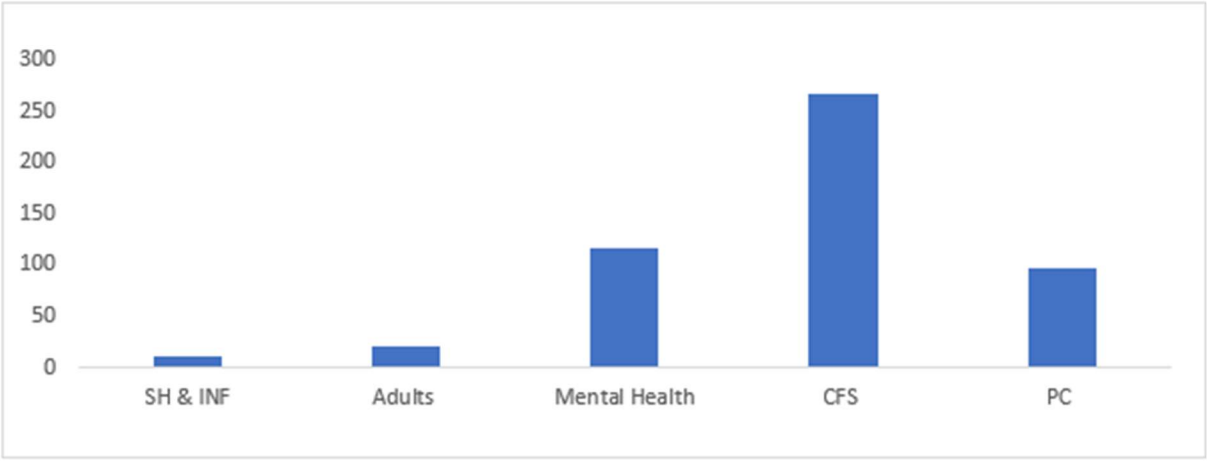


Figure 15: Research recruitment by Service Line since April 2023

b. Studies currently underway

CPOS Questionnaire Study

A study to explore a children's palliative care outcome scale validation questionnaire; for ages 5-18 years. Children living with life-long threatening or limiting conditions; their families and heath care providers have been asked to highlight what wellbeing measures matter most to them. To ensure they are best supported; the validation scale has been devised to help assess and meet their needs. The final stage of this study involves asking children, families, and staff to complete the measure twice; to check it accurately measures what it intends to measure.

Retrospective analysis of Glycopyrronium Bromide use in children under 3 Study

A study to collect retrospective data on the use of glycopyrronium bromide for the treatment of excessive drooling in children with chronic neurological disorders. This study aims to establish the safety and efficacy of use in this age group with the intention to extend the current license to include children under 3 years.

Paediatric post pneumococcal conjugate vaccine study

Study to examine the bacteria in nasal carriages of children under 4 years, to ensure Prevenar vaccines given in the UK infant immunisation programme remains effective at preventing meningitis and other forms of pneumococcal infection.

The ELSA Study

A screening study programme to find out children's risk of developing type 1 diabetes in children aged between 3-13 years. The study involves finger stick dried blood spot screening Clinics to test for antibodies in

various community settings including schools and GP surgeries. For those children who test positive for antibodies; families will be offered targeted educational support and opportunity for further blood test.

c. Studies currently in setup

Strengthening programme for ambulant adolescents with cerebral palsy (ROBUST)

A RCT study to determine the effectiveness of an adolescent (12-18 years) specific physiotherapy strengthening programme, compared to usual physiotherapy treatment care. Programme will last 4 months, then at 6- and 12-months participants with their carers will be asked to complete a questionnaire about their walking and ability to carry out daily activities.

Stretching programme for ambulant children with cerebral palsy (SPELL)

A RCT study to determine the clinical effectiveness of a child-specific dynamic stretching programme, compared to usual NHS physiotherapy treatment care for children with spastic cerebral palsy. The programme will last 4 months, then at 6- and 12-months participants with their carers will be asked to complete a questionnaire about their walking and ability to carry out daily activities.

Annex A: Making Data Count Icon Crib Sheet

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

Solent NHS Trust - 2023/24 System Oversight Framework

The NHS System Oversight Framework is aligned with the ambitions set out in the NHS Long Term Plan and the 2023/24 NHS operational planning and contracting guidance. The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

A set of oversight metrics are used to support the implementation of the framework at a system level. The Hampshire and Isle of Wight Integrated Care System (HIOW ICS), that Solent is part of, is in System Oversight Level 4, highlighting the additional support being received from NHS England with regards to managing the financial deficit of the ICS through a Recovery Support Programme. The metrics reported below are those included within the 2023/24 updated technical guidance, for which Solent contributes towards the HIOW ICS performance.

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance		Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance		Jan-24 Trending Performance	Jan-24 Variance
Quality, Access & Outcomes	S035a: Overall CQC rating (provision of high-quality care)	-	-	Annual Metric							
	S007c: Elective Activity - Value weighted elective activity growth (ERF Income v Target v6)	E	100.0%	121.7%				122.5%			
	S009d: Patients waiting more than 65 weeks to start consultant-led treatment	E	0	0				0			
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	E	100.0%	59.4%				59.9%			
	S121a: NHS Staff Survey compassionate culture people promise element sub-score		0	Annual Metric							
	S121b: NHS Staff Survey raising concerns people promise element sub-score	I	0.0%	Annual Metric							
	S124a: Percentage of occupied adult beds occupied by patients who no longer meet the criteria to reside	-	-	Metric under development							
	S125a: Long length of stay for adult acute mental health (discharges with LOS over 60 days / all discharges)	E	0.0%	7.4%				3.0%			
	S125b: Long length of stay for older adult mental health (discharges with LOS over 60 days / all discharges)	E	0.0%	50.0%				8.3%			
	S126a: Diagnostic activity waiting times – percentage of patients who have been waiting more than 6 weeks	E	95.0%	40.0%				46.0%			
	S128a: Virtual wards – percentage occupied	I	100%	160%				144%			
	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	549				537			
	S084a: Children and young people (ages 0-17) mental health services access (number with 1+ contact)	-	-	Metric under development							
	S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (3 months rolling)	E	0	0				0			
	S107a. Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	E	70.0%	64.0%				70.0%			

	Indicator Description	Internal /External Target	Target	Feb-24 Current Performance	Feb-24 Trending Performance	Feb-24 Variance	Jan-24 Current Performance	Jan-24 Trending Performance	Jan-24 Variance
Looking after our people	S072a: Proportion of staff agree their organisation acts fairly on career progression, regardless of ethnic background, gender, religion, sexual orientation, disability or age	I	58.6%	Annual Metric					
	S063a: NHS Staff Survey Safe environment - Bullying and harassment theme score	I	790.0%	Annual Metric					
	S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	I	0.0%	Annual Metric					
	S063c: Proportion of staff who say they have experienced harassment, bullying or abuse at work from patients/service users, relatives or other members of the public	I	0.0%	Annual Metric					
	S067a: Leaver rate	I	14.0%	12.7%	?		12.6%	?	
	S068a: Sickness absence (working days lost to sickness)	I	5.0%	5.1%	?		5.4%	?	
	S071a: Proportion of staff in senior leadership roles who are from a BME background	I	12.0%	7.2%	?		7.1%	?	
	S071b: Proportion of staff in senior leadership roles who are women	I	62.0%	74.3%	?		74.5%	?	
	S071c: Proportion of staff in senior leadership roles who are disabled	I	3.2%	10.3%	?	H	8.2%	?	H
	S133a: Staff Survey – We Are Compassionate and Inclusive People Promise element score	I	0.0%	Annual Metric					
Finance and Use of Resources	S118a: Financial Stability	E	-	Metric under development					
	S119a: Financial Efficiency	E	-	7.0%			6.0%		
	120a: Finance – Agency Spend vs agency ceiling	E	100.0%	Metric under development					
	120b: Agency spend price cap compliance	E	100.0%	Metric under development					

Key

In-month Performance Indicator

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

Trending Performance Indicator

- P — Target has been consistently achieved, for more than 6 months
- F — Target has been consistently failed, for more than 6 months
- ? — There is a variable and inconsistent performance against the target

Variance Indicator

- H — Special Cause Variation, for improved performance. The trend is either:
  - Above the mean for 6 or more data points
  - An increasing trend for 6 or more data points
  - Near the control limit for 2 out of 3 data points
  - The value exceeds the upper control limit
- H — Special Cause Variation, for poor performance. The trend is either:
  - Above the mean for 6 or more data points
  - An increasing trend for 6 or more data points
  - Near the control limit for 2 out of 3 data points
  - The value exceeds the upper control limit
- L — Special Cause Variation, for improved performance. The trend is either:
  - Below the mean for 6 or more data points
  - An decreasing trend for 6 or more data points
  - Near the control limit for 2 out of 3 data points
  - The value exceeds the lower control limit
- L — Special Cause Variation, for poor performance. The trend is either:
  - Below the mean for 6 or more data points
  - An decreasing trend for 6 or more data points
  - Near the control limit for 2 out of 3 data points
  - The value exceeds the lower control limit
- Common Cause Variation, the information is fluctuating with no special cause variation.

Board and Committee Summary Report

NHS Solent NHS Trust

Title of Paper	**NHS Provider Licence – Self Certification 2023/24**
Date of paper	**15 April 2024**
Presentation to	**Trust Board**
Item No.	**12.1**
Author(s)	**Dominic Ford, Governance Programme Lead**
Executive Sponsor	**Andrew Strevens, Chief Executive**
Executive Summary	**The Trust is required to comply with all relevant conditions of the Provider Licence issued by NHSE. This paper provides a self-assessment of compliance, reviewed by Executive Directors, with the relevant conditions of the licence and a declaration of compliance to be signed by the Chair and the Chief Executive Officer (CEO), following approval by the Board.**

Action Required	**For decision?**		**For assurance?**	**Y**
Summary of Recommendations	**The Board is asked to:** • **Receive assurance that the Trust complies with the relevant conditions of the Provider Licence and approve the assessment of compliance**			
Statement on impact on inequalities	**Positive impact (inc. details below)**		**Negative Impact (inc. details below)**	**No impact (neutral)** **X**
Positive / negative inequalities	**This paper provides assurance that existing arrangements within the Trust comply with the relevant conditions of the Provider Licence. As no changes will be instigated by this paper the impact is neutral.**			
Previously considered at	**The Remuneration and Nominations Committee reviewed the self-assessment at the meeting of 24 March 2023.**			

Strategic Priority this paper relates to

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

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

Level of Assurance *(tick one)*	**Significant**		**Sufficient**	**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 the Board**							
Executive Sponsor Signature	 Andrew Strevens							

NHS Provider Licence – Self Certification 2023/24

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

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

Annual Declaration

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

Signed by:

Mike Watts, Chair

Date:

Signed by:

Andrew Strevens, **CEO**

Date:

Licence number: 400051

Item 9.3

Solent NHS Trust – Compliance with NHS Trust Provider Licence

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

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

2. Trusts Working in Systems	
WS1: Cooperation	
1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	This applies to the Trust at present and when it becomes part of a foundation Trust.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.	Annual Report 2022/23 What We Do page 11 describes the Trust working with NHS bodies and local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner; i) as necessary and appropriate for the purposes of developing and delivering system plan(s). ii) as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year iii) as necessary and appropriate for the purposes of delivering agreed people and workforce plans. b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i) as necessary and appropriate for the purposes of delivering NHS services. ii) as necessary and appropriate for the purposes of improving NHS services.	3.a i) & iii) & 3.b i) & ii)The Trust is committed to improving collaboration between employers across the ICS to increase overall workforce supply and enable health and care staff to work across the Hampshire and Isle of Wight system. Trust Strategy 2021-25 p59 3.a ii) The Trust will work in collaboration with its system partners to achieve financial balance.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a. the Secretary of State for Health and Social Care; or b. NHS England. For the purpose of this condition, cooperation is considered synonymous to collaboration.	The Trust reviews all guidance published by NHSE and the Board is informed of the progress of the implementation of required actions.
WS2: The Triple Aim	
1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	This applies to the Trust at present and when it becomes part of a foundation Trust.

