Agenda

In-Public Meeting

Date: 3 June 2024
Timings: 09:30 – 12:50

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 15 April 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** – *Six-month report* • **Freedom to Speak Up –** *Annual Report*	Chief of Nursing and AHPs	To receive
10-minute break 11:00-11:10					
Items to receive					
8	11:10	10mins	**Chief Executive's Report**	CEO	To receive

9	11:20	30mins	**Integrated Performance Report** *Including:* • *Safe* • *Caring* • *Effective* • *Responsive* • *People* • *Finance* • *Research and Improvement* • *System Oversight Framework*	Executive Leads	To receive
10	11:50	15mins	**Code of Governance Compliance**	Programme Governance Lead	To approve
11	12:05	15mins	**Information Governance Annual Report and Data Security and Protection Toolkit Assessment Plans**	Data Protection Officer & Head of IG & Digital Security	To receive
12	12:20	10mins	**Research & Development Annual Report**	Chief Medical Officer	To receive
Governance					
Reporting Committees and Governance matters					
13	12:30	15mins	**People Committee –** *Verbal update of meeting held 22 May 2024*	Committee Chair & Acting CPO	To receive
14			**Mental Health Act Scrutiny Committee –** *No meeting held to report. Next meeting 14 June 2024*	Committee chair	To receive
15			**Audit & Risk Committee –** *No meeting held to report. Next meeting 21 June 2024.*	Committee chair	To receive
16			**Quality Assurance Committee –** *No meeting held to report- May meeting rescheduled to June TBC*	Committee chair	To receive
17			**Non-Confidential update from Finance & Infrastructure Committee** – *No meeting held to report- May meeting rescheduled to a date in June TBC*	Committee chair	Verbal update
18			**Charitable Funds Committee –** *Exception Report from meeting held 9 May 2024*	Committee chair	To receive

19			**Remuneration and Nominations Committee –** *Non-Confidential verbal update of meeting held 23 May 2024*	Committee chair	To receive
Any other business					
20	12:45	5mins	**Any other business and reflections including:**	Chair	-
21			• ***lessons learnt and living our values*** • ***matters for cascade and/or escalation to other board committees***	Chair	
22	12:50	---	**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	-

Minutes

Solent NHS Trust In Public Board Meeting

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

Chair: **Mike Watts,** Acting Trust Chair (MW)	
Members: **Andrew Strevens,** CEO (AS) **Nikki Burnett**, Chief Finance Officer (NB) **Debbie James**, Chief Strategy & Transformation Officer (DJ) **Dan Baylis**, Deputy CEO & Chief Medical Officer (DB) **Alasdair Snell,** Chief Operating Officer (ASn) **Sorrelle Ford**, Acting Chief People Officer (SF) **Gaurav Kumar**, Non-Executive Director (GK) **Vanessa Avlonitis,** Non-Executive Director (VA) **Stephanie Elsy,** Non-Executive Director (SE) **David Kelham,** Non-Executive Director (DK) **Apologies** **Angela Anderson,** Chief of Nursing and Allied Health Professionals (AA) **Dominic Ford**, Governance Programme Lead (DF)	**Attendees** **Sam Hemingway,** Deputy Chief of Nursing & AHPs (on behalf of AA) (SH) **Sam Stirling**, Corporate Affairs Administrator **Aderemi Aderibigbe**, AD of Quality, Safety, Governance and Risk *(for item 13)* (AAd) **Anna Rowen**, Associate Director of Diversity and Inclusion *(for item 14)* (AR) **Public Observers** **Paul Lewzey,** Southern Health Governor (PL)
Patient Story **Elaine Holland**, Patient Advocate (EH) **Lavinia Ellis**, Special Care Dental Service (LE)	**Staff Story** Richard Brown Sarah Martin

1	**Chairman's Welcome & Update** • **Apologies to receive** • **Confirmation that meeting is Quorate** • **Register of Interests & Declaration of Interests**
1.1	MW welcomed all to the meeting. Apologies were received as noted above.
1.2	The meeting was confirmed as quorate. The register and declarations of interest form was circulated. There were no new declarations made.
2	**Patient Story**
2.1	SH introduced EH and LE to the meeting. EH provided an overview of her grandson's health condition and explained continued challenges faced. Negative experience following care received within the Special Care Dental Service was shared and EH expressed upset and concern of treatment, which led to complaint raised. Issues regarding communication in relation to follow up appointment was also explained and the importance of ensuring appropriate action following the experience highlighted. SH informed of early review at Board, however commented on reflections undertaken and discussions held. Consideration of training needs were emphasised.

2.2	AS thanked EH for sharing and apologised for the experience. AS asked about experience of the complaint process and EH confirmed strong communication between the service receptionist and the Complaints Team to ensure a prompt response. EH further emphasised the importance of advocating against treatment experienced and raising at this level.
2.3	DB explained provision of Dental services across Hampshire and Isle of Wight and reflected negative experience shared. Importance of learning and understanding challenges to ensure this was not repeated and correct feedback and support was in place emphasised. LE assured of discussions to be had with the member of staff and commented on hard work of the service to support individuals with special care needs. Importance of lessons and training as a result of this experience was reiterated.
2.4	DK commented on considerations of work required to regain confidence and DB commented on prompt visit required. EH expressed reservations and shared positive care now being received.
2.5	VA highlighted the importance of Board follow up and assurance of training and reflective practice undertaken to ensure impact on the family was clear. EH provided background of care and needs of her grandson and importance of continued role to advocate was emphasised. The Board commended EH for bravery in sharing experiences. *EH & LE left the meeting.*
3	**Staff Story**
3.1	SF introduced RB and SM to the meeting. SM shared presentation regarding work of the CAMHS academy. • Approach to recruitment and retention approach was highlighted. • The Board were informed of aim of this work in ensuring a resilient adaptable workforce. • Collaborative discussions with young people were confirmed and commission of internal Community Engagement team to outreach to specific areas and gain feedback was noted. • SM highlighted the importance of ensuring representative of communities served. • Work of the Research and Innovation Team in supporting this work was commended. • SM explained initiative 'understand my world and improve my care', with material being created to educate practitioners and layer-up learning. • The Board were informed of the vision of the academy and presented the virtual online suite. • The 5 pillars and domains were shared and strong partnerships highlighted. • The Board were informed of tube map and roles, including rotational nurse posts. • SM presented the 2024/25 academy workstreams and commented on the importance of developed training programmes.
3.2	SF reflected on usefulness of this tool within the new organisation to consider as a workforce planning tool, which could assist in areas such as onboarding. Considerations of cultural elements were highlighted, and usefulness of different platforms noted.
3.3	ASn commented on strong progress in terms of scope and ambition and queried evident results in relation to sustainable retention. SM confirmed aim to launch after the new Trust had been established, with expectation of impacts evidenced within 1 year.
3.4	DB suggested usefulness of oversight by the new designate Board. **Action- DB to connect with Satnam Sagoo (HIOW Chief People Officer).** Regarding interface with social media elements, DB commented on learning from innovative platforms and how these could influence this area.

3.5	DJ emphasised the importance of building evidence and targets to ensure progress/achievement. SM informed of set targets/milestones, with specific measurables being set at the launch to ensure reflective of current position. DJ queried collaboration of testing/development and SM provided an overview of all areas involved, including communications and clinicians.
3.6	DK queried how aligns with the transition from CAMHs into adult care and RB commented on known challenges and considerations within specific transition group forum to consider pathways and different ways of working.
3.7	MW commended positive work and reflected on use as an enabling tool for the clinical strategy. *SM & RB left the meeting*.
4	**Reflection on Patient and Staff Stories**
4.1	The Board reflected on stories presented. In relation to the patient story, MW commented on the importance of follow up to ensure wellbeing and appropriate actions being taken. DB reflected on usefulness of hearing a case early in the process.
5	**Minutes of the meeting held 4 February 2024**
5.1	The minutes of the previous meeting were agreed as an accurate record.
6	**Action Tracker & Matters arising**
6.1	The following action was agreed as closed: AC005071
7	**Safety and Quality – contemporary matters including:** • Board to Floor Visits Feedback 6 month report • Freedom to Speak Up - *verbal update*
7.1	SH presented the Board to Floor Visits Feedback Report. Challenges arranging visits was reported and continued review into the future format of the Board to Floor visits were highlighted. MW queried the impact of the reduction in the number of visits undertaken and SF commented on the importance of visibility to ensure recognition and appreciation of hard work taking place in services. Continued discussions within People Committee were shared and SH also confirmed work of the Engagement Team to link with services, particularly in relation to Fusion information. The Board were assured of appropriate governance arrangements in place and the importance of transformation elements noted. VA reflected on discussions held at People Committee and the importance of ensuring inclusion of Corporate Services within planning discussions. **Action- SH to review.** The Board discussed the value of Board to Floor visits and consideration of prioritisation required.
7.2	There were no matters of Freedom to Speak Up to report.
7.3	AS provided a contempory update in relation to the handover of Shearwater estate. It was confirmed that a written update would be provided to a future meeting, however AS provided positive early feedback at this stage.
8	**Chief Executive's Report**
8.1	AS presented the report. • AS confirmed that this was his last Board meeting as the accountable officer for Solent NHS Trust and confirmed discussions taking place to ensure clear transition.

	• The Board were informed of challenge raised on behalf of the BAME Committee in relation to Workforce Matters and confirmed that an appropriate response would be provided to the People Committee. • An update in relation to ongoing system work was provided. • Challenges in relation to waiting lists (as detailed within the Integrated Performance Report) were noted. Further detailed discussions within Confidential Board was confirmed. • Feedback from recent attendance at the Southern Health Council of Governors Meeting was provided. Follow up actions were shared and usefulness of the session noted.
8.2	DK reflected on opportunities to engage with groups, such as the Guides. AS informed of continued work in these areas.
8.3	MW reflected on potential ESR access issues and SF confirmed that there were no current issues reported, with improved number of payroll errors.
8.4	MW queried reference to environmental conditions reported on PLACE Assessments. SH explained challenges in relation to estate however assured of continued adherence to IPC guidelines. Overall positive position was shared. **The Board received the CEO Report.**
9	**Clinical Professional Engagement and Leadership Report (inc. professional strategic framework and nurse revalidation) (Nursing, AHPs and medical workforce)**
9.1	SH shared an overview of the key summary of activity and progress made throughout the last reporting period. • The Board were informed of successful inaugural Enhancing Practice Conference held. • SH shared an overview of awards presented. • Increasing number of professional nurse advocates was reported. Close working with Fusion colleagues in relation to future planning, including alignment to the RIPPLE model, was confirmed. • The importance of close monitoring in relation to clinical apprentices as part of workforce planning was emphasised. Challenges were discussed and continued oversight assured.
9.2	VA reflected on the staff story and potential use of these principles and other initiatives to assist with retention. SF commented on review as part of workforce planning. DJ asked about prioritisation areas and SF commented on work being commissioned with the toolkit for organisational design.
10	**Board Assurance Framework Compliance**
10.1	AS presented the report and explained ongoing work taking place to review, particularly as part of Fusion. DK queried decrease in score and AS explained further discussions required in Confidential Board.
11	**Integrated Performance Report**
11.1	ASn shared key escalations from the report. • An overview of profiling tool used was provided and decrease in waiting list confirmed. Consideration of impacts was noted and cautious optimism for the initiative highlighted. • ASn provided an update in relation to diagnostic waits and the Cardo Echo Service. Additional resource was confirmed and continued executive level monitoring assured. • System pressures were highlighted and ASn confirmed that reflections following the winter period were being reviewed. Continued consideration of capacity and demand was reported.

	• The Board were informed of significant demand and capacity pressures within the mental health crisis team. Full oversight and updates from the triumvirate were confirmed.
11.2	VA commended the Trust for lack of increase in off framework agency usage despite additional beds opened.
11.3	VA reflected on challenges within the MSK/Pain service. DB emphasised hard work of the service and briefed on background and decommissioning of some elements. Collaborative working with the ICB to identify specific pathways and continued discussions were noted. MW commented on considerations of how Fusion will address elements of performance gaps. DB emphasised the need for the new designate Board to consider priorities and key strategic objectives in each of the priority areas. Considerations of learning and ongoing discussions across the ICB was confirmed.
12	**NHS Provider Licence Report**
12.1	AS presented the report and confirmed annual submission to NHSE. **The Board approved the NHS Provider Licence Report.** *AAd joined the meeting.*
13	**Patient Safety Incident Response Plan**
13.1	AAd shared the plan, following Solent Board approval in October 2023. Work to align across organisations and ensure review of differences for approval across all organisations was confirmed. It was noted that changes were minimal, and priorities had been captured accordingly. AAd informed of considerations of timeframes for learning responses in aligned format.
13.2	VA commended comprehensive and well aligned plan. *AR joined the meeting.* MW agreed and queried potential limitations at the 1 July 2024. AAd explained expectation for enabling functions to be in place which would enable transition to this plan, once approved by both Trust Boards.
13.3	SF asked about training/staff differences in operating this single plan. It was confirmed that differences had been identified and planning to bring together a joint programme across the Fusion pathway was continuing, to cover gaps and specific training elements.
13.4	The Board discussed gaps and differing approaches across Trusts in relation to training. Planning to ensure consistent approach was highlighted and critical culture elements were emphasised. Importance of ensuring oversight across all Boards, with granular detail at service level to ensure clinicians feel safe across services, was discussed. AAd agreed and confirmed weekly review of incidents with staff and continued support being provided. AS commented on new role as the Chief Integration Officer to ensure collaborative considerations/discussion. MW commented on planning and alignment to governance/GGI work and emphasised the importance of designate Board assurance and frequent scrutiny required.
13.	**The Board approved the Patient Safety Incident Response Plan, for final approval at the ICB.** *ADr left the meeting.*
14	**Equality Delivery System (EDS)**
14.1	SF explained statutory requirements and mandatory domains to deliver. Considerations as part of Fusion were highlighted. AR provided an overview of rigorous process being undertaken and confirmed Board approval required to agree scores presented. It was noted that a full plan would be presented, and AR confirmed extensive review of each domain with associated action planning.

14.2	ASn queried scoring and correlation to current position. Full review at the People Committee was confirmed, including consideration of trends, economic picture, comparative benchmarking, and significant amount of ongoing work.
14.3	NB queried review of different areas and the effect this would have on the score and action plan. AR explained holistic perspective and targeted review to ensure development and building on best practice. Continued oversight at the People Committee was confirmed. DJ asked how services would be selected using this tool and AR suggested review in planning stages, considering holistic oversight. MW commented on the importance of focus on wider planning and learning from the exercise going forward to inform future reviews.
14.	**The Board approved the Equality Delivery System scoring.** *AR left the meeting.*
15	**People Committee –** *Exception Report of meeting held 8 February 2024 and 21 March 2024*
15.1	The Board noted the exception report from the February 2024 Committee.
15.2	MW shared key highlights from the March 2024 meeting. • Discussions regarding request for further assurance in relation to Rostering was noted. • Feedback from the Wellbeing Fund and insight from Wellbeing Bubbles was shared. • Review of bank worker agreement was confirmed and consideration at the next People Committee and via safe staffing was noted.
16	**Mental Health Act Scrutiny Committee**
16.1	There was no meeting held to report.
17	**Audit & Risk Committee –** *Exception Report of meeting held 9 February 2024*
17.1	DK provided an overview of the current position. Continuous assurance was noted and DK shared an update in relation to Fraud providers in place across organisations.
18	**Quality Assurance Committee-** *Exception Report of meeting held 21 March 2024*
18.1	VA presented the report. • Extensive discussions in relation to incidents were confirmed. Background/context was provided to the Board and efforts to reduce unclosed incidents explained. Challenges relating to conflicting priorities were acknowledged, however assurance was provided on significant progress made. Follow up at the next Committee was confirmed. • Discussions in relation to complaints alignment was highlighted. Consideration of the policy and response time differences were noted. Assurance required at the designate Board was acknowledged and continued work reported.
19	**Non-Confidential update from Finance & Infrastructure Committee** – *Meeting 25 March 2024*
19.1	There were no formal items of escalation to raise at the In Public meeting.
20	**Charitable Funds Committee –** *Exception Report from meeting held 23 February 2024*
20.1	GK provided key escalations from the report. • Alignment to Southern Health charity was reported. • DJ commented on timing of the transfer and contingency planning in place.

21	**Remuneration and Nominations Committee –** *Non-Confidential verbal update from meeting held 14 March 2024*
21.1	There were no formal items of escalation to raise at the In Public meeting.
22	**Any other business and reflections including:** • ***Lessons learnt and living our values*** • ***Matters for cascade and/or escalation to other board committees***
22.1	The Board formally thanked AS for his hard work as Chief Executive to date and explained arrangements going forward.
22.2	PL provided feedback as an observer of the meeting. • Sensitive response to the patient story was acknowledged. • Further interest in change management and systems was noted. • Strong collaborative Fusion discussions and considerations of the designate Board were highlighted. • PL reflected on the challenging financial situation and clear oversight.
22.3	No other business was discussed and the meeting was closed.
23	**Close and move to Confidential meeting**

Action Tracker

Overall Status	Source Of Action	Date Action Generated	Minute Ref	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
Open	In Public Board	15/04/2024	3.4	AC005072	Staff Story- CAMHS Academy	DB suggested usefulness of oversight by the new designate Board. Action- DB to connect with Satnam Sagoo (HIOW Chief People Officer).	Dan Baylis	
Open	In Public Board	15/04/2024	7.1	AC005073	Board to Floor Feedback 6 Month Report	VA reflected on discussions held at People Committee and the importance of ensuring inclusion of Corporate Services within planning discussions. Action- SH to review.	Sam Hemingway	

Board and Committee Summary Report

Title of Paper	Board to Floor 6 monthly update					
Date of paper	May 2024					
Presentation to	In-Public Trust Board – June 2024					
Item No.	7.1					
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	In-Public Trust Board is asked to note the 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, In-Public Trust Board is asked to consider whether this paper provides: sufficient assurance, and, whether any additional reporting/ oversight is required.							
Executive Sponsor Signature	 Angela Anderson							

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 is important to acknowledge the competing demands currently on 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	

Board and Committee Summary Report

Title of Paper	Freedom to Speak up Q.4 and Annual Report 23/24.				
Date of paper	03 June 2024				
Presentation to	In Public Trust Board				
Item No.	7.2				
Author(s)	Nina Bellamy Interim Lead Freedom to Speak Up Guardian				
Executive Sponsor	Angela Anderson Chief of Nursing and Allied health Professionals				
Executive Summary	• There was a total of 119 concerns raised through FTSU for 23/24. • The number of cases sees a sustained increase compared to the previous year. • The report updates on the work of the Freedom to Speak up team for Q.4 2023/24 and an overview of the full year. It reviews relevant staff survey results as well as areas of learning for the service in light of national reports. • All concerns are managed and supported, with appropriate guidance offered by FTSU Guardians, in line with national FTSU guidance.				
Action Required	For decision?		For assurance?	x	
Summary of Recommendations	In Public Trust Board is asked to: • To note the content of this report and take assurance that Speak Up arrangements are meeting the workforce requirements.				
Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) x
Previously considered at	n/a				

Strategic Priority this paper relates to

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

For presentation to Board and its Committees: - To be completed by 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	 Angela Anderson							

Freedom to Speak Up activity Quarter 4 and review of the year.

1.1. **Context**

This report sets out Freedom to Speak Up data from the last quarter of 2023/24 whilst also looking back over the full year. In quarter 4 the Solent, Southern and Isle of Wight Guardians worked together to ensure full readiness for Fusion that included transfer of cases from the Isle of Wight in Q1 of 2024/25 and harmonising polices from all partner organisations.

1.2 National update for Quarter 4

1.2.1 The National Guardian Office published revised guidance for recording and reporting data and for the first time suggests that organisations should collect data around protected characteristics, they however emphasise this as a voluntary process recognising not all contacts will wish to disclose this information. We have where possible already endeavoured to record this information anonymously with varying success around return rates.

1.2.2 The National Guardian welcomed the report by the Health Services Safety Investigation Body (HSSIB) and endorsed their recommendation that organisations consider the voice of temporary (agency/bank) workers in patient safety investigations. The Patient Safety team at Solent have reviewed the report and advise that temporary staff are considered at clinical decision meetings and included where possible. They are also connected with the Trauma Risk Management (TRiM) programme to ensure support is provided to temporary workers.

1.2.3 The National Guardian office have announced their next review will be into the speaking up experience of overseas trained workers. Solent has expressed an interest in participating in this review pending the publication of the full terms of reference.