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

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

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

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

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

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

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

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

NHS1: Information to update the register Ctd	
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.	
4. The obligation in paragraph 3 shall not apply to: (a) any document provided pursuant to paragraph 2; (b) any document originating from NHS England; or (c) any document required by law to be provided to NHS England by another person.	
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short, written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	
NHS2: Governance arrangements	
1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSE.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	On an annual basis the Trust has implemented a process of governance reviews (via the Remuneration and Nominations Committee) including; • Reviewing composition, skill and balance of the Board and its Committees • Reviewing Terms of Reference • The completion of an Annual Report for each Board Committee incorporating a reflection on the achievement of objectives and business conducted in year. A mid-year review of each Committee is also conducted. The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quoracy as well as any recommendations made following Internal Auditors (or other external review). The Executive Team Portfolios are continuously reviewed. The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.

NHS2: Governance arrangements Ctd	
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time; and b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have systems and processes in place to meet any guidance issued by NHS England on digital maturity d. comply with the following paragraphs of this Condition.	a. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSE. b. The Trust's Annual Report describes the Trust's compliance with guidance on tackling climate change and delivering net zero emissions. c. The Trust's Digital Strategy describes how the Trust meets requirements on digital maturity. There is a dedicated governance reporting structure for digital services to enact guidance issued by NHSE in respect of digital maturity.
4. The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation.	The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. • The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. • There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. • The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quoracy as well as any recommendations made following Internal Auditors (or other external review). • The Executive Team Portfolios are continuously reviewed. • Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. • Established escalation processes allow staff to raise concerns as appropriate.
5. The Licensee shall establish and effectively implement systems and/or processes: a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	• We regularly review our governance processes including our Board Code of Conduct and associated protocols. • Internal control processes have been established and are embedded across the organisation as outlined within the Annual Governance Statement. The Board has agreed actions to enhance the internal controls regarding pre-employment checks and recruitment processes. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls.

NHS2: Governance arrangements Ctd	
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.	
6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quoracy as well as any recommendations made following Internal Auditors (or other external review). The Executive Team Portfolios are continuously reviewed. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. Established escalation processes allow staff to raise concerns as appropriate.
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	• Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. Details of the composition of the Board can be found within the public website.

5. NHS Controlled Providers Conditions	
CP1: Governance arrangements for NHS-controlled providers	
1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.	NHS-controlled providers are providers who are: Not NHS trusts or NHS foundation trusts, they are controlled by or more NHS Trust and are required to hold a provider licence. This condition does not apply to Solent.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time; and b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have systems and processes in place to meet any guidance issued by NHS England on digital maturity d. comply with the following paragraphs of this Condition.	
4. The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).	
5. The Licensee shall establish and effectively implement systems and/or processes: a. to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	NHS-controlled providers are providers who are: Not NHS trusts or NHS foundation trusts, they are controlled by or more NHS Trust and are required to hold a provider licence. This condition does not apply to Solent.

5. NHS Controlled Providers Conditions	
CP1: Governance arrangements for NHS-controlled providers Ctd	
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.	NHS-controlled providers are providers who are: Not NHS trusts or NHS foundation trusts, they are controlled by or more NHS Trust and are required to hold a provider licence. This condition does not apply to Solent.
6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	

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

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

<table>
<tr><th>CoS 2: Restriction of the disposal of assets Ctd</th><th></th></tr>
<tr><td>7.Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.</td><td rowspan="2"></td></tr>
<tr><td>8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where: a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to: i. transactions of a specified description; or ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.</td></tr>
<tr><td>9. In this Condition:
<table>
<tr><td>“disposal”</td><td>means any of the following:
(a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or
(b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or
(c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or
(d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered,
and references to “dispose” are to be read accordingly;</td></tr>
<tr><td>“relevant asset”</td><td>means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee’s ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;</td></tr>
<tr><td>“relinquishment of control”</td><td>includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and “relinquish” and related expressions are to be read accordingly.</td></tr>
</table></td><td>The Trust has noted the meaning of the terms used in this condition.</td></tr>
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CoS 2: Restriction of the disposal of assets Ctd	
10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding: a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.	The Trust will have regard to guidance issued by NHSE in respect of the management and recording of assets.
CoS 3: Standards of corporate governance, financial management and quality governance	
1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services provided by the Licensee, and b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.	The Trust has governance structures in place for the management and oversight of quality and finance via groups and Committees of the Trust Board. The arrangements would be regarded as suitable for; a. provider of commission requested services. b. provide reasonable assurance of going concern c. provide reasonable safeguards against quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.	The Trust applies systems and standards to maintain high standards of corporate governance, financial management and quality a. in response issued by NHSE b. to use risk ratings published by NHSE and c. to maintain the risk rating regarded as acceptable by NHSE.
CoS 4: Undertaking from the ultimate controller organisation	
1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and	The Trust does not have an ultimate controller. Paragraphs 1 to 5 do not apply to the Trust.

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

CoS 5 – Risk pool levy Ctd	
2.In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	The Trust has noted the requirement to pay sums payable by way of levy or any interest payable within 28 days of a demand in writing from NHSE.
CoS 6: Cooperation in the event of financial or quality stress	
1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: **a. the ability of the Licensee to continue to provide commissioner requested services due to [quality stress], or b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to [quality stress]** c. the ability of the Licensee to carry on as a going concern	The Trust has noted the obligation to give written notice to NHSE in the event of concerns around quality stress or going concern.
2. When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.	This paragraph does not apply to the Trust as there are currently no concerns around quality stress or going concern.
CoS 7: Availability of resources	
1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	The Trust has noted it should act in a manner to ensure it has the required resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	The Trust has noted it should not by its actions create a material risk to the availability of the require resources required resources.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or	a. The Trust submitted the following to NHSE at the same time as the Annual Report in 2023. 1. A Statement of Directors Responsibilities in respect of the accounts, confirming the directors belief they present a fair and balanced view. 2. Trust Accounts Consolidation Schedule (showing the separate accounts in the Trust) signed by the Chief Executive Officer. 3. Certificate on summarisation schedules signed by the Director of Finance and the CEO. 4. Statement of the Chief Executive's responsibilities as the accountable officer of the Trust. 5. A letter to NHSE from the CEO confirming there were no events after the reporting period.

CoS 7: Availability of resources Ctd	
limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources". c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".	6. The above documents confirm the opinions of the Directors and CEO that the accounts form a fair and balanced view of the Trust's financial status. 7. The Trust will comply with any further requirements or changes to the format of submissions to confirm the availability of required resources.
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	The Statement of Directors Responsibilities in respect of the accounts, that takes into account the main factors considered when issuing the certificate
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	The Statement of Directors Responsibilities was signed by the Chief Finance Officer and the Chief Executive Officer 20.06.23 and provided to NHSE.
6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3	The Trust has noted it must inform NHSE if the expectation regarding required resources changes.
7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	A Statement of Directors Responsibilities in respect of the accounts, Statement of the Chief Executive's responsibilities as the accountable officer of the Trust are published in the Trust's Annual Accounts.
8. In this Condition: "distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; "Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts; "Required Resources" means such: a. management resources including clinical leadership, b. appropriate and accurate information pertinent to the governance of quality c. financial resources and financial facilities, d. personnel, e. physical and other assets including rights, licences and consents relating to their use, and f. subcontracts , and g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.	The Trust has noted the meanings of the terms in this condition.

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

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

Board and Committee Summary Report

Title of Paper	Hampshire and Isle of Wight Healthcare NHS Foundation Trust (HIOWH NHS FT) – Proposed Patient Safety Incident Response Plan
Date of paper	05/04/2024
Presentation to	Solent NHS Trust Board Meeting (In-Public), 15 April 2024
Item No.	13.1
Author(s)	Aderemi Aderibigbe – Associate Director of Quality, Safety, Governance and Risk
Executive Sponsor	Angela Anderson – Chief of Nursing and Allied Health Professions
Executive Summary	• Solent NHS Trust board (In Public) approved the Solent Patient Safety Incidents Response Plan at its in-public meeting in October 2023. This plan has been in operation within the Trust since our transition to the new NHS Patient Safety Incident Response Framework (PSIRF) on 30th October 2023. However, because it was anticipated that a new plan would be required for the proposed HIOWH NHS FT, the plan development teams across partner organisations worked closely to ensure our plans were as aligned as possible and that minimal changes would be required to ensure a combined plan for HIOWHNHSFT can evolve. • Therefore, as part of project FUSION, the PSIRF Policy Working Group came together to merge PSIRF Plans from Southern Health NHS Foundation Trust, Isle of Wight NHS Trust and Solent NHS Trust. There were no major changes of note in the combined plan compared with current plans. • Minor changes include removal of references to Southern Health or Solent's individual services and/or structures and replacing them with generic references until new organisation is live as planned in July 2024. • Description of required data analysis approach and stakeholder engagement activities undertaken by the partner organisations in the evolution of individual PSIRF plans were also combined within this document. • Local Priorities were also combined to include and reflect all three organisation's identified priorities. • Timeframes for learning responses were updated to align them with updated PSIRF Policy. • It is anticipated that further minor amendments of job titles and meeting/committee structures may be required as they evolve and are agreed for the new organisation. These have been highlighted 'yellow' within this document where 'placeholder' names have been used. • The Trust Board is asked to note that the organisational Patient Safety Incident Response Plan is and will be a 'live' document, subject to ongoing review and amendments as new patterns emerge within organisational patient safety intelligence and consequent need for new or amended local priorities and learning response approach.