1.2.4 In Quarter 4 the Independent Review of Greater Manchester Mental Health Trust was published. This has been considered via Quality and Safety however there are several references throughout the document relating to Speak up including;

- Staff suggesting that speaking up meant putting oneself at risk of 'career suicide',
- Board taking assurance that low speak up numbers was a positive sign and
- Many of the calls to the Guardian related to poor behaviours of senior leaders who were reported as 'shouting' and overriding local clinical decisions.

Staff at Solent have at times expressed concerns and anxieties about their future when speaking up. Staff have also reported poor culture and behaviours with some senior leadership teams and clinical voice not being heard.

Learning from this report will feed into our Improvement Plan.

1.3 Update Q4 Proactive work

1.3.1 In the last quarter of 23/24 a harmonised Speak Up policy was approved for the new organisation. Processes relating to Speak Up have also been harmonised with partner organisations to ensure smooth transition.

1.3.2 Work continued to develop a Speak Up Strategic improvement plan based on our reflection and self-assessment planning tool (using National Guardian Office templates) which was shared with the Board in January 2024. This has been briefly paused as the National Guardian office has announced they will publish a new National Strategy in May 2024 which will need to be considered in our local plan. The strategy will be developed with staff side engagement including working alongside our network of champions and allies.

1.3.3 The Lead Guardian continues to provide bespoke training sessions focusing on civility and respect and the wider team provide Speak Up awareness and updates across many teams.

Considerable work has been done to refresh training materials both to increase accessibility and to harmonise approaches across all partner organisations.

1.3.4 Guardians work continually with other corporate function such as employee relations, Equality and Diversity, Organizational Development; Safety leads and others to share learning, triangulate information and identify emerging issues where possible.

2. Data

2.1 Quarter 4 (Q4) Data

2.1.1 During Q4 21 staff contacted the Freedom to Speak Up team, this compares to 22 in the same quarter last year. However overall numbers contacting the Guardian team for the year were higher than the previous year (119 contacts previous year compared to 78 contacts for 22/23)

2.1.2 Three of these calls were raised anonymously, staff choosing not to reveal their identity. Most colleagues remain 'confidential' in that they are happy for the Guardian team to know their identity but not their local team/manager.

2.1.3 Table one below shows breakdown by Service Line against National Guardian Office theme in quarter 4.

Service Line	Inappropriate attitudes & behaviours	Worker safety or well being	Bullying & Harassment	Culture of workforce	Other	Total
ADP	2		1			**3**
ADS	2	1				**3**
Child &Family	1	4	1		1	**7**
Corporate	4	1		1		**6**
FM Estates	1					**1**
Primary Care			1			**1**
Total	**10**	**6**	**3**	**1**	**1**	**21**

Table 1

2.1.4 In this quarter 10 of 21 cases relate to attitudes/behaviour and 3 of 21 relate to bullying and harassment. Attitudes and behaviours continue to be the most frequently reported theme throughout the year. Whilst concerns in these categories have tended to be about behaviours across managers/peers and other staff in this quarter, however a number of concerns have related to lack of understanding and civility around long term conditions and hidden disabilities. The guardians have worked alongside managers and the EDNA team to support understanding and utilisation of health passports. However, as will be discussed later staff, survey data shows a more rounded (and improving) data set around civility at work. Learning from speak up is fed through to colleagues who are leading on leadership and values as we move forward into the newly formed organisation.

2.1.5 Worker safety and wellbeing issues ranged from the impact of managers behaviours affecting wellbeing, lack of staffing and senior support, terms of employment and restructuring of services.

2.1.6 Other contacts relating to allegations of fraud which was referred to the Trusts Local counter fraud specialist.

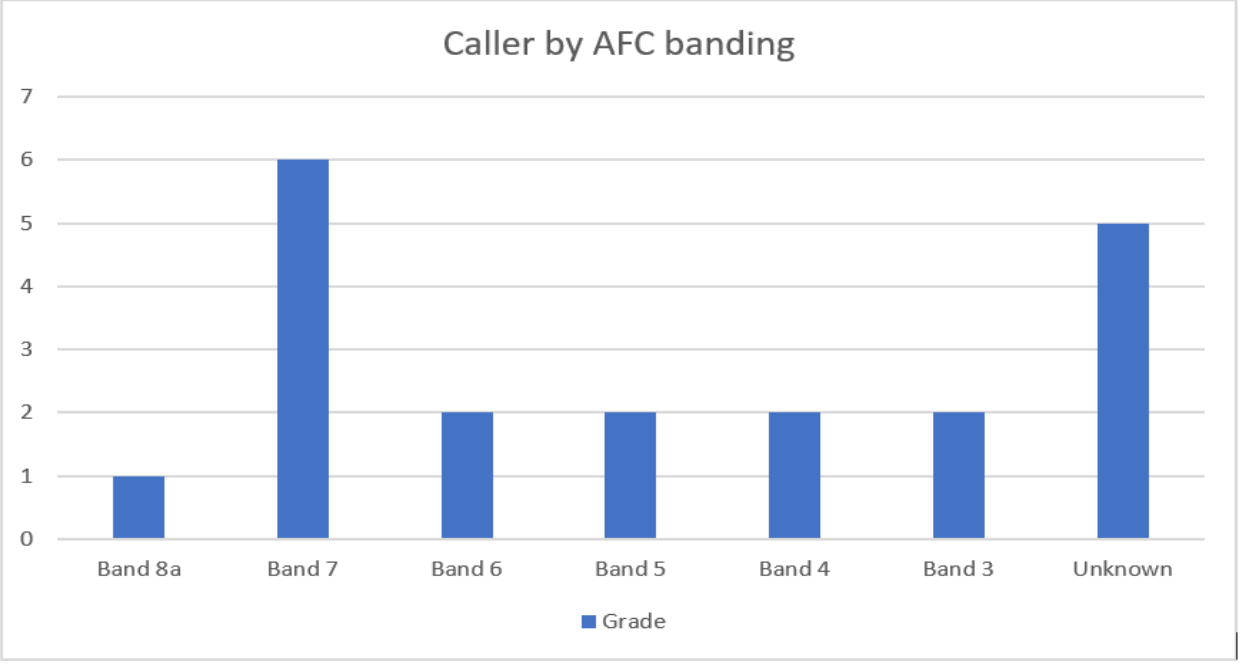


Table 2

2.1.7 Table 2 breaks this quarters data into AFC banding. The highest number of callers are at band 7 level. Whilst for this quarter there is an even distribution across bands 3 to 6.
Banding data for 2 callers was not captured and the remaining 3 callers where banding has not been recorded are in the case where callers have remained anonymous. This is the first quarter where data has been captured by staff banding and will be monitored for any trends in the forthcoming data for 24/25.

2.1.8 Table 3 below looks at callers by Professional group – Administrative and clerical staff have represented the highest numbers of contacts. 66% of these calls related to attitudes and behaviours including bullying and harassment.

2.1.9 Registered Nurses were the next highest staff group to contact the and again attitudes and behaviours was the most common reason for contacting the team at 75% of all calls from this group.

Table 3

2.2 Annual data

2.2.1 In 2023/24 a total of 119 people contacted the Guardian service. This is an increase on the previous year up from 78 in 2022/23.

2.2.2 Table 4 below shows distribution across themes by Service Line.

Service line	Inappropriate attitudes & behaviours	Worker safety & wellbeing	Bullying & Harassment	Culture or workforce	Racism &Discrimination	Patient Safety/ quality of care	Other	Total
ADP	9	4	1	4	1	1		20
ADS	3	1	1	1	1			7
Child & Family	6	6	7	1	1		3	24
Corporate	14		3	5	3	1		26
Primary Care	3	3	1					7
FM Estates	3	1						4
MPP	3	3		1	1			8
Mental Health	4	5	1		1		1	12
Sexual Health	3	2	1				1	7
Medical & Dental		1						1
Other			2				1	3
Total	48	26	17	12	8	2	6	119

Table 4

2.2.3 The distribution is even according to Service Line size. As we have seen across the year inappropriate attitudes (40%) is the most frequent reason for contact with the Guardian service. When combined with bullying and harassment it totals 55% of all calls (nominal increase from 54% last year).

2.2.4 Overall corporate teams have raised the highest number of concerns 22% of all calls made and 29% of reports relating to attitudes and behaviours. There is no one team identified as a hot spot. The majority of calls related to attitudes and behaviours have been raised by administrative and clerical staff and describe being treated unfairly, poor communication and service restructuring.

2.2.5 We have received a total of 17 anonymous callers in 23/24 a total of 14% of all contacts made to the service. We saw an increase of anonymous reports in Q.3 which related to a particular service line which is being given executive oversight.

2.2.6 This year we saw 22 % of cases had an element of worker safety or wellbeing concerns. Concerns have been raised in relation to staffing levels and workload, wellbeing with possible service changes and fusion into the new organisation, lack of compassion and understanding of carer roles and adjustments for long term conditions.

2.2.7 Other concerns brought to the guardian team related to contractual issues, secondment arrangements (signposted to Human Resources where appropriate), colleagues wishing to share 'soft intelligence' around services, HR processes and errors and/or delays.

2.2.8 It is important to note that people calling to speak about attitudes and behaviours often cited the impact of these behaviours on worker safety and wellbeing. Data capture has been updated for 24/25 to record both the primary and secondary elements of a concern raised. Whilst low cases with an element of patient safety or quality have been reported the guardian is working with the patient safety and quality team to triangulate any incidents of increased patient safety reported with a specific focus in areas of ongoing cultural work.

2.2.9 Table 5 below shows the distribution by professional group. The overwhelming majority of cases 39% have been reported by additional clinical services. Prior to Q.4 the team had not captured AFC banding for any staff group. This data is now recorded with the aim of greater understanding for 24/25.

Table 5

3.0 Staff Survey and Speak Up culture:

3.1 Given the high number of colleagues who raise concerns regarding attitudes and behaviours it is important to triangulate data and look at similar themes within the staff survey. Whilst the number speaking up about inappropriate attitudes is rising, staff survey tells us that overall, the number who experience these types of behaviours has fallen slightly. Table 6 below looks at the number of colleagues who feel they have been bullied, harassed, or abused by colleagues (there is not a staff survey question specifically about attitudes, but as shown through data reported to the Guardian when inappropriate attitudes was given as an option the number of those reporting bullying fell significantly). The number experiencing (as reported in the staff survey) these behaviours has dropped slightly however the numbers prepared to report the bullying or abuse has improved by 3.5% points and is better than the sector score which indicates more people are prepared to speak out.