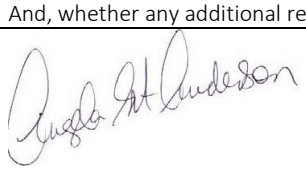
Action Required	For decision?	Y	For assurance?	Y
Summary of Recommendations	The Trust Board is asked to approve the proposed Patient Safety Incidents Response Plan for the new organisation HIOWH NHS FT from 1st July 2024.			
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	X
Positive / negative inequalities	N/A					
Previously considered at	Previously considered and approved by: Clinical Steering Group (Project FUSION) on 26/03/2024					

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	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	 Angela Anderson							

Item 13.2

Patient Safety Incident Response Plan; 2024/25

	NAME	TITLE	DATE
Author/s	Georgia Walker	Quality and Patient Safety Project Manager, Southern Health NHS Foundation Trust	07/02/2024
	Liz Hall	Head of Patient Safety, Southern Health NHS Foundation Trust	07/02/2024
	Pauline Jeffrey	Head of Quality and Safety, Solent NHS Trust	07/02/2024
	Teresa Power	Patient Safety Specialist, Solent NHS Trust	07/02/2024
	Natalie Mew	Head of Nursing and Quality, Isle of Wight NHS Trust	07/02/2024
	Beverley Fryer	Head of Nursing and Quality, Isle of Wight NHS Trust	07/02/2024
Reviewers	Suzanne van Hoek	Deputy Chief Nurse, Quality Governance and Patient Safety, Southern Health NHS Foundation Trust	07/02/2024
	Aderemi Aderibigbe	Associate Director of Quality, Safety, Governance and Risk, Solent NHS Trust	07/02/2024
	Jennifer Edgington	Divisional Director of Nursing & AHP's, Isle of Wight NHS Trust	07/02/2024
Executive Lead	Paula Hull	Director of Nursing & Allied Health Professionals, Southern Health NHS Foundation Trust	14/02/2024
	Angela Anderson	Chief of Nursing and Allied Health Professionals, Solent NHS Trust	11/02/2024
Authoriser/s	Clinical Steering Group		

	Integrated Care Board	

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
08/01/2024	PSIRF Policy Working Group attendees	1	All	Merging of PSIRF Plans from Southern Health NHS Foundation Trust, Isle of Wight NHS Trust and Solent NHS Trust. Sovereign SHFT plan amended for HIOW from July 2024. No major changes highlighted.
08/01/2024	Head of Patient Safety, Southern Health NHS Foundation Trust	1	All	Job titles and meeting/committee structures will need to be reviewed when agreed for the new organisation is live in July 2024 (highlighted in yellow in the policy)
18/01/2024	PSIRF Policy Working Group attendees	1	All Pg 3 Pg 10 Pg 17 Pg 23	Removed references to Southern Health or Solent's individual services and/or structures and replaced them with generic references until new organisation is live in July 2024. Foreword/Executive Summary amended to use wording from Solent's PSIRF Plan. Updated section 4 to refer to individual organisation's PSIRF Plans. Local Priorities have been combined to include all three organisation's priorities. Timeframes for learning responses updated to align with updated PSIRF Policy. Added Organisational PSIRF plans as appendix A.
25/01/2024	PSIRF Policy Working Group attendees	1	Pg 21 Pg 23 Pg 24 Pg 30	Reviewed section 6b to make relevant to new organisation from July 2024. Reviewed section 7 to make relevant to new organisation from July 2024. Reviewed section 8 to make relevant to new organisation from July 2024. Removed appendix D as only relevant to Southern Health NHS Foundation Trust and awaiting direction of improvement programmes for new organisation
07/02/2024	PSIRF Policy Working Group attendees	1	Pg 15	Local priorities list has been amended to include joint priorities across all 3 organisations and individual ones from Southern Health NHS Foundation Trust

Contents

1. Foreword/Executive Summary

"*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 the Trust. We aim to foster a culture that encourages staff to report patient safety incidents and to be supported to do so, without fear of blame. We will focus more on the human factors and systems approach to learning form things that go wrong and improving.

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.

Please refer to previous organisation's PSIRF Plans for detailed information in appendix A.

2. Purpose and Scope

This patient safety incident response plan sets out how we, Hampshire and Isle of Wight Healthcare NHS Foundation Trust (the Trust), will seek to learn from patient safety

incidents reported by staff, patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations by:

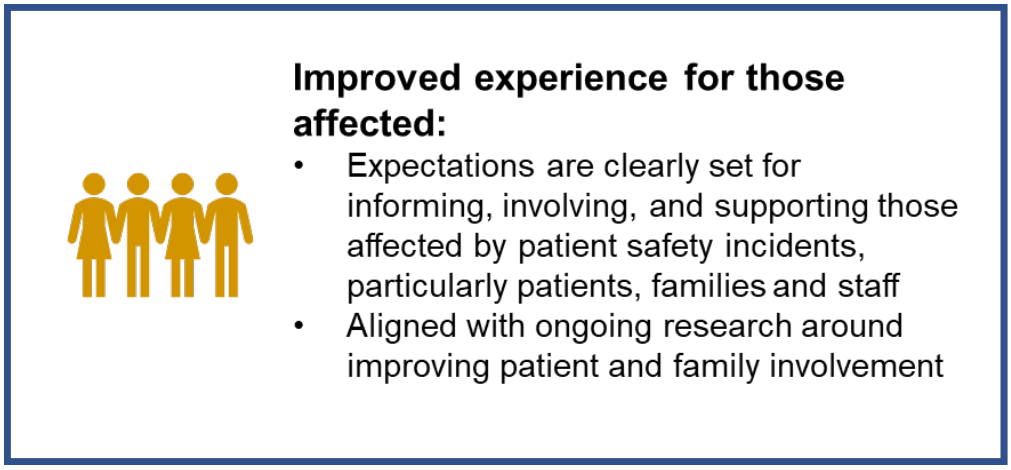
- refocusing investigations towards a systems approach and the rigorous identification of interconnected causal factors and systems issues.
- focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety issues and incidents.
- focus on safety critical behaviours, human factors and the just culture that supports learning and improvements in care.
- transferring the emphasis from the quantity to the quality of patient safety incident investigations such that it increases our stakeholders' (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents.
- demonstrating the added value from the above approach.

The aim of this approach is to continually improve and therefore it is important to note that this plan will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The framework sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on page 12-14.

This plan should be read alongside the introductory NHS England Patient Safety Incident Response Framework 2020, which sets out the requirement for this plan to be developed.

The key principles of the Patient Safety Incident Response Framework are:



We want to engage meaningfully with our patients, families, carers, and staff to ensure that their voice is heard in any of our learning responses. The framework sets out best principles for this engagement and key to this is our move to appointing patient safety partners which will ensure that the patient voice is involved at all stages.

More proportionate and effective response:

- Changes blunt rules to determine what to learn from and what not to learn from
- Resource planning based on thorough understanding of patient safety incident profiles and ongoing improvement activity.
- Supports organisations to be more proportionate, sensitive and considered in their approach

Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We are aiming to foster a culture in which people feel they can highlight incidents knowing they will not be blamed, or action taken that is not proportionate to what has happened. This reflects the work we are doing to strengthen our psychologically safe environments. The framework reinforces the importance of having conversations where people have been affected by a patient safety incident, no matter how difficult that is.

Better range of methods for learning:

- Promotes a range of methods for responding to and learning from patient safety incidents
- Moves away from Root Cause Analysis (RCA) , towards a system-based approach to learning.
- Timelines are more flexible and set in consultation with the patient and/or family
- Quality of response and resulting improvement work is the priority

The framework promotes a range of system-based approaches for learning from patient safety incidents, rather than methods that assume simplistic, linear identification of a single cause.

The focus of a system-based approach is examining the components of a system (e.g. person(s), tasks, tools and technology, the environment, the wider organisation) and understanding their interdependencies (i.e. how they influence each other) and how those interdependencies may contribute to patient safety.

A system-based approach will identify where changes need to be made internally in the Trust and collaboratively with our partners/ external agencies to improve healthcare across the system for our patients.

Strengthened governance and oversight:

- Regulators and bodies like Integrated Care Board (ICB) and Commissioners will consider the strength and effectiveness of organisations' incident response processes
- Makes leaders of organisations providing healthcare accountable for how their organisation responds and improves following patient safety incidents.

Where previously, we have had set timescales and external organisations to approve what we do – the framework gives us a set of principles that we will work to, and we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents.

The plan should be considered alongside the Patient Safety Incident Response Framework Policy which outlines the requirements of the framework and the 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.

2a. Strategic aims

The plan has the following strategic aims:

- Improve the safety of the care we provide to our patients, and improve our patients', their families', and carers' experience of it.
- Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.
- Further develop systems of care to continually improve their quality and efficiency.
- Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a patient safety incident investigation is identified.
- Improve the use of valuable healthcare resources.

2b. Strategic objectives

We are working to achieve the following strategic objectives through the implementation and transition to this plan:

- Act on feedback from patients, families, carers, and staff about the current problems with patient safety incident response and patient safety incident investigations in the NHS.
- Develop a climate that supports a just culture and an effective learning response to patient safety incidents.

- Develop a local board-led and commissioner and integrated care system around patient safety incident investigations and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.
- Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents. The aim is to:
    - make investigations more rigorous and, with this, identify causal factors and system-based improvements
    - engage patients, families, carers and staff in investigations and other responses to incidents, for better understanding of the issues and causal factors
    - develop and implement improvements more effectively
    - explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

3. Our services

We are the main provider of community health, specialist mental health and learning disabilities services for people across Hampshire and Isle of Wight. We serve the population across all areas of Hampshire, Portsmouth, Southampton and Isle of Wight, with care available for every stage of their lives. The range of services the Trust provides is detailed below.

The range of services provided includes:

Adult mental health services including	• Adult and older people's inpatient wards and Places of safety. • Community and Crisis Support Teams, Crisis house and crisis alternatives. • Low and medium secure services for adults including a learning disability unit. • Eating disorders, early intervention in psychosis, gambling and stalking support. • NHS talking therapies Acute hospital psychiatric liaison and mental health NHS 111.
Services for children and families including	• Child and adolescent mental health services, including low/medium secure inpatients. • Health visiting, School nursing, Child Health services and immunisations. • Children's paediatrics, therapies and continuing care. • Perinatal and maternal mental health services. • Safeguarding and looked after children.
Physical health services including	• Community nursing, therapies and palliative care. • Community hospitals, urgent treatment centres, urgent response and virtual wards. • Outpatients, community diagnostic hubs & phlebotomy. • Musculo-skeletal, podiatry and pain management services. • Specialist teams e.g. tissue viability; bladder and bowel; falls; diabetes, neuro-rehab. • Sexual health, specialist dental and wheelchair services.
Primary Care	• Provision of some general practice services.
Learning disability	• Community learning disability services for children, young people and adults.

Please refer to the full business plan for the Trust via this link SH02480_Fusion_FBC_document.pdf (mcusercontent.com).

4. How we defined our patient safety incident profile

We have a continuous commitment to learning from patient safety incidents as set out in our patient safety commitment which outlined our response to the NHS National

Patient Safety Strategy 2019. We have and continue to develop our understanding and insights into patient safety issues over a period of years.

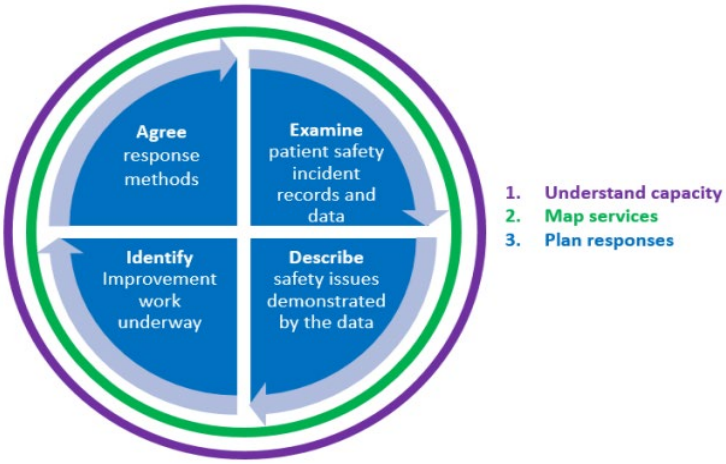
For the development of this plan, Southern Health NHS Foundation Trust, Solent NHS Trust and Isle of Wight Trust have collaborated and included the individual organisation's plans prior to the new Trust forming. Please see appendix A for the plans.

The PSIRF Plan will be reviewed after the first year of the new Trust to understand if our patient safety incident profile has changed and our response plan will require updating.

Development and Oversight

The development of our PSIRF Plan followed the nationally recommended implementation project phases and a summary of how we did this is outlined below:

- Project Manager to develop plan and monitor workstreams
- Implementation Working Group and Oversight Group
- PSIRF Training group
- Focussed meetings with Director of Nursing and Chief Medical Officer
- Early orientation to Board and Quality and Safety Committee
- Hampshire and Isle of Wight Patient Safety Incident Response Framework group



Stakeholder Engagement

The Patient Safety Team's, within Southern Health NHS Foundation Trust and Solent NHS Trust, commenced planning for transition to the new framework in advance of the national release of documents in August 2022. We engaged with key stakeholders, both internal (including subject matter experts, clinical staff, patients and carers) and external (including local and specialist commissioners and other providers in Hampshire). To ensure wide stakeholder engagement for this new framework and the creation of this plan the information was shared with various internal and external groups of staff and committees as shown below to provide comments.

- Attendance at NHS England PSIRF webinars

- 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 meetings with Director of Nursing and AHP, Chief of Nursing and Allied, Healthcare Professionals and Deputy Chief Medical Officer
- Updates provided to key meetings including Quality Assurance Committee and the Trust Board
- Hampshire and Isle of Wight Patient Safety Incident Response Framework group
- Project Fusion PSIRF Group

Please refer to previous organisation's PSIRF Plans (appendix A) which provides additional details on how we engaged with our stakeholders, numbers of sessions and attendees.

We consulted extensively with several early adopters, including Isle of Wight Trust and Community and Mental Health Trusts, to enable us to understand the practicalities of planning for and implementation of the framework and their assistance has been invaluable.

This process also involved identification and specification of the methods used to maximise learning and improvement which led to the development of the local focus for our incident responses listed on page 14-19.

The framework is a key component of the Just and Learning Culture Strategy and more information about how a just culture will be embedded is available in the PSIRF Policy.

Data Analysis

To define our patient safety incident response profile, data from a variety of sources was considered alongside the feedback and information provided by internal stakeholders and subject matter expert. Data and information (both qualitative and quantitative) that were considered included:

- Patient safety incidents from our incident system. The time period for this varied across the previous organisations, please refer to the PSIRF Plans in appendix A
- Serious incident and high risk/red root cause analysis investigations
- Complaints and concerns
- Patient and staff surveys regarding patient safety and communication
- Freedom To Speak Up cases
- Risks (Solent NHS Trust)
- Claims
- Inequalities data

Where possible we considered what any elements of the data tell us about inequalities in patient safety. As part of our workshops, we considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

Patient safety issues highlighted by the 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 for Southern Health NHS Foundation Trust and Table 2 for Solent NHS Trust.

As part of the preparation work for the Trust, the Isle of Wight considered incidents relevant to mental health and community services, which are in the main, set out in tables 1 and 2 below.

Sussex Partnership NHS Trust advised that their plan does not include specific priorities for the Children and Adolescent Mental Health Services transferring into the Trust. In quarter one 2024/25, work will be undertaken to define suitable priorities for these services.

Table 1 – Summary of top patient safety incidents per service (Southern Health NHS Foundation Trust)

Service	Incident Category
Adult mental health	• Self harm or self injurious behaviour • Disruptive or dangerous behaviour • Medicines management incidents • Assault, abuse or threat to service user • Treatment or care related issue • Admission and discharge
Older persons mental health	• Slip, trip or fall - service user • Medicines management incidents • Assault, abuse or threat to service user • Disruptive or dangerous behaviour • Accident, injury or medical emergency -service user
Learning Disabilities	• Assault, abuse or threat to staff • Adult safeguarding – non Southern Health • Disruptive or dangerous behaviour • Information governance or confidentiality breach
Children and adolescent mental health services	• Self harm or self injurious behaviour • Treatment or care related issue • Disruptive or dangerous behaviour • Security concern • Medicines management incidents
Childrens and families	• Staffing issues • Documentation, communication recording non information governance • Treatment or care related issue • Information governance or confidentiality breach • Child safeguarding - non Southern Health
Adult forensic	• Assault, abuse or threat to staff • Security concern • Disruptive or dangerous behaviour • Medicines management incidents • Self harm or self injurious behaviour
Physical health	• Pressure ulcer-develop/deteriorate since admission

	• Slip, trip or fall - service user • Medicines management incidents • Documentation, communication recording non information governance • Treatment or care related issue
Others incident categories	• Restrictive practice – in particular prone restraints • Suicides • Infection prevention control • Place of safety breaches

Table 2 – Summary of top patient safety issues per service (Solent NHS Trust)

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

These incident categories were considered with support from internal stakeholders, with further details on the subcategories within the themes considered to determine our patient safety incident profile.

5. Our patient safety incident response plan: national requirements

The framework allows us to use resources to maximise improvement, 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 3 and we fully endorse this approach as it supports the aim to learn and improve within a just and restorative culture. The table reflects the national priorities that are relevant to us, please refer to the Guide to

responding proportionately to patient safety incidents for the full list of national requirements. The approach to these incidents will be discussed with the relevant commissioners for the service.

Table 3 – National patient safety incident priorities relevant to the Trust

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	Create local organisational actions and feed these into the quality improvement strategy
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 strategy
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 strategy 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 strategy 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 strategy to evidence learning and changes to practice as a result.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR)	Respond to recommendations as required and feed actions into the quality improvement strategy to evidence

	Locally led patient safety incident investigation (or other response) may be required alongside the LeDeR – organisations should liaise with this	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. Refer for Child Death Overview Panel review	Respond to recommendations as required and feed actions into the quality improvement strategy to evidence learning and changes to practice as a result.
Safeguarding incidents in which: Babies, child, 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 the quality improvement strategy 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 strategy to evidence learning and changes to practice as a result.

6. Our patient safety incident response plan: local focus

The framework allows us to explore patient safety incidents relevant to their context and the populations served. Table 4 sets out the combined local priorities from all three organisations.

Table 4 – Local patient safety incident priorities

Patient safety incident type or issue	Planned response	Anticipated improvement route
Combined priorities across all 3 organisations		
Suspected/completed/attempted Suicides in inpatients and patients receiving mental health care under the Trust's services	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.
Critical Medication errors	Review from Medicines Safety Officer followed by routine thematic analysis presented 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 Divisional/Service Line Governance and upward reporting through the governance structures.
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.
Delayed Recognition of deterioration of an inpatient requiring admission to an acute hospital or resulting in death (excluding palliative care/end of life care)	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 Divisional/Service Line Governance and upward reporting through the governance structures.
Patient under the Mental Health Act who go Absent Without Leave and/or escape from a forensic unit or abscond from an inpatient unit	SWARM Huddle After action review Patient safety incident investigation	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 Divisional/Service Line Governance and upward reporting through the governance structures.

Category 3 and 4 pressure Ulcers (In HIOWH NHSFT newly acquired or deterioration) (under review due to national changes pending)	Review by Tissue Viability specialists using bespoke template followed by monthly thematic analysis to Patient Safety Group for Physical Health. 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 Divisional/Service Line Governance and upward reporting through the governance structures.
Communication issues with relatives resulting in patient safety incidents for patients receiving care from Mental Health Services	SWARM huddle for single cases. Multi-Disciplinary team review for themes in multiple cases	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 Divisional/Service Line Governance and upward reporting through the governance structures.
Communication issues with patients/ parents/carers and Legal Guardians resulting in patient safety incidents for patient receiving Child and Family Services care	SWARM huddle for single cases. Multi-Disciplinary team review for themes in multiple cases	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 Divisional/Service Line Governance and upward reporting through the governance structures.
Inpatient slips, trips and falls (scope/focus TBC SHFT reviewing, falls lead SHFT/Solent)	SWARM huddle	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 Divisional/Service Line Governance and upward reporting through the governance structures.
Southern Health Local Priorities		
Access/admission/handover/discharge/ transfer issues (TBC currently under SHFT Review)	SWARM huddle	Identify safety actions to be added onto local quality improvement plans

	After action review / Patient safety incident investigation	Quality improvement project
Disruptive or dangerous behaviour by a service user to other service users (TBC currently under SHFT Review as most of these meet safeguarding referral threshold)	SWARM huddle After action review / Patient safety incident investigation	Identify safety actions to be added onto local quality improvement plans Quality improvement project
Self-harm resulting in admissions to an acute hospital/ Emergency Departments	SWARM huddle After action review	Identify safety actions to be added onto local quality improvement plans Quality improvement project
Restrictive Practice: • Pharmacological restraint • Prolonged prone restraint (over 4 minutes) • Failure of de-escalation and/or repeated restraint • Prolonged seclusion and long-term segregation (Currently under SHFT Review via Restrictive Practice Committee)	SWARM huddle After action review / Patient safety incident investigation	Identify safety actions to be added onto local quality improvement plans Quality improvement project

The most appropriate learning response to support the identification of learning will be decided at a weekly incident response meeting as part of the governance process (appendix B).