	Trust Score 2022	Trust Score 2023	Sector Score
Service User	**18.2%**	**19.3%**	**25.1%**
Manager	**6%**	**6%**	**8.6%**
Colleague	**10%**	**10.7%**	**14.7%**
Did you report it	**58.7%**	**62.2%**	**61.6%**

Table 6

3.2 Given the low numbers of concerns raised relating to patient safety and quality it is important to consider this against the staff survey questions. Table 7 below specifically looks at questions related to if staff feel safe to Speak Up about 'clinical concerns'. Whilst 82% of staff feel secure raising a concern about clinical practice, only 74% are confident that the organisation would address their concern. Staff do not always feel confident that concerns are acted upon and feel they do not always get feedback on the outcome of concerns raised. GDPR and confidentiality guidelines mean that it may not always be appropriate for outcomes to be shared.

	Trust Score 2022	Trust Score 2023	Sector Score
Q20 a Would feel secure raising concerns about unsafe clinical practice.	**83.9%**	**81.9%**	**74.7%**
Q 20 b Would feel confident organisation would address concerns about unsafe clinical practice	**77%**	**74.1%**	**60.2%**

Table 7

3.3 There are other staff survey questions that can be used to look at speak up culture and these are set out in Table 8 below. These questions on the whole show that Solent scores higher than the sector score. Whilst there has been slight improvement from last year in encouraging reporting of incidents and being treated fairly. There is however a slight decline in staff experiencing kindness and respect with each other. The guardian team are working with service lines on their action plans resulting from staff survey. Facilitating workshops and awareness as requested.

	Trust Score 2022	Trust Score 2023	Sector Score
Q19a My org treats staff who are involved in an error near miss or incident fairly	**74.3%**	**75.1%**	**59.5%**
Q 19 b My org encourages us to report errors near misses or incidents	**93.9%**	**94.5%**	**88%**
Q8b The people I work with are kind and understanding to each other	**83.7%**	**82.9%**	**77.3%**
Q8cThe people I work with are polite and treat each other with respect	**83.5%**	**82.6%**	**78.6%**

Table 8

4.0 Training

4.1. Speak Up Training is mandatory for all staff and current uptake is at 92%. The Guardians regularly deliver additional ad hoc and focused sessions on Speak Up
4.2. The Guardian team provide input into a number of education programmes, speaking about the Guardian service and the importance of creating the right culture to enable speaking up. The Guardian team also provide visability at Trust conferences, local and divisional teams meetings raising awareness about the importance of speaking up and feeding back where appropriate on themes trends and learning.
4.3. The Guardian team continue to grow our champions network and continous training as per guidance as set out by the National Guardians Office.
4.4. Annual NGO Guardian refresher training for 24/25 will focus on equity, diversity and belonging and will be a mandatory part of guardians' foundation training going forwards.

5.0 Feedback

What has been difficult to report on this year has been wider demographic detail. All callers (where possible) to the service are invited to feedback via an anonymous survey. Feedback has been low, and a number of techniques have been engaged with limited success – where we have had feedback it has been generally positive and on the whole staff are prepared to speak up again. We will be asked to provide (on a voluntary basis) demographic detail so a more direct approach to obtaining this data is being tried. We have also been engaging with our staff networks to keep raising awareness of the service across all demographics and protected characteristics.

6.0 Commentary

The Speak Up team has been working coheseively with Southern Health colleagues through most of the past year – this has enabled wider access to the service for staff.

Improvements have been made to data capture for 24/25 to provide more robust understanding of elements of concerns raised and demographics of staff raising concerns.

More staff are speaking up, and more staff are speaking up about local attitudes and team cultures and impact on staff wellbeing. The new organisation is causing a level of anxiety for staff in terms of job security, equitable pay and leadership. This is being fed back to managers and senior colleagues as well as those supporting the change processes.

When leaders actively listen and take action it fosters a just culture. The leadership framework for the new organisation describes qualities every leader will adopt. The framework firmly includes speaking up and highlights the importance of creating a safe speaking up environment, but also the requirement that leaders themeselves speak up and challenge appropriately.

We have seen instances where colleagues have chosen to leave the organisation because of what they have seen as poor experiences as a result of eg organsiational change or feeling unsupported and under valued in their role. Where this has occurred senior colleagues have been advised and involved.

There has been opportunity for staff to feed into positive change as a result of speaking up; as an example staff have been given the opportunity to shape policies as a result of speaking up about their experiences

7.0 Recommendations

The board is asked to note the content of this report and take assurance that Speak Up arrangements are meeting the workforces requirements.

Item 8

CEO Report – In Public Board

Date: 23 May 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

Sexual Health service update

The trust was recently awarded a seven-year contract to continue to deliver an Integrated Sexual Sealth and HIV service across Hampshire and the Isle of Wight (HIOW), following a successful procurement process.

At Solent NHS Trust, our goal is to provide high quality sexual health care to people across our area. Our services include a wide range of offerings from contraception, Sexually Transmitted Infection (STI) testing and treatment, HIV care, sexual health promotion, outreach, and psychosexual counselling.

To increase access to our services, we are making some changes to our clinic hours and locations. We are also increasing our efforts to reach higher-risk populations by expanding our community pop-up and outreach clinics across HIOW. These targeted clinics help ensure that everyone, especially those most in need, can receive important sexual health services.

From 1 June 2024, certain smaller clinics will be moving and offered at different locations. This means that we can continue to deliver safe, timely and effective care without compromising on the services we offer. We know that more and more people access our services online, and we will also be increasing our opening days, times and offering evening and weekend appointments.

Locations and opening hours will be available and regularly updated on our website: www.letstalkaboutit.nhs.uk/clinics

Solent sites rated highly by patients

We celebrated how annual data published by NHS England reveals that Solent NHS Trust is highly regarded in its non-clinical areas identified as important by service users and the public. The PLACE (Patient-Led Assessments of the Care Environment) programme aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families, and carers.

The 2023 results detail how Solent has scored top in four categories against other organisations in the South-East region overall: Food combined 95.43%; Privacy and dignity 94.58%; Dementia 94.22%; Disability 93.84%. We shared the accomplishment to all staff as well as issuing a press release and highlighting on our social media channels.

Portsmouth Mental Health Hub celebrates first year success

In April, team members of the Portsmouth Mental Health Hub celebrated the first anniversary of the phoneline and website supporting local residents. Since the phoneline was created in April 2023, it has handled over 3,500 calls for people aged 16 and over, where fully trained call handlers have either arranged an appointment with services such as Talking Therapies or PositiveMinds or have offered support to connect with local organisations including HIVE Portsmouth, social support, or substance misuse organisations.

The website component followed in December 2023 and has had more than 6,000 views with 1,800 people accessing the information and resource webpages available. We shared the achievement across internal and external platforms with celebratory photos and a press release.

New Southampton rehabilitation centre named

Solent NHS Trust has proudly unveiled the name of its new state-of-the-art rehabilitation centre at the Western Community Hospital – called the South of England Rehabilitation Centre.

Scheduled to open its doors to patients in autumn 2024, the new centre represents a significant milestone in the city's healthcare infrastructure as well as being the biggest Estates project in Solent's history. The £21 million modern, purpose-built unit will replace two existing rehabilitation wards currently at the Royal South Hants Hospital in Southampton, will increase the number of beds available from 43 to 50, and will more than double the number of single rooms with en-suite facilities.

The extra beds and improved facilities will mean Solent staff can treat more people, closer to home. It will help to reduce the amount of time people stay in hospital, freeing up much needed beds and helping to reduce the backlog of patients awaiting treatment. We marked the announcement via a press release, social media posts and content for colleagues.

Experience of Care Week

To mark Experience of Care Week (29 April - 3 May) we showcased the brilliant and important work of Solent's Community Engagement and Experience Team so that people can understand their powerful partnerships with patients, families, carers, volunteers, and staff to ensure the community voice is at the heart of what they do.

The team strives to build trusting relationships with the local communities who share the same ambition of improving our service for people in the local community. Chrissy Gregson, Volunteer and Patient Experience Manager, spoke to us about her role in the team. We shared Chrissy's insight on our website and through our online channels.

Solent driving waste reduction

Coloured crockery is to be introduced at Solent's community hospitals after trials showed it cut food waste considerably. The dramatic reduction – caused simply by switching from traditional white crockery to blue – was realised after an eight-week trial. For full details, read the press release which was issued to local media and highlighted across Solent Estates and Facilities and Trust-wide channels.

National recognition for work with adolescents

Karina Redfern, a nurse at Solent has been recognised by the Roald Dahl's Marvellous Children's Charity by being selected as one of their Roald Dahl Nurse Specialists for her contributions to Transition services. Karina supports children as they transition from child to adult healthcare services. A transition specialist nurse will work with early teens to 25-year-olds solely on this area, creating pathways for them to follow as they move through the system, supporting them clinically and emotionally. We shone the light on this specialist area of nursing through a press release being shared to local media and across our online platforms.

New Trust update

Since the last update, several significant milestones have occurred in the run up to the creation of Hampshire and Isle of Wight Healthcare NHS Foundation Trust. On 1 May colleagues and services from Isle of Wight NHS Trust's Community, Mental Health and Learning Disability Services were welcomed into Southern Health as part of the next phase of creating our new Trust.

Solent Chief Executive Andrew Strevens took up his designate Chief Integration Officer role on 1 May - simultaneously Ron Shields became Solent's Interim Chief Executive. To coincide with the transfer of Isle of Wight colleagues, our new staff portal went live on 1 May and is accessible by all staff from Southern and Solent.

The third and final phase of creating the new Trust will, subject to regulatory approvals, take place on Monday 1 July when Solent NHS Trust and Southern Health NHS Foundation Trust (including the Island's services) come together, and the new Trust is then created.

Nurses Day Conference and Church Service

A Nurses Day Conference was held on 8 May for Solent and Southern nurses, taking place both in person in Winchester as well as on the Isle of Wight from where everyone was connected by a livestream for the day.

Pat Cullen visits Southampton

The General Secretary of the Royal College of Nursing (RCN), Pat Cullen, visited services based at the Western Community Hospital and Adelaide Health Centre on 13 May.

The visit was part of Pat's regular visits to NHS Trusts across the country to speak to members about the nursing profession and hear feedback. She was very impressed with those who she spoke to and appreciated everyone's honesty and time.