Thematic reviews will be utilised as a learning response tool for any local or national priority when a theme or trend has been identified. A thematic review could also be used following a series of after action reviews which have identified a learning theme.

Additionally:

- any patient safety incident resulting in significant learning outside of the local priorities will be considered at a triage meeting (see appendix B).
- Patient safety incidents with low learning identified will be considered at local level and any safety actions identified in local quality improvement plans. When a theme of low learning incident types is identified this will be considered for a thematic review.

A number of incident types have been excluded from the priority categories as they have improvement delivery plans in place based on learning identified from previous investigations. Please refer to appendix C for these incident types.

Delivery of these improvement plans will be monitored by the Patient Safety Team and via their respective specialist subgroup. A combination of both process and outcome metrics will be utilised to measure their effectiveness once fully complete.

We will use the outcomes of the learning responses to inform our patient safety improvement planning and it will also inform our next patient safety strategy.

Key points for clarification:

- All incidents will continue to be reported in line with the Trust's existing patient safety incident reporting guidance 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 learning, or these may 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.
- Completed thematic reviews will be reviewed and discussed at their appropriate forums to identify required improvement actions.
- Oversight of improvement will be agreed with the Integrated Care Board.
- Mortality reviews will not form part of the process unless they are a patient safety incident (refer to the Trust's Learning From Deaths Policy)
- Staff health and safety incidents will be reviewed under a separate process however where this is related to a patient safety incident a joined-up review approach will be explored.
- A resource analysis was undertaken to identify the anticipated capacity to support the transition to the framework. There is sufficient capacity in the Investigating Officers Team to support the number of anticipated Patient Safety Incident Investigations which require to be carried out by expert investigators. The analysis has considered capacity for additional ad-hoc patient safety incident investigation, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.
- For incidents involving other providers, the Trust will work collaboratively with the identified provider to complete a joint investigation where required.

6a. 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:

Learning Tool	What is it?	Who conducts it?	Timeframes
SWARM Huddle	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.	Team Lead/Ward Manager	Ideally during the same shift or within 48 hours
Multi-Disciplinary 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)	To be led by a patient safety facilitator who will use the MDT as source of data for learning about a series of	30 working days

	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.	events or a theme	
After Action Review	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. After action review generates insight from the various perspectives of the multi-disciplinary team.	A Senior Lead who hasn't been involved in the incident. This could be anyone from within the multi-disciplinary team, local or remote to the participants	30 working days
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	Subject Matter Experts, Investigating Officers, or other suitably trained professionals who will use the multi-disciplinary team review as one source of data for learning about a series of events or a theme	30-60 working 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 Officer	60 working days – depending upon complexity of the case and agreement with patient/family, this will take no

			longer than 6 months

Clinical Teams will be responsible for undertaking local learning responses such as a SWARM huddle, after action review and multi-disciplinary reviews, however our Investigating Officers and suitably trained professionals can provide support and coaching.

In addition to support and coaching, training on the learning response tools will be delivered across the Trust via the Quality and Patient Safety Team.

6b. Support for clinical teams

It is recognised that implementation of this new framework is a significant change in culture, mind set and processes for teams within the Trust. which will require a focus on behaviour and implementation science. Extensive work has been undertaken with various forms of communication and engagement with key stakeholders for the development of this plan. Alongside this, the Trust are upskilling clinical teams to undertake good quality learning responses and implement improvements through nationally mandated training, coaching and support during the transition period by Investigating Officers and suitably trained professionals.

Training
The Patient Safety Incident Review Framework has three training requirements set out for learning response leads, engagement leads and those in an oversight role, these include:

1. **Involving those affected in the Learning Process**
   - Effective communication and involvement
   - Being open and apologising, Duty of Candour
   - Compassionate Engagement with those affected
   - Just Culture

2. **Systems Approach to learning from patient safety incidents**
   - Introduction to complex systems, system thinking and human factors
   - Learning response methods and capturing work as done e.g. SWARM huddles or after action reviews
   - Safety action, monitoring and improvement

3. **Oversight of Learning from Patient Safety Incidents**
   - Effective oversight and supporting processes
   - Maintaining an open, transparent and improvement focused culture
   - Patient Safety Incident Investigation commissioning

Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Further details are outlined in the Patient Safety Incident Response Framework Policy.

In addition to the specific PSIRF training requirements, staff are to complete levels 1 and 2 of the Patient Safety Syllabus which is available via Learning and Development Platform:

- Level 1 - Essentials of Patient Safety for all NHS staff
  - All staff
  - Board and Senior Leaders

- Level 2 - Access to Practice
  - System Thinking and Risk
  - Human Factors and Safety Culture

7. How we defined our patient safety improvement profile

The framework will support us in our drive to constantly improve our services with the aim for the people who use our services, their families, and carers, to have the best possible experience and outcomes.

Quality Improvement is an essential part of our approach where we use a standard set of tools to enable staff to make improvements to their services.

Our Quality Improvement approach involves:

- Identifying a specific area for improvement
- Taking the time to fully understand the situation from different perspectives, gathering data and feedback
- Using techniques to find solutions, involving staff (and other professionals), patients and families so everyone has a voice
- Constantly testing and adapting once changes have been made.

As part of this framework, we plan to focus on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally utilising our Quality Improvement approach.

Our aim is for everyone in the Trust to use Quality Improvement in their teams and services. Quality Improvement empowers our staff, patients, and carers - and helps us develop a culture of continuous learning and improvement. The Quality Improvement Team offer staff training in various forms and provide advice and support for projects underway.

National patient safety improvement programmes

There are five national patient safety improvement programmes from NHS England, three of which are relevant to our Trust. The programmes each have a set of aims and objectives to achieve over a number of years and they support a culture of safety, continuous learning and sustainable improvement across the healthcare system.

Alongside the national patient safety improvement programmes, the NHS England Patient Safety Strategy illustrates a number of improvement objectives which are carried out within the Trust. These include safety of older people, safety of those with a learning disability and antimicrobial resistance and healthcare-associated infections.

Monitoring of actions and improvements
Local quality improvement projects and actions identified from patient safety incident investigations are monitoring by divisional/service line governance.

Trust wide improvement projects are monitored through the most appropriate forum for example Clinical Safety Group, Quality Oversight Group, and Quality Committee. The Integrated Care Board are a key part of these groups to support a system wide approach to learning and improvement and enable improvement oversight.

8. Next steps to strengthen our Patient Safety Incident Response Framework during transition

- Triage process in place to ensure all patient safety incidents are managed appropriately as per this framework.
- Ongoing engagement with key stakeholders and feedback from staff, patients, families and carers.
- Continued promotion of a Just and Learning Culture and improved psychological safety for colleagues. Further work to improve our patient safety culture using the NHS England's improving safety culture practical guide.
- Evaluate effectiveness of learning response tools for our local patient safety priorities. Explore the opportunities of digital tools to support this.
- Monitoring of the compliance and culture change required related to Being Open and Duty of Candour for all incidents resulting in moderate harm or above.
- Ascertain staff feedback of their experience with the new framework including ownership and engagement.
- Define outcome measures to support the compliance of the framework standards and the effectiveness of the learning identified.
- Any actions that resulted from learning tools prior to the forming of the new organisation, will be tracked through the Quality and Patient Safety Team.
- The plan will be subject to ongoing refinements and a full review is schedule for August 2025.