Penny Mordaunt MP visits Highclere

We welcomed Portsmouth North MP, Penny Mordaunt, and HIOW ICB representatives, to tour the Highclere Medical Centre construction site in Cosham and meet colleagues working on the project. The centre will be a modern purpose-built surgery in the heart of the community, housing six consulting rooms, three treatment rooms and admin space, along with a bright and welcoming entrance and waiting area.

All main rooms will be located on the perimeter to access natural light and will face away from the neighbouring Treetops sexual assault referral centre. It is hoped the medical centre, being built on a former car park, will be welcoming its first patients by early 2025.

Section 2 – Internal matters (not reported elsewhere)

There are no matters to highlight.

Great Care

Safety matters

There are no matters to highlight.

Great Place to Work

Workforce matters

There are no matters to highlight.

Great Value for Money

Estates and infrastructure

Celebrating Silver

Dave Smith has been awarded a silver medal at a prestigious regional cooking competition. Dave, based at St Mary's Community Health Campus, was praised for his chicken chasseur dish at the Hospital Caterers Association (HCA) Wessex branch's Salon Culinaire 2024.

The French bistro favourite won Dave a silver medal and certificate in the competition's saute chicken class.

Dave's class was judged by Philip Shelley, Senior Operational Manager at NHS England, John Feeney, Culinary and Innovation Director at Griffith Foods, and Phil Yeomans, Executive Chef at Lainston House Hotel near Winchester.

Our key risks

Operational Risk Register

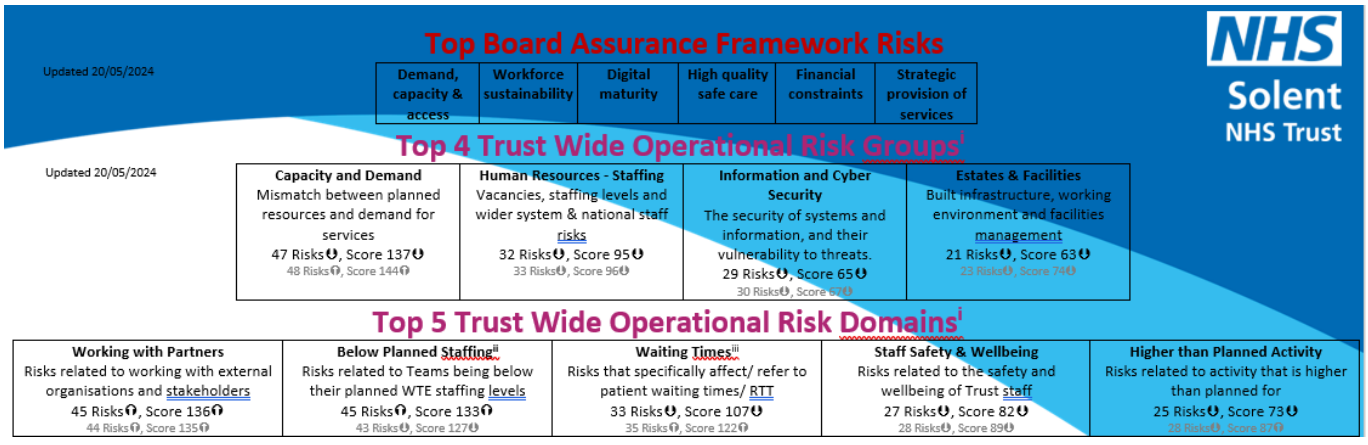
The risk pyramid summarises our key strategic and trust wide operational risks. Our top risk groups are:

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

Our top Risk Domains are:

1. Working with Partners
2. Below Planned Staffing
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 May 2024, executive leads reviewed the detail within their respective BAF entries and provided relevant updates. Adjustments to raw, residual and target score/dates were made as well as updates the risk narrative to reflect 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 May 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	L4 X S4 = 16	L3 X S4 = 12 End Q4 2024/25
#8- Strategic provision of services	L5 X S5 =25	L4 X S4 = 16	L4 X S3 = 12 End Q1 2024/25
#6 -Digital maturity	L3 X S3 = 9	L3 X S3 = 9	L3 X S3 = 9

Section 3 –System and partnership working

Project Fusion

Project Fusion, the programme to create Hampshire and Isle of Wight Healthcare, continues to progress well. Community, mental health and learning disability services successfully transferred from the IOW Trust to Southern Health on 01 April, as part of the ongoing phased transition. We continue to work towards full establishment of the new organisation on 01 July. This is subject to regulatory approval and, considering the recent announcement regarding the general election in July, confirmed timescales will be guided by NHS England and the Secretary of State. The boards of Southern and Solent are already working closely together to ensure continued momentum and a smooth transition.

Trust Board Integrated Performance Report (IPR)
March – April 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 March and April reporting period are:

Patients waiting > 18 weeks

The number of patients waiting more than 18 weeks to access our services has continued to grow throughout 2023/24 due to mismatches in capacity and demand within many of our services. In response to the national planning guidance for 2024/25, we have committed to delivery of a system plan to eliminate all community over 52-week waiters and reduce the number of community patients waiting for more than 18 weeks by 25%. Whilst this is challenging as there is no additional investment to support this initiate, plans are being identified by services with the largest waiting lists to determine how they can achieve this.

Reduction in Bed Days Lost to NCtR Patients

Recent efforts within the Portsmouth Transfer of Care Hub (TOCH) have shown extremely positive improvements in the number of bed days lost to patients who no longer have the criteria to reside (NCtR) following the implementation of a number of actions. This reduction not only streamlines the discharge process for patients, but releases capacity within the acute, improving overall system flow.

Financial Position

The Trust has a surplus plan of £7m for 2024/25, flowing into the overall £70m deficit plan submitted across the ICS. Delivering the combined plan presents significant challenges that will require close monitoring and co-ordinated efforts in order to maximise achievement in year. A number of system wide initiatives have been set out to tackle our cost drivers and are included in plans across the system, recognising that there is still much work to do in order to validate the impacts and crystallise the benefits.

The system plan includes a target reduction in corporate WTE of 2,000. Corporate WTEs are defined as any WTE not directly delivering patient care. Solent's proportion of this WTE reduction is 220.

The Trusts cost improvement programme for 2024/25 continues to be as challenging as the ambition set in the prior year with a value for 2024/25 of £30.4m, of which £5.5m is unidentified as at M1 reporting. Of the plans developed many rely on releasing the efficiencies across the workforce as a result of Fusion and driving headcount reductions through our services by unlocking productivity gains and removing duplicative work.

The month 1 position is an adjusted deficit of £267k, £286k worse than the planned, attributable to the residual unidentified CIP. A relentless focus on financial performance across the organisation will be required to maintain current momentum and the full identification and delivery of the stretching plans we have for the year ahead.

1. Safe

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-24 Current Performance		Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance		Mar-24 Trending Performance	Mar-24 Variance
Safe	Occurrence of any Never Event	E	0	0		P	L	0		P	L
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	0		P	L	0		P	L
	VTE Risk Assessment	E	95.0%	96.7%		?		96.7%		?	
	Clostridium Difficile - variance from plan	E	0	0		?		0		?	
	Clostridium Difficile - infection rate	E	0	0		?		0		?	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	E	0	0		P		0		P	
	Escherichia coli (E.coli) bacteraemia bloodstream infection	E	0	0		P		0		P	
	MRSA bacteraemias	E	0	0		P		0		P	
	Admissions to adult facilities of patients who are under 16 yrs old	E	0	0		P	L	0		P	L

b. Key Performance Challenges

A number of metrics showing positive variation, demonstrating consistent achievement of the target and positive trends, reflecting the efforts made my services to maintain safe provision.

Incident Reporting

The total number of incidents reported, and incidents reported per 1,000 contacts, have remained within the control limits again during March and April, with no significant variation.

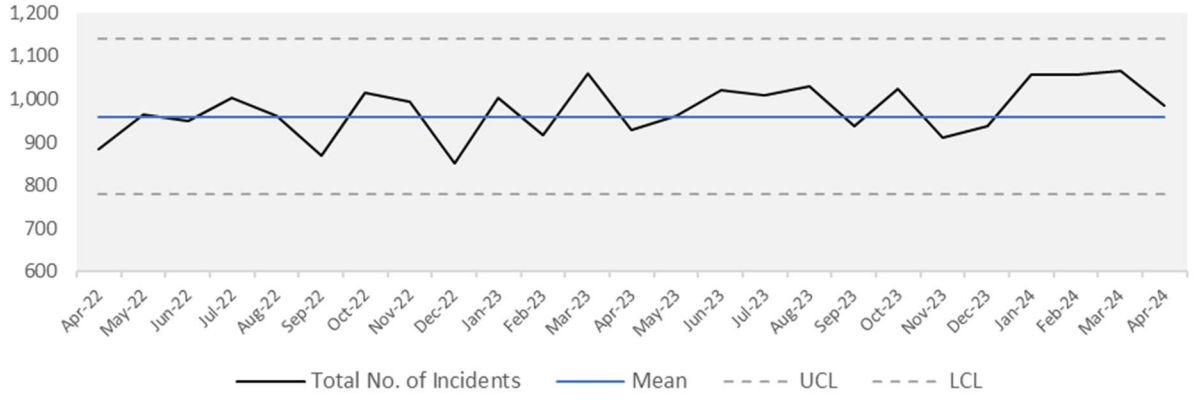


Figure 1: Total number of incidents reported by month

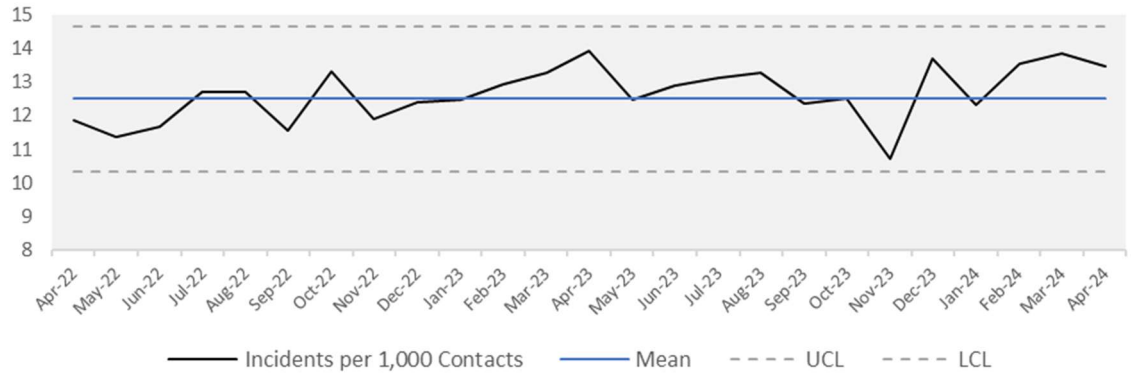


Figure 2: Number of incidents reported per 1,000 patient contacts

There continues to be wide variation between the number of incidents reported by individual service lines compared to the same period last year.

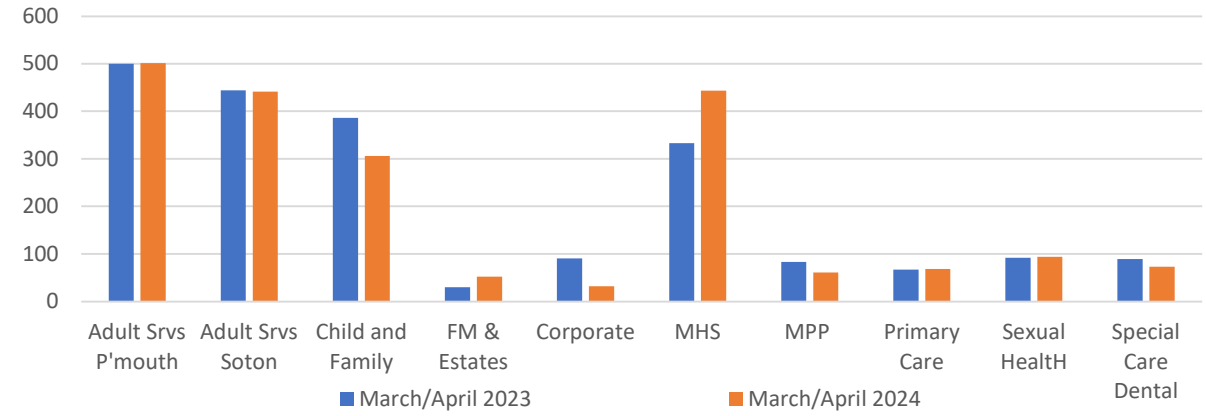


Figure 3: Total number of incidents reported by service

The most notable variance relates to the increase in incident reporting within the Mental Health Service in March/April 2024, attributable to the following:

- The Orchards Unit (Hawthorn and Maple Wards) has experienced high volumes of Assault – Physical incidents with 25% of all reported incidents in the period relating to this Cause Group. Three patients in total account for 62% of the incidents.
- As reported previously, there continues to be a significant increase in self-harm incidents on Hawthorn Ward resulting from the acuity of one patient. However, the unit is also continuing its use of SWARM Huddle learning response methodology to review every incident when it occurs. The outcomes from this piece of work will be presented at a future Learning from Incidents and Deaths Panel to promote wider shared learning across the trust.
- There have been twice as many HR Staffing related incidents reported within the Crisis Resolution and Home Treatment Team due to reported vacancies and staffing shortages.

In contrast, the number of incidents reported by the Child and Family Service has reduced due to improved ICT following the roll out of new laptops and work on connectivity at several sites. There has also been work with system partners to resolve issues with Badgernet (maternity records) and incident reporting has subsequently reduced.

2. Caring

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-24 Current Performance		Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance		Mar-24 Trending Performance	Mar-24 Variance
Caring	Community FFT % positive*	E	95.0%					98.2%			
	Mental Health FFT % positive*	E	95.0%					93.9%			
	People Pulse Survey - Advocacy Theme (Recommended for Care & Employment)	E	0	-				7.2			
	Mixed Sex breaches*	E	0	0				0			
	Plaudits	I	-	116				114			

b. Key Performance Exceptions

Friends and Family Test (FFT)

As of 1 April 2024, Solent have moved to a new patient experience system provider, Qualtrics, jointly with our colleagues at Southern Health NHS Foundation Trust. There has been a 25% reduction in FFT responses received during April 2024 because of initial transition issues, however we are expecting the number of responses to increase over the coming weeks as we resolve issues around QR codes and text messaging. This has not, however, had an impact on the proportion of people reporting as positive experience of our service.

The transition has also presented some challenges in the categorisation of FFT responses into community and mental health. The overall trust position saw positive responses at 96%, however the breakdown of community and mental health services is not yet available. This will be rectified in due course as more granular data becomes available.

3. Effective

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-24 Current Performance		Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance		Mar-24 Trending Performance	Mar-24 Variance
Effective	Bed Occupancy - Lower Brambles (Community)	I	92.0%	93.6%		P	H	97.2%		P	H
	Bed Occupancy - Fanshawe (Community)	I	92.0%	94.0%		P	H	95.7%		P	H
	Bed Occupancy - Summerlee (Community)	I	92.0%	93.9%		P	H	101.6%		P	H
	Bed Occupancy - Spinnaker (Community)	I	92.0%	94.2%		P	H	104.6%		P	H
	Bed Occupancy - Brooker (OPMH)	I	85.0%	56.2%		?		58.9%		?	
	Bed Occupancy - Hawthorns (Adult MH)	I	85.0%	89.2%		P	H	97.6%		P	H
	Bed Occupancy - Maples (Adult MH)	I	85.0%	87.0%		?		95.2%		?	
	Bed Occupancy - Kite (Acquired Brain Injury)	I	92.0%	95.0%		?		95.2%		?	
	Bed Occupancy - Snowdon (Neuro Rehab)	I	92.0%	89.0%		?		99.1%		P	H
	Length of Stay - Lower Brambles (Community)	I	24.0	35.4		?		27.0		?	
	Length of Stay - Fanshawe (Community)	I	24.0	19.8		?		22.4		?	
	Length of Stay - Summerlee (Community)	I	18.0	49.2		?	H	46.0		?	H
	Length of Stay - Spinnaker (Community)	I	24.0	24.0		?	H	21.6		?	H
	Length of Stay - Brooker (OPMH)	I	78.5	19.7		P		52.0		P	
	Length of Stay - Hawthorns (Adult MH)	I	34.9	21.7		P		30.8		P	H
	Length of Stay - Maples (Adult MH)	I	48.6	16.2		P		33.6		P	
	Length of Stay - Kite (Acquired Brain Injury)	-	-	0				0			H
	Length of Stay - Snowdon (Neuro Rehab)	-	-	28.4				27.6			
	Non-Criteria to Reside (NCtR) [patient count]	-	-	23				26			
	% clients in settled accommodation	E	59.0%	47.1%		?	L	39.4%		?	L

Bed Occupancy – Community Wards (Fanshawe, Lower Brambles, Summerlee and Spinnaker)

In response to system planning and pressures, our ambition is to ensure our wards are filled to a high occupancy rate and that the length of stay is reduced. On this basis, we have changed the way our occupancy rates are viewed against the targets, with a higher occupancy rate now indicating positive performance. Subsequently, all occupancy rates in our community wards are flagging a positive special cause trend and

variation because the occupancy rates have been above the target and mean for more than six consecutive months.

Length of Stay – Summerlee and Spinnaker

The average length of stay at discharge across our Portsmouth community wards is flagging a high special cause variation on both Summerlee and Spinnaker, due to sustained performance higher than the mean (Spinnaker) and upper control limit (Summerlee). This was an expected increase due to the extended nature of the admission criteria across the wards to support the pressures across the PSEH system.

Length of Stay – Brooker

The average length of stay on our Older Persons Mental Health ward, Brooker, has flagged a positive special cause trend as it has been consistently decreasing for several months. This reduction was anticipated following the redesign of the OPMH model with the intention to move more care provision into the community service and reduce the reliance on inpatient care. Whilst the capacity of the inpatient ward has remained static in reporting terms, the staffing used to manage the vacant capacity has been flexed to support the extension of the community service, ensuring effective use of the workforce to deliver the best outcomes for our patients.

Bed Occupancy and Length of Stay – Hawthorns

Length of Stay - Maples

The average length of stay on Hawthorns and Maples has flagged a positive special cause trend as they have both consistently been below the target length of stay (based on the 2022 NHS Benchmarking Network Mental Health Project findings) for a sustained period, despite having seen the average length of stay and occupancy rate on Hawthorns increasing above the mean in recent months. This is due to several factors including a new body of senior medical staff joining the service and familiarising themselves with local systems, processes, and patients, as well as several delays in discharge including residential and placement issues. This has also resulted in the use of some out of area placements (2 in April / 1 in May) and is expected to return to normal levels by the end of quarter 1.

b. Key Performance Exceptions

Elective Recovery Fund (ERF)

Solent's performance of the Elective Recovery Fund for 2023/24 has closed with a 23% overperformance, based on local data. The national end of year data has not yet been published, and therefore the final value associated to this activity has not yet been derived by the HIOW ICB. This is a fantastic achievement for Solent and one we are very proud of.

TFCDesc	Activity Actual	Activity Plan	Activity Variance	Income Actual	Income Plan	Income Variance
Cardiology Service	1253	1204	49	£239,323	£229,964	£9,359
CPMS - CP/LAC	1008	745	263	£194,544	£143,785	£50,759
CPMS - General Paediatrics	161	76	85	£39,767	£18,772	£20,995
CPMS - Neurodisability	1114	833	281	£215,002	£160,769	£54,233
Diabetes Service	65	116	-51	£9,295	£16,588	-£7,293
Pain Management Service	1127	897	230	£259,210	£206,310	£52,900
Physiotherapy Service	21002	17876	3126	£4,053,386	£3,450,068	£603,318
Trauma and Orthopaedic Service	12118	9003	3115	£2,181,240	£1,620,540	£560,700
Total	**37848**	**30750**	**7098**	**£7,427,670**	**£6,034,688**	**£1,392,983**

Figure 4: Cumulative ERF performance 2023/24 (local data) at M12 compared to baselines v9

It is understood that the targets for 2024/25 will remain the same as 2023/24, although this has not yet been formally published. We are continuing to deliver the same activities as in 2023/24 whilst we await confirmation. We are also investigating whether there is a small cohort of additional activity in our paediatric MSK service which should be eligible for inclusion in ERF however the outcome of this is not yet concluded.

Urgent Community Response (UCR) – 2-Hour Performance

Delivery of UCR remains relatively consistent with the position as reported in recent months. Southampton UCR team continue to achieve the 70% target despite pressures within the system, and the Portsmouth team continue to relax the 2-hour target to provide a wider range of support to the PSEH system, resulting in performance below the 70%. This is with agreement from the ICS and will likely continue for some time.

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
2 Hour Referrals	401	430	455	434	334	321	350	300	329	234	311	393	4292
Compliant	243	273	285	317	272	274	284	248	272	191	270	298	3227
Compliance %	61%	63%	63%	73%	81%	85%	81%	83%	83%	82%	87%	76%	75%

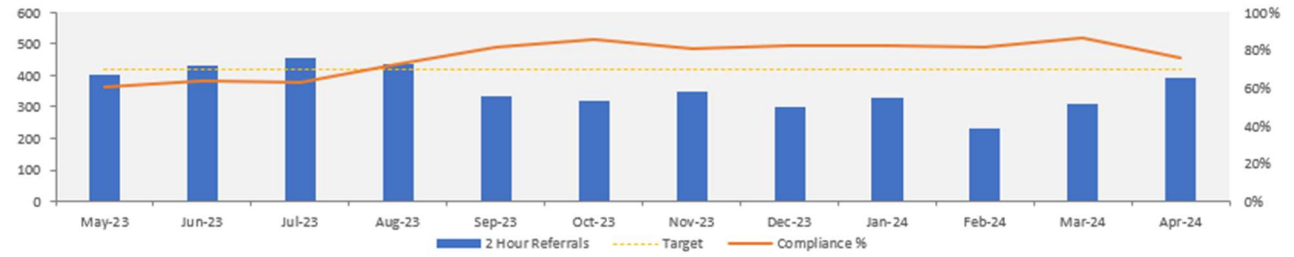


Figure 5: Southampton UCR 2-hour compliance, previous 12 months

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	YTD
2 Hour Referrals	281	258	301	303	270	330	311	289	304	287	274	299	3507
Compliant	226	171	213	215	171	225	169	156	172	195	184	158	2255
Compliance %	80%	66%	71%	71%	63%	68%	54%	54%	57%	68%	67%	53%	64%

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

Virtual Wards

The occupancy on the virtual wards across both cities continues to be greater than 100%, but is showing a slight downward trend, most significantly in Portsmouth. This is not unexpected as we move into spring and the winter pressure begins to subside, but also is likely to reflect the tighter controls around the delivery of this service remaining within funded capacity as we move into 2024/25.

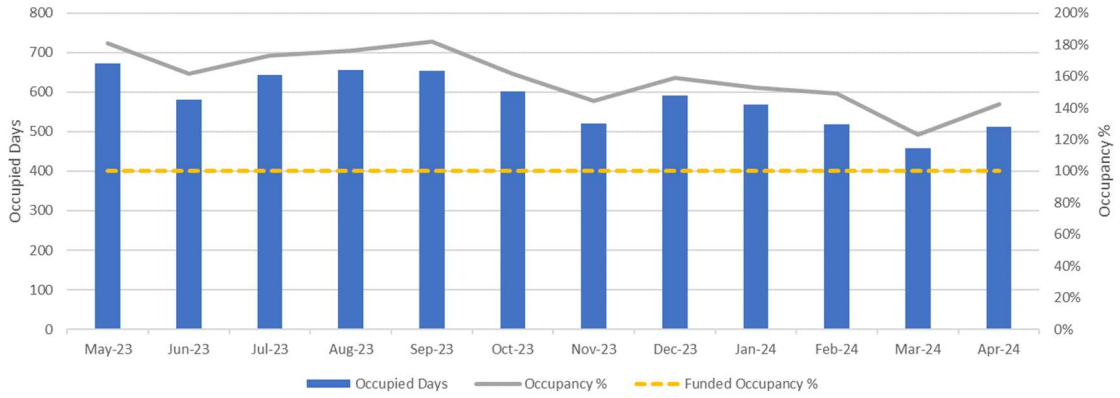


Figure 7: Southampton Virtual Ward Occupancy

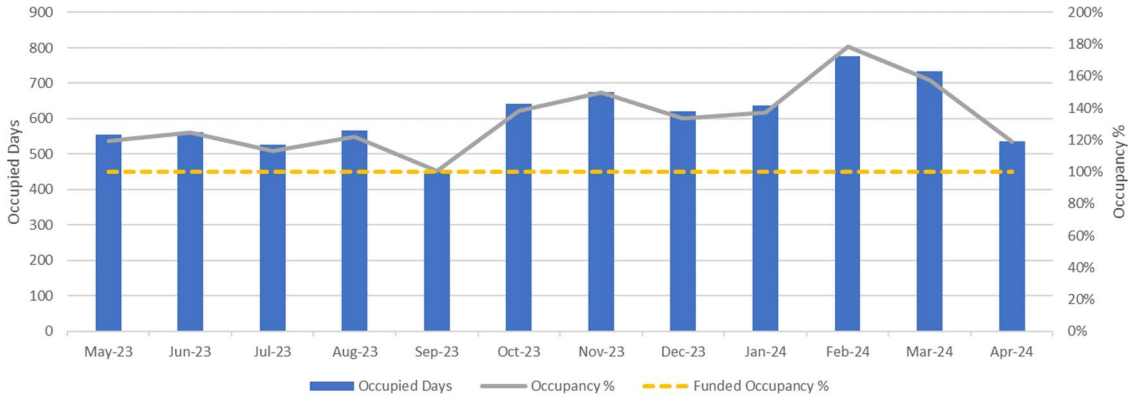


Figure 8: Portsmouth Virtual Ward Occupancy

4. Responsive

a. Performance Summary

	Indicator Description	Internal /External	Target	Apr-24 Current Performance		Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance		Mar-24 Trending Performance	Mar-24 Variance
Responsive	Patients waiting > 18 weeks	-	-	7012			H	6926			H
	Accepted Referrals	-	-	26080				24994			
	Formal complaints per 1000 WTE	-	-	2.3			L	2.7			L
	Number of complaints	I	15	7	●	P		8	●	?	
	Number of complaint breaches	-	-	3				3			
	RTT incomplete pathways*	E	92.0%	99.6%	●	?	H	99.6%	●	?	
	Maximum 6-week wait for diagnostic procedures	E	99.0%	39.4%	●	?	L	39.0%	●	?	
	Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	28	●	?		49	●	?	
	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50.0%	100.0%	●	P		60.0%	●	?	
	Talking Therapies - Proportion of people completing treatment moving to recovery	E	50.0%	53.1%	●	P		53.2%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 6 weeks	E	75.0%	86.8%	●	P	L	93.8%	●	?	
	Talking Therapies - Waiting time to begin treatment - within 18 weeks	E	95.0%	99.8%	●	P		99.8%	●	?	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score*	E	95.0%	87.5%	●	?	L	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 has deteriorated further within the last two months, with the upper control limit being breached for the best part of a year.

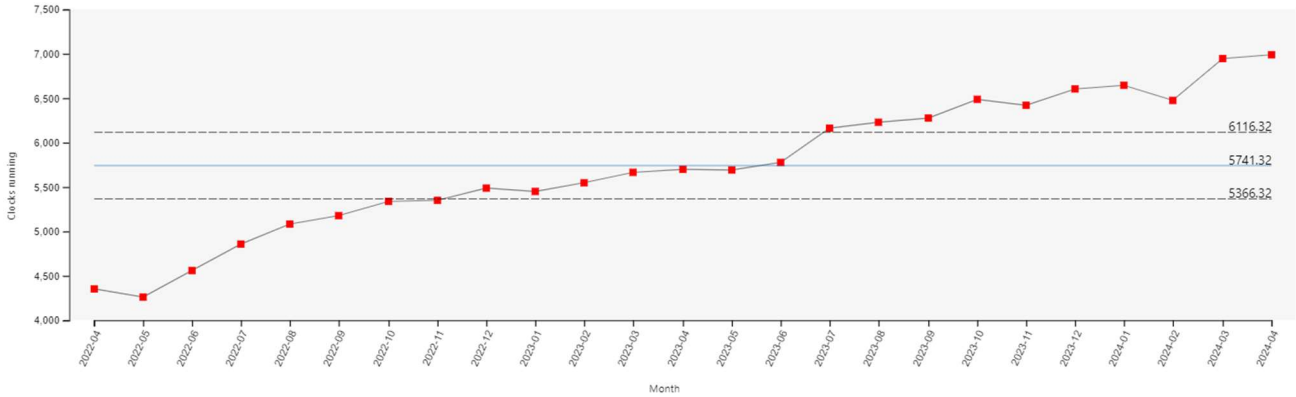


Figure 9: Number of patients waiting for more than 18 weeks – Trust-wide (excluding Dental and Talking Therapy Services)

As part of the national planning guidance for 2024/25, there is an ambition to reduce the long waiters in our community health services (as defined by the Community Health Services sitrep). HIOW ICB have targeted us to eliminate over 52-week waiters completely and deliver a 25% reduction in patients waiting for more than 18 weeks for these services. Whilst this is challenging as there is no additional investment to support this initiate, plans are being identified by services to determine how they may achieve this.

Number of complaints / Complaints per 1,000 wte

There has been consistent performance of complaints per 1,000 WTE, within the normal range, since 2022. Since January 2024, we have seen a decrease in the number of complaints per 1000 wte, now below the mean but remaining above the lower control limit. This period has seen one of the lowest numbers of complaints since the end of the COVID period, which we attribute to the increased focus given to resolving concerns early.

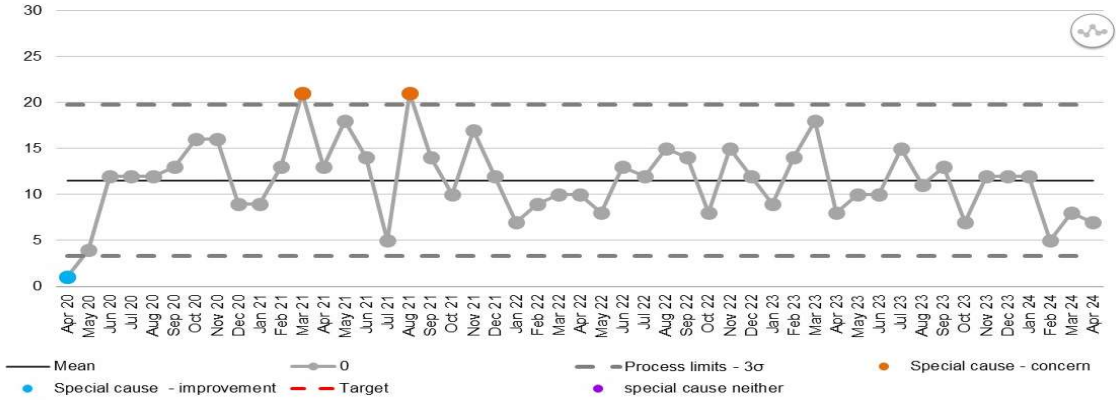


Figure 10: Number of complaints received by month

During this reporting period, Mental Health Services were cited in the highest proportion of complaints received. We reviewed these complaints for specific themes however, they were spread across different services with two complaints related to the Crisis Team, one complaint related to the Mental Health Hub, one complaint related to the Orchards and one to NHS Talking Therapies. However, whilst the teams are different, the main underlying theme for people making a complaint related to values and behaviours of staff.