Appendix A – Previous Organisation's PSIRF Plans

Southern Health NHS Foundation Trust

Patient Safety Incident Framework

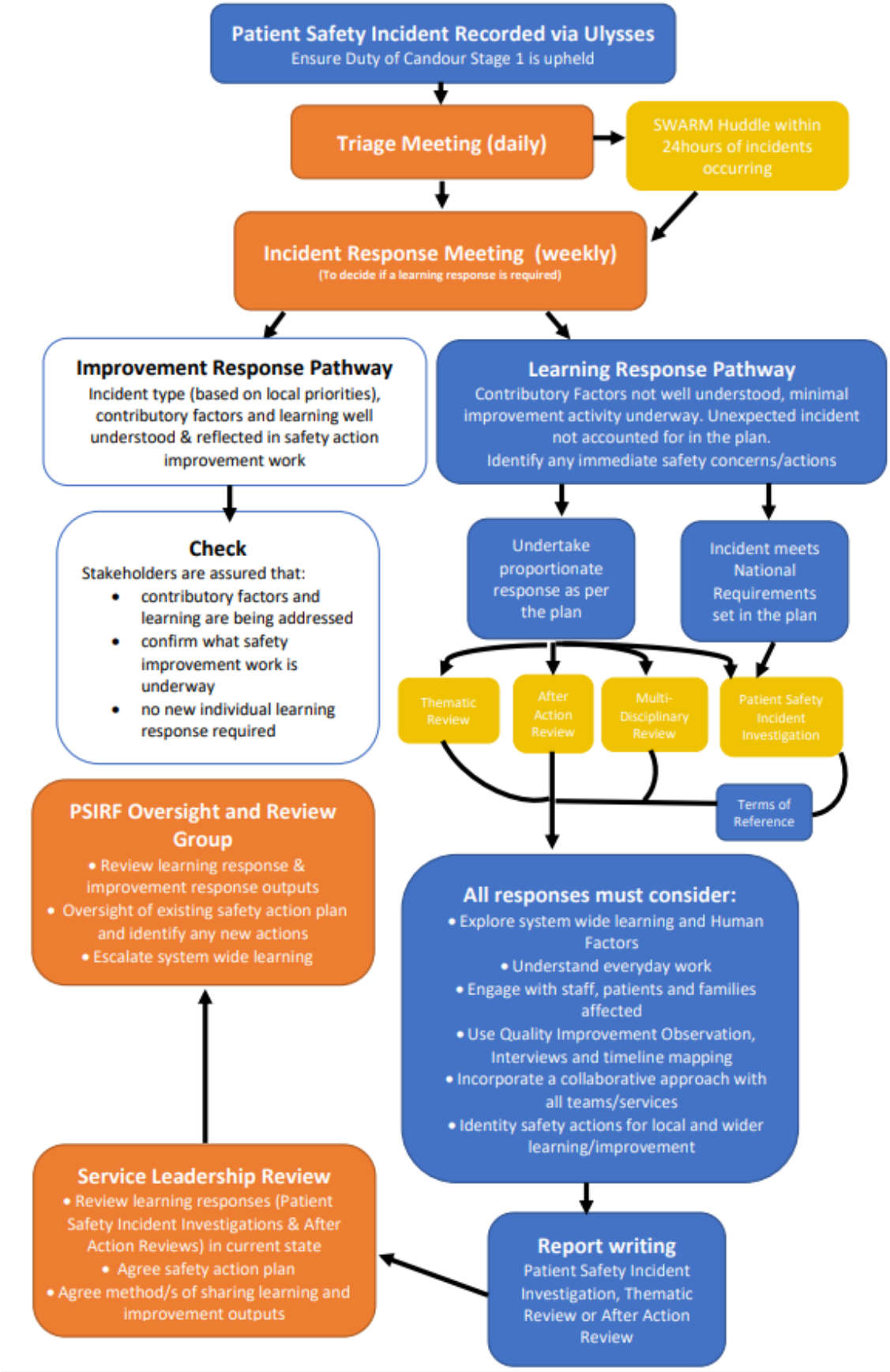
Solent NHS Trust

Patient Safety Incident Response F

Isle of Wight Trust

PSIRP 2023-24 Local Priorities plan..pdf

Appendix B – Patient Safety Incident Response Governance Structure



Appendix C – Other incident management

Patient safety incident type or issue	Planned response	Anticipated improvement route
Death's that do not meet 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 Patient 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.
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	Review by operational managers in conjunction with Infection Control and Prevention team and cross system reporting, as necessary. 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 Patient Safety Team if there are significant safety concerns. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised Notifiable diseases will be reported to Board and Public Health England as per Trust policy	Create local safety actions and feed these into the quality improvement programme when required.

closure or decontamination issue		
Place of safety breaches*	Review at separate Place of Safety panel for grading and response type *If moderate harm or above, these will be reviewed in line with the framework	Identify safety actions to be added onto local quality improvement plans

Appendix D – Glossary of terms

Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the framework is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

Patient safety incident investigation
Patient safety incident investigations are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

After action review
After action reviews are a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents.

Multi-Disciplinary Review
An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.

SWARM Huddle
The SWARM huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

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.

Older Persons Mental Health
An inpatient or community service for people older than 65 with a functional or organic mental health illness such as depression, schizophrenia, or dementia.

Adults Mental Health

An inpatient or community service for adults with mental health illnesses such as depression, schizophrenia, mood disorders and anxiety.

Child and Adolescent Mental Health Services
Services that support young people experiencing poor mental health, or difficult feelings or experiences. Child and Adolescent Mental Health Services can work with schools, charities, and local authorities.

Psychiatric Intensive Care Unit
Psychiatric Intensive Care is offered to service users who are compulsorily detained and require treatment in low secure conditions during an acutely disturbed phase of serious mental disorder.

Ministry of Defence
The Ministry of Defence is the department responsible for implementing the defence policy set by His Majesty's Government and is the headquarters of the British Armed Forces.

Critical Incident Stress Management
A voluntary and confidential service for all staff that offers you and your team support following traumatic or critical incidents. It is operated by colleagues who offer this service in addition to their normal 'day jobs'. They have undergone specific and intensive training (and receive ongoing supervision and updates), to enable them to offer a specific model of support to colleagues following traumatic incidents in the workplace.

Absent Without Leave
A service user is absent without leave if s/he is away from the ward without prior arrangement or the agreement of the multidisciplinary team. This may occur because the service user has absconded or because the service user has failed to return from agreed leave. The service user's whereabouts may be known to staff.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Board and Committee Summary Report

Title of Paper	Equality Delivery System (EDS 2024)
Date of paper	5 April 2024
Presentation to	Board
Item No.	13.1
Author(s)	Elton Dzikiti, Diversity and Inclusion Partner
Executive Sponsor	Sorrelle Ford
Executive Summary	Equality Delivery System (EDS) implementation by NHS provider organisations is **mandatory** as per the NHS Standard Contract and is aligned to NHS England's Long-Term Plan. Specifically, the commitment to an inclusive NHS that is fair and accessible to all. Solent has worked alongside Southern Health NHS Foundation Trust to undertake this year's EDS, although the focus was still on sovereign service lines. The action plan will, however, be developed be reviewed to see how best actions can best be implemented for the new organisation. Reviewed activity for all domains has been found to be 'achieving', just one tier short of the 'Excelling' category.

Action Required	For decision?	(Y)	For assurance?	(Y)

Summary of Recommendations	The Board is asked to: • receive the report • agree to the rating of 'achieving' based on the evidence reviewed and provided in the main report

Statement on impact on inequalities	Positive impact (inc. details below)	x	Negative Impact (inc. details below)		No impact (neutral)	
Positive / negative inequalities	EDS allows us to review and develop our approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.					
Previously considered at	JCNC					

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	x	10. New ways of working	x	14. Supportive Environments	x
4. Life-course approach		11. Growing for the future	x	15. Partnership and added value	x
5. One health and care team					
6. Research and innovation	x				
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	*Sorrelle Ford* Chief People Officer

Equality Delivery System

1. Purpose

- EDS implementation by NHS provider organisations is **mandatory** as per the NHS Standard Contract and is aligned to NHS England's Long-Term Plan. Specifically, the commitment to an inclusive NHS that is fair and accessible to all.

- EDS comprises 11 outcomes spread across three **domains**: 1. Commissioned or provided services 2. Workforce health and wellbeing 3. Inclusive leadership. The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement.

- For this year, we are undertaking EDS as an **individual** organisation, but working alongside Southern Health NHS Foundation Trust. An action plan will be developed jointly.

- Guidance to support assessment of Domains 1 of EDS allows organisations to review a specific service and to use the learning from the process to expand the impact. Within Solent, a decision was made to start with a focus on Children and Family Services with a view to expanding this to other services in the future. The review engaged with people across the whole organisation, such as corporate teams, staff networks, unions etc. The report has drawn on other evidence from surveys and reports such as WRES; WDES and the Annual Staff Survey.

2. Situation, Background and Actions to date

Meetings have been held with various stakeholder, in particular with those that have contributed evidence such as Child and Family Services leadership team; Occupational Health, Governance and Community Engagement Services. Meetings have also included senior Equality, Diversity, Inclusion and Belonging leads both within Solent and Southern Health NHS Foundation Trust. Collated evidence has been reviewed and rated based on the given scoring rate for the three domains.

Through collaboration with stakeholders, we have agreed an overall EDS Organisation Rating of **Achieving Activity**.

1. Assessment - Risks and Issues

There haven't been any major identified risks and issues.

2. Next steps and actions

- Following presentation of the EDS report to the People Committee, JCNC and the Board, stakeholders will continue to be involved in a further review of the information provided before submission to NHS England/publication on the Trust website.

- A detailed action plan to identify the actions we need to take to move, sustain or improve our rating will be developed alongside Southern Health NHS Foundation Trust

- The EDS review will be included in the **Public Sector Equality Duty** (**PSED**) report, which will be published by 30 March 2025.

Item 14.2

Solent NHS Trust – Equality Delivery System 2 submission April 2024

1.0 What is the Equality Delivery System 2 (EDS2)

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

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

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers, 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. Aspirate

2.0 Scoring system

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

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

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

How we compare with last year's score

Our overall score last year was 22. While have achieved 22 again for this year, this has to be seen in the context of maturity of services that submitted themselves for review – as well the evidence provided. The 'stagnant' score isn't necessarily pointing to a deterioration or lack of progress on how as a Trust we are performing. Rather, it is a reflection of the differences that can be observed between and among individual teams and how evidence is gathered over the course of the year. The Action Plan will, therefore, reflect a need to encourage the consistent collection and collation of evidence across all service lines as that will allow us to observe and analyse comparable patterns and themes.

3.0 Summary of assessment (Full assessment provided in appendix 1)

DOMAIN 1 - Commissioned or Provided services

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

Achieving activity (2)

EDS allows organisations to focus on a specific service as a starting point for discussion. In order for this to be a meaningful exercise, it is important that the learning from the assessment is disseminated to other services. For purposes of the Domain 1 submission, Solent mainly focused on the Learning Disability Service (LD) but also considered, separately, evidence from initiatives such as

i. **The Solent GP Surgery** - the Community Engagement Team worked with the surgery and local community to address issues of accessibility and reported negative experiences.
ii. **The Building Resilience and Strengths –** The Equality, Diversity, Inclusion and Belonging Team facilitated sessions on anti racism, enabling teams to explore, through a safe space, race, equality, diversity and unconscious bias without judgement

- **Bilingualism -** The Bilingualism template on Systm 1 has been amended to reflect the principles from an audit undertaken by Child and Family Services

The review considered evidence from a national survey (Year 4 Learning Disability Improvement Standards (LDIS)) that the LD survey participated in, which revealed we fulfil the objectives of national policy and strategy regarding the provision of services for people with a learning disability, autism or both.

Tellingly, 71% of patients (or carers) surveyed greed that if they needed to be seen in an emergency they were seen quickly. The national average was 59%.

Over the last year, LD has introduced a number of initiatives such as sensory boxes – offered to all services across the Trust. Many people with learning disabilities and neurodivergent conditions experience sensory overload, especially in busy and stressful situations. Healthcare environments can be incredibly overwhelming. This can have a significant impact on engagement with services and an individual's anxiety levels. Many people can benefit from some very simple sensory techniques which help them manage.

Having considered the evidence, a score for developing activity has been recommended as the review of LD is based on just but one metric, that is a national survey, which may have missed a lot more local nuance. It would be good, for example, for the service to initiate or generate local and regular surveys to ensure they provide ample opportunities for services users to provide their feedback.

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

Achieving activity (2)

Evidence from the national Year 4 Learning Disability Improvement Standards (LDIS) survey demonstrated that Solent NHS Trust demonstrated:

- were one of 50% of trusts reporting able to isolate/disaggregate specific outcome data regarding patients with a learning disability.

- were one of 57% of trusts readily able to identify children, young people and adults with a Learning Disability and/or autistic patients, who are on waiting lists for assessments and/or treatment.
- on average, 0.8% of patients on EPR systems had an LD flag.

Additional evidence considered for this domain included:

- Participation by Public Health staff at the Partnership for Education Attainment and Children's Health (PEACH) programme in July 2023. PEACH was created to support schools in improving the health and wellbeing of their pupils, staff and families through physical activity, healthy eating, PSHE and emotional wellbeing and mental health
- The Community Engagement Team has been working closely with some of our marginalised communities to get a better understanding of their health needs and a better understanding of how they want to receive health services

The score for this outcome is 2 and is described as a 'achieving activity'. To increase the score we need to provide evidence to demonstrate what the data is telling us and what we have done to address any inequalities identified. We also need for the patient voice and participation to be even more pronounced in the initiatives.

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

Achieving activity (2)

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

The national Year 4 Learning Disability Improvement Standards (LDIS) survey showed that on average, 2.9% of total complaints received were regarding the care and treatment of patients with a learning disability during 2021/2022. Solent had received no such complaints.

We were also one of 50% of Trusts who are using "Ask Listen Do" good practice resources to improve feedback, concerns and complaints for children, autistic people and families.

However, to achieve a higher scoring, it is recommended that more detailed work is undertaken to engage with services to ensure everyone is safe and free from harm – and importantly – is aware of processes to make complaints (and are supported in doing so).

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

Achieving activity (2)

According to the Learning Disability Improvement Standards report:

- 80% of patients stated that staff did listen to what their family thought. This is slightly higher than the national average of 76%
- 89% of patients agreed that staff told them about appointments and meetings in a way they could understand. This is better than the national average of 78%
- 89% of patients agreed that it if they stayed in hospital, it was easy for their family to visit them. This is higher than the national average of 68%

The score for this outcome is 2 but the Trust can improve even further by understanding the experiences of the patients who did not feel listened to; told about their appointments in a way they understand or found it wasn't easy for their family to visit them in hospital.

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

Achieving activity (2)

There are a lot of options in place to support staff manage their physical and mental health, largely led by the Occupational Health.

The score for this outcome is 2 and is described as a 'achieving activity. In order to increase the score to 3, we would expect to see data broken down so that we can assess whether proactive steps are taken to offer support to communities where the risk of prevalence of a particular condition is higher.

Although there are a lot of available opportunities, there needs to be more work done to check if staff are aware of these provisions and address any barriers to access.

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

Achieving activity (2)

The assessment does not address this outcome in sufficient detail.

The score for this outcome is 2 and is described as a 'achieving activity', only because there is evidence relied on such as the Workforce Race Equality Standard Data and annual Staff Survey.

In order to increase the score, we would need to cross reference this outcome with action plans from previous staff surveys data and employee feedback to demonstrate a significant decrease in bullying and physical violence from any source.

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

Achieving activity (2)

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

The score for this outcome is 2 and is described as 'achieving'. In order to increase the score to 3 we need to see a breakdown of data to assess whether support is delivered in a way that takes cultural differences into account. Gathering of data to demonstrate that access to these support offers is equitable for people from under-represented groups would also improve this score.

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

Achieving activity (2)

National comparisons of Staff survey data confirm that Solent is one of the top 3 Mental Health and Community trusts to be recommended as a place to work (with a score of 72.6%). The assessment demonstrates that there is a significant amount of activity to support the Health and Wellbeing of our staff.

The score for this outcome is 2. The assessment could be further enhanced through the inclusion of data and tables to confirm the scores when benchmarked against peer organisations. Important to break down the survey results to understand differential responses for underrepresented groups, including Internationally Educated Nurses/staff where there have been known to be issues.

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

Achieving activity (2)

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

The score for this outcome is 2 and could be improved by reviewing data and information to confirm that the Senior Leadership team are leading and addressing health and workforce equalities across all service lines.

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

Achieving activity (2)

Board papers reviewed have provided a wealth of evidence in equality, diversity, inclusion and belonging being considered or incorporated as part of decision making. Instructive papers taken to board include:

- EDS action plan update to Board June 2023
- EDIB Annual Report to Board August 2023
- Working with people and communities annual report

The score for this outcome is 2 and is described as a 'achieving activity'. In order to increase the score there is a need to demonstrate that actions are in place to identify and address the inequalities – and there is follow through on commitments made by senior leadership.

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

Achieving activity (2)

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

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

The score for this outcome is 2 and is described as achieving. In order to increase the score to 3 we would need evidence that staff and patients have been involved in assessing our compliance.

5.0 Conclusion

Domain	Outcome	Score
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	2
	1B: Individual patients (service users) health needs are met	2
	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	2
	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	2
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	2
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	2
	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**

EDS Action Plan				
EDS Lead- Anna Rowen / Elton Dzikiti			**Year(s) active -** 2023-2024	
EDS Sponsor – Sorrelle Ford			**Authorisation date -**	
Domain	**Outcome**	**Objective**	**Action**	**Completion date**
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	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. .	This will be done by: • creating engagement opportunities with service users to identify barriers and lead to actions that improve access. This will be done in partnership with • the Community Engagement Team • the Academy The Children and Family service line will continue to manage and analyse patient data to understand and implement improvement measures. The expected outcome of this will be: • a positive impact on waiting times • evidence that access to treatment is equitable. Am action plan has been developed by the Child and Family Services, which will, among others, result in: • Staff across C&F services having opportunities to partake in inclusive supervision which includes reflective practice, case audit and eyes on training/supervision • Staff following Trust guidance for recruitment allies alongside service line guidance for use of young recruiters and parent/carer representatives	Sept 24 March 25 End of Q4 24/25 End of Q1 24/25

	1B: Individual patients (service users) health needs are met	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.	This will be done by increasing engagement and access to services from unrepresented groups such as BAME communities, people in the traveller community, those experiencing deprivation and poverty This will be achieved through continued collaborative work with the • Service line, • Participation leads • Community Engagement Team • Equality and Diversity Team It will further create engagement opportunities using discovery conversations and a strengths-based asset approach which will further ensure health needs are being met. This approach will ensure that quantitative and qualitive data is used to inform what impact of actions to date and what else needs to be done to address any inequalities identified.	Sept 24 Dec 25
	1C: When patients (service users) use the service, they are free from harm	To ensure that Co-production continues in a sustained way to support the development and delivery of services.	This will be done by: • ensuring co-production from early onset of service scoping, design and delivery. • ensuring patient voice is reflected and embedded in on going service delivery programmes and quality assurance cycles. This will be done through the continued collaborative work of: • Service line • Participation leads • Community Engagement Team • Equality and Diversity Team	Ongoing

	1D: Patients (service users) report positive experiences of the service	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.	This will be done by. • developing the data collection that illustrates a demographic breakdown • ensuring feedback from people from under-represented groups is equivalent to feedback from people from majority groups. • Supporting service lines to work with communities to understand different ways of collecting their feedback • implementing inclusive and transparent feedback mechanisms across service lines	Ongoing

Domain	Outcome	Objective	Action	Completion date
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	To understand the extent to which different groups of people access health offers, particularly where prevalence of certain health conditions are higher. Use this information to proactively address any inequalities identified.	To improve • the way we communicate with staff about health and wellbeing services ensuring we develop targeted messaged for groups at higher risk of certain health conditions • the approach we take to reach marginalised or hard to reach groups This would be achieved by: • ensuring data is broken down and analysed to identify patterns of inequality • assessing whether proactive steps are being taken to offer support to communities where the risk of prevalence of a particular condition is higher.	Ongoing / March 25
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To support staff who experience harassment and improve accessibility to appropriate specialist support and advice.	To work with: • Occupational Health (professional health and wellbeing services) • People Partnering • the Trust Executive • and other stakeholders To: • ensure correct prevention processes are in place and to make access to professional support a simple process • assess impact of interventions and triangulate outcomes with those included in the staff survey action plan	Ongoing / March 25

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To improve the reach of access to mental health services for all staff groups	The Health and Wellbeing Plan (based on the NHSE Health and Wellbeing Framework) focuses on: • continually evaluating what is needed by staff • providing appropriate, easy to access levels of mental health support. In order to increase the score to 4 we need to see: • a breakdown of data to assess whether support is delivered in a way that takes cultural differences into account • Gathering of data to demonstrate that access to these support offers is equitable for people from under-represented groups	Ongoing / March 24
	2D: Staff recommend the organisation as a place to work and receive treatment	To continue to raise awareness of specialist support e.g., Musculoskeletal/physiotherapy access, menopause 1-1 support, Employee Disability and Neurodiversity Advice service	To do this we will: • promote these specialist services • measure impact on staff health and wellbeing as well as organisational factors such as sickness absence and retention rates. The assessment could be further enhanced: • through the inclusion of data and tables to confirm the scores when benchmarked against peer organisations • breaking down the survey results further to understand differential responses for underrepresented groups i.e. –is the number of Disabled staff at Solent recommending Solent as a place to work consistent with the Trust-wide response rate.	Ongoing / March 25

Domain	Outcome	Objective	Action	Completion date
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	To further develop the role modelling and voice of senior leaders and increase activated allyship	This will be done by: • maximising the opportunities already created for Board members and system leaders to champion equality and diversity (for example, measure impact of the allyship/ sponsorship staff networks) • collecting and analysing data and information to confirm that the Senior Leadership team are leading and addressing health and workforce equalities across all service lines e.g., Include a specific section in PRM and QIR reports which highlight inequalities.	Ongoing / March 25
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To ensure that a continued review of governance through an EDIB (Equality, diversity, inclusion and Belonging) lens is established as a norm and sustained consistent practise.	This will be done by: • Analysing board and committee papers (including cover papers) to assess the extent to which equality and health inequalities are considered and discussed and that actions are in place to identify and address the inequalities identified. Board papers include a question on Equality Impact, but this is not always completed so there is an opportunity to expand this section and ask for an EDI narrative.)	Ongoing / March 25
	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	Further engagement and ownership EDIB Plan and People Strategy- so to ensure that actions are owned and acted on at service line level	This will be done by: • Board members and leaders to be familiar with the EDIB action plan • sharing with teams to identify local actions to support and improve Equality, diversity, inclusion and belonging (EDIB). • providing evidence that staff and patients have been involved in assessing our compliance.	Ongoing / March 25

Board and Committee Summary Report

Title of Paper	People Committee Exception Report February 2024, for March Board				
Date of paper	14/02/2024				
Presentation to	In Public Board Meeting				
Item No.	15.1				
Author(s)	Tina King, Business Manager, People Directorate				
Executive Sponsor	Mike Watts, Trust Chair				
Executive Summary	This is to update the Board on the People Committee held on 8 February 2024. The Committee received an update on staff survey results (currently embargoed), Occupational Health and Wellbeing, Workforce Intelligence, Sickness absence, Employee Relation cases, BAF, Equality Delivery System Report, People Team activity, Fusion, Communications and engagement and the mid-year effectiveness results were reviewed. Issues with the transfer of new records to our OH system was discussed together with the unpredicted number of managers referrals from Southern Health which was causing 30% more workload than expected – more resource had been requested temporarily. The demand for the MMR jab and length of time an individual would need to take off work if they were affected by measles was discussed as a risk. Modelling within in the system will be explored around this issue. Closure of some of the OH services available to staff across the ICS including menopause, EDNA, MSK were highlighted due to removal of funding from ICS. This raised concerns. The length of time taken to resolve ER cases was discussed and the importance of being consistent in approach with all populations was discussed. The Committee asked for a summary at the next meeting of the long-term cases together with the improvements in People Practices and Just Culture. The EDS report was reviewed, and the Committee were assured that the overall scoring of 'achieving' was appropriate. This will now escalate to the Board. It was noted there will be one action plan for the new organisation.				
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)
Positive / negative inequalities					
Previously considered at	*N/A*				