It should be noted that values and behaviours of staff is not isolated to Mental Health Services we have previously highlighted this as an ongoing theme in feedback across the trust. In response to this feedback, since February 2024, working with colleagues from Learning and Development and a company called SimmComm we have delivered forum theatre training which seeks to provide targeted training to teams. We are now working to explore further opportunities to support services.

RTT Incomplete Pathways

Performance of RTT Incomplete Pathways has flagged a positive special cause variation as performance is outside of the upper control limit, indicating a significant event has occurred. As a community provider only a small proportion of our services are consultant-led, and therefore eligible for the RTT standard. In February 2024, NHS England revised the guidance for the reporting of RTT information, removing community-based services from the submission. This includes not only our Community Paediatrics Medical service, but also Pain services and Diabetic Medicine. Whilst these services are still required to work within the RTT standards, they are no longer included within national publications of waiting times, significantly improving our reported position.

As previously reported, the challenges within the Community Paediatrics Medical service have been ongoing for a substantial length of time and are not yet demonstrating an improvement. Therefore, monitoring of the removed services will continue internally to ensure oversight remains of the lengthy waiting list challenges. We are providing additional targeted management support to the CPMS over the coming months to aid a turnaround in performance.

Maximum 6-week Wait for Diagnostic Procedures

The 6-week wait for diagnostic procedures has flagged a negative special cause variation due to performance being below the mean for more than 6 months. As previously reported, the waiting lists for the Cardiology service are a concern and the provision of echocardigram and monitor diganostic tests specifically.

The support provided by UHS, beginning in March, has been suspended as it was not providing reliable enough capacity to sufficiently improve the waiting list position. An alternative third party provider, Your World, is due to start provision of echocardiography in early May, and monitors a few weeks later on our behalf. It is anticipated that the backlog of patients waiting for an echocardiogram will take 11 months to clear, and 19 months for those waiting for monitor due to the additional time taken for reading the results of the monitors. Performance against the trajectory will be closely tracked by service, escalating any concerns through the necessary channels.

Early Interventions in Psychosis Access

Talking Therapies Recovery Rates

Talking Therapies 6/18 week waiting times

Performance across a range of mental health access metrics have flagged positive special cause trend indicating consistent achievement of the targets for a sustained period of time. We are very proud of our Mental Health services for their continued positive performance.

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

Adults Community Services – Portsmouth

Bed Days Lost to NCtR Patients

There has been a concerted effort to reduce the number of bed days lost to patients with no criteria to reside (NCtR) in PHU as we are coming out of winter there, and these have more than halved in the past few weeks.

Figure 11: Number of bed days lost to patients with no criteria to reside

The Transfer of Care Hub (TOCH) team have achieved this by planning 72 hours in advance of a patient becoming medically fit for discharge, changing the format of the MDT meetings which review medically fit patients, and strengthening the integration model with social workers based at the TOCH.

Speech and Language Therapy Waiting Lists

Performance against the trajectory to reduce the waiting lists for the Speech and Language Therapy service in Portsmouth has slipped during April due to planned and unplanned absence within the service. The action plan is being revised to include the extension of the Care home project and self-referral pilot. The focus remains meeting clinical demands whilst managing waiting list initiatives. A revised trajectory will be shared in due course.

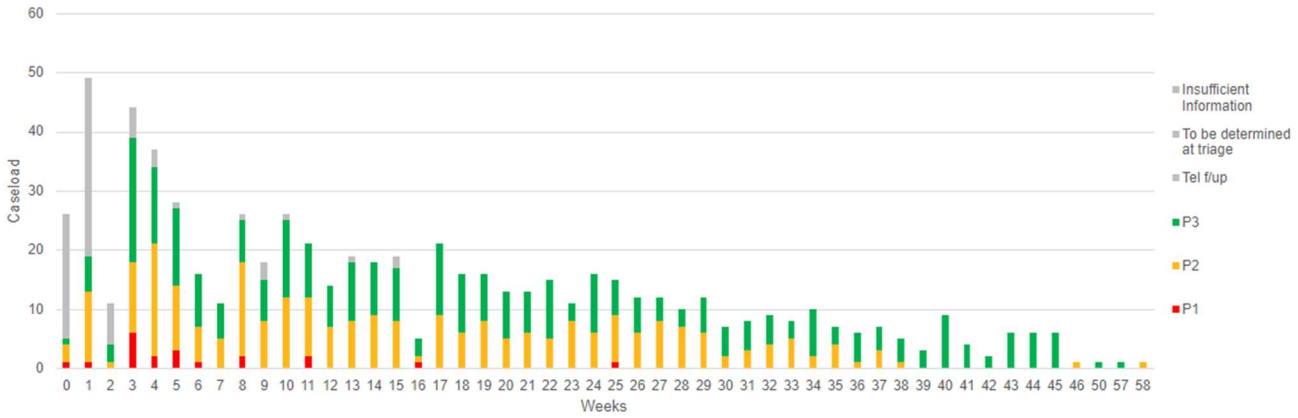


Figure 12: Speech and Language Therapy Caseload by weeks waiting

Mental Health Services

Secondary Psychological Therapies

Following many years of lengthy waiting lists for Secondary Psychological Therapies, the new pathway implemented by the service has seen a reduction in waiting times and the number of patients waiting across multiple different therapies. A foundation programme was introduced, consisting of 5/6 sessions where patients are assessed and triaged and subsequently offered support directly, or added to a specific pathway as appropriate. This ensures the right people are added to the right pathways, making access to therapy more responsive. The overall waiting list has come down from around 140 to 93 patients and there are now less than 10 patients waiting for more than a year. The aim is to continue this reduction down to an ideal position of 6 months.

Sexual Health Services

Demand for HIV Services

It was reported two months ago that the increasing caseload of HIV patients was being closely monitored, and if growth continued at the same rate, the caseload would soon become unsustainable. The trend has continued, with the common theme of patients coming into the service for the first time having been diagnosed and previously treated overseas. Many patients with this background come to the service with multiple comorbidities and little or no medical history, requiring intensive management in the same way as a new patient would.

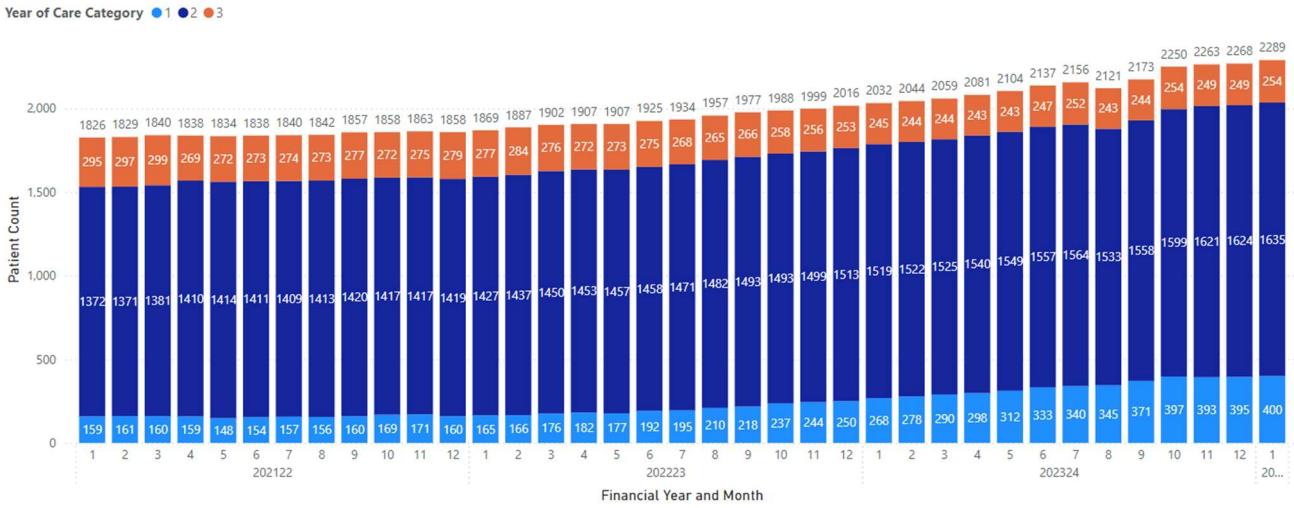


Figure 13: HIV Caseload by Year of Care category (1 = New, first year of a new diagnosis or ARV therapy / 2 = Stable, on steady ARV therapy / 3 = Complex, usually comorbidities)

In addition to the already increasing caseload, acute trusts are soon to start testing for HIV, having recently been allocated funding to support this and increase the coverage of testing. This could result in associated management costs of the test results for the service with no commensurate increase in funding. We are working with our Local Authority commissioners who are following this up with HIOW ICB, to ensure this provision does not detrimentally impact the wider Sexual Health Service.

5. People

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-24 Current Performance		Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance		Mar-24 Trending Performance	Mar-24 Variance
People	Sickness (annual)*	I	4.5%	5.1%				5.9%			
	Sickness (in month)	I	4.5%	5.0%				5.4%			
	Turnover (annual)*	I	14.0%	12.4%				12.8%			
	Turnover (in month)	I	1.2%	0.7%				1.5%			
	New starters (FTE)	-	-	40.71				31.91			
	Proportion of Temporary Staff (in month)	I	3.6%	4.1%				5.8%			

b. Key Performance Exceptions

Sickness

We are seeing a gradual downward trend in sickness absence overall, consistent with seasonal trends where we have seen lower levels of sickness absence reported in April and May. There remain some service areas where sickness is increasing, particularly in Mental Health and FM & Estates. Further work will be undertaken through the performance review meetings and more granular reporting into episodes to understand themes and trends around this absence. A focused 'well-being bubble' conversation will be held to enable this qualitative data to feed through.

Turnover

Turnover continues to be below target and is predicted to continue until such a time as organisational