Strategic Priority this paper relates to	Great Care		Great Place to Work		Great Value for Money	
	1. Safe effective services	x	8. Looking after our people	x	12.Digital transformation	
	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)*	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	 Mike Watts, Solent NHS Trust Chair							

Board and Committee Summary Report

Title of Paper	People Committee Exception Report March 2024, for April in Public Board				
Date of paper	26/03/2024				
Presentation to	In Public Board Meeting				
Item No.	15.2				
Author(s)	Tina King, Business Manager, People Directorate				
Executive Sponsor	Mike Watts, Trust Chair				
Executive Summary	This is to update the Board on the People Committee held on 21 March 2024. The Committee received regular updates including - Occupational Health and Wellbeing, Workforce Intelligence data, Employee Relation cases including a summary of the long -term cases and improvements made in People Practices. It was agreed that due to the transaction delay People Forum would be repurposed and be reinstated in a different format to be more aligned to transitional support. The Equality Diversity Inclusion and Belonging (EDIB) Action plan was reviewed. The staff survey results were also reviewed, and discussion took place how we carry the planning into the new Trust. The Committee requested 'Board to Floor' visits to take place for Corporate Teams as it was recognised that staff were feeling particularly unsettled in these areas, due to Fusion. The Committee asked for more assurance around rostering optimisation and requested a paper comes to the next meeting. They were particularly interested in keeping a close watch on staff taking annual leave from their substantive post and signing up to Bank shifts. The Committee wanted assurance that staff are getting the rest time that they need. This would be a piece of work picked up Head of People Services, working with services and our Deputy COO and will come back to the next Committee meeting. It was decided that, to provide the Committee with Assurance on how staff are currently feeling, there would be an agenda item at the next meeting with feedback from Wellbeing Bubbles, which are carried out within the Service Lines with the People Partners.				
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)	
Positive / negative inequalities					
Previously considered at	*N/A*				

Strategic Priority this paper relates to	Great Care		Great Place to Work		Great Value for Money	
	1. Safe effective services	x	8. Looking after our people	x	12.Digital transformation	
	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)*	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	 Mike Watts, Solent NHS Trust Chair							

Board and Committee Summary Report

Item 17

NHS Solent NHS Trust

Title of Paper	Audit and Risk Committee Escalation Report						
Date of paper	April 2024						
Presentation to	In Public Trust Board – April 2024						
Item No.	16						
Executive Summary	The aim of this paper is to update the In-Public Trust Board on items discussed at the Audit and Risk Committee meeting during February 2024.						
Action Required	For decision?		For assurance?	Y			
Summary of Recommendations	The In Public Trust Board is asked to: • Take assurance from the escalations reported by the February Audit and Risk Committee.						
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral)	x	
Previously considered at	N/A						

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

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

Level of Assurance *(tick one)*	Significant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance, the In-Public Trust Board is asked to consider whether this paper provides: Sufficient assurance, and, whether any additional reporting/ oversight is required by a Board Committee(s)							
Non-Executive Sponsor Signature	*David Kelham* David Kelham, Non-Executive Director and Audit and Risk Committee Chair							

Audit and Risk Escalation Report

Summary of business transacted at the February Audit and Risk meeting and escalations to report to April In-Public Trust Board meeting.

Internal Audit Update

The committee were briefed on the key areas from the February 2024 Internal Audit Progress report, noting the planned completion of the internal audit plan by 31st March, and planned handover arrangements between the internal audit teams.

The Committee received assurance from the February 2024 internal audit progress report.

External Audit Update

The committee received the audit planning report for 2023/24 and noted the learning from last year's audit. The Audit Committee Chair noted there were regular planned meetings with the external audit team. No additional fees were anticipated.

The Committee received assurance from the external audit progress report.

Finance Assurance update

The committee received an update on all STW's processed since the last meeting, totalling £621k and received assurance that the number of the STWs was in response to emergency or time critical requirements.

The Committee also welcomed the appointment of the valuer.

The Committee received assurance from the financial assurance report.

Counter Fraud, Bribery and Corruption update

The Committee was advised of the key areas of focus from the February 2024 Counter Fraud Progress report, noting the importance proactive work, including around English language tests, and noting the award nomination for the LCFS team, who will be the LCFS provider in the new organisation.

The Committee received assurance from the Counter Fraud Progress report.

Consolidation of the processing of key financial systems

The Committee was advised of the work led by the Fusion Finance Steering Group on the consolidation of financial systems in preparation for the new organisation, and strong progress made, particularly important in the context of the risks to delivery of CIPs and the financial plan in 2024/25.

The committee was assured by the work on the consolidation of the financial systems.

Clinical Audit Annual Plan Six Monthly Review

The Committee received a report on clinical audit and service evaluation activity which highlighted variations and improvements in standards. The Committee noted an area of poor initial compliance where standards had improved markedly and was assured that there were several assurance systems to identify and address risks and issues of compliance and quality.

The committee received assurance from the update provided which showed positive assurance of improvements in practice and strong assurance around quality of care.

Review of the effectiveness of the Board Assurance Framework (BAF)

The committee received assurance from the update provided, noting the improvements to risks around digital maturity and financial constraints and work to develop the BAF for the new organisation.

1Board and Committee Summary Report

Title of Paper	Quality Assurance Committee Exception Report				
Date of paper	March 2024				
Presentation to	In Public Board				
Item No.	18				
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 March 2024.				
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	x	8. Looking after our people	x	12.Digital transformation	
2. Alongside Communities		9.Belonging to the NHS		13. A greener NHS	
3. Outcomes that matter	x	10. New ways of working		14. Supportive Environments	x
4. Life-course approach		11. Growing for the future		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 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. Challenges in terms of resource were reported.

- **Urgent Matters of Safety-** The Chief of Nursing and AHPs briefed the Committee on demobilisation process taking place in relation to additional bed capacity. Ongoing work with social care was confirmed and positive outcomes noted. Formal thanks to staff was highlighted.

- There were no **Partnership Governance Arrangements** to share. An update in terms of position with Project Fusion and development of quality governance framework was provided.

- The Committee **noted** the following regular reports presented:
    - **Patient Safety Quarter 3 Report including Learning from Deaths, Learning from Sis and Incidents**
    - **Safeguarding Quarter 3 Report**
    - **Safe Staffing Quarter 3 Report**
    - **Experience of Care (including Patient Experience/Complaints & Community Engagement) Q3 Report-** It was agreed to specifically escalate reference to the volume of open incidents and the challenge around the new complaints target and how this could be achieved.
    - **Infection Prevention & Control Q3 Report**

- **Performance & Quality Exception Report-** key escalations were presented, including:
    - Cardiac Echo wait times- continued oversight, mitigations and current position were explained.
    - Resolution of patient transport risks were noted.
    - A summary of escalations in relation to improvement was provided.
    - Positive elements of deep dive within mental health services was shared.
    - Reduction in medication errors was highlighted.

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

- **Regulatory Compliance matters (including CQC matters, recent visits and any NHSE/I items)-** Increase in enquires received by the CQC was explained and planned review confirmed.
  Further considerations in relation to the development of quality account priorities for 2024/25 was reported.

- The Committee received the **Board to Floor 6 Month report**. Key themes were summarised, and importance of NED attendance emphasised.

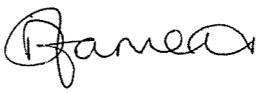
- The **Board Assurance Framework (BAF) consideration and oversight of risks Report** was reviewed and update in terms of risk scoring progress noted.

Board and Committee Summary Report

Title of Paper	Charitable Funds Committee Exception Report				
Date of paper	23/02/2024				
Presentation to	In Public Board Meeting				
Item No.	20				
Author(s)	Belinda Brown, Executive Assistant to Chief Executive				
Executive Sponsor	Gaurav Kumar, NED – Committee Chair, Debbie James, Executive Sponsor				
Executive Summary	• **Welcomed** Michael Bernard to the committee, as an observing Non-Executive Director from Southern Health NHS Foundation Trust and the Brighterway Charity Chair. • **Received** the Finance Report for Quarter 3, covering the period from 01 October 2023 to 31 December 2023. • was **informed** that the charity had a surplus position of **£77,067** within Q3 and a surplus position of **£81,328** YTD. • The committee was **updated** on the charity's account balances as at the end of Q3, **£183,048.00** in the 60-day notice account and **£83,633.00** within the charity's cash account. • **Received** an update on donations received within Q3, including a donation of **£5,000.00** to Spinnaker Ward, donations totalling **£1,908.00** from four separate commercial donations, and two donations to Cardiac services totalling **£200.00**. • **Received** an update on a legacy donation to the charity of **£64,627.77**, "in general recognition of the NHS in Hampshire". • **Received** an update on charity expenditure within the quarter, including (i) staff welfare: **£391.00** expenditure for Jubilee House (coffee machines and thermal mugs), **£212.00** on support for a staff Thank You event, and **£100.00** for a Commercial team wellbeing event, and (ii) patient welfare spend of **£586.00** at CAMHS West, Horizon building (clinical room refurbishment). • **Received** an update on the Covid-19 appeal grants, (i) NHSCT Charity Development grant, and (ii) the Stage 3 Recovery grant • **Agreed** to use the remainder of the NHSCT development grant on joint charity activities with Brighterway Charity, for areas such as software tools, website development and engagement events. • **Received** an update on the use of the charity funds for the development of an outside gym area for Jubilee House. • The committee gave **support** to the use of charitable funds to support celebration events planned for the closure of Solent NHS Trust • **Received** an update on the transfer of charitable funds to the new organisation. The committee **supported** the recommendation to merge the charity prior to transfer to the new organisation. • The committee **noted** that the Solent charity's objectives had been achieved. • The committee **received** an updated from the Communications team. • The committee **received** an update for the Estates team.				
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)
Positive / negative inequalities					
Previously considered at	*N/A*				

Strategic Priority this paper relates to	Great Care		Great Place to Work		Great Value for Money	
	1. Safe effective services	x	8. Looking after our people	x	12.Digital transformation	
	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)*	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	 Debbie James, on behalf of Gaurav Kumar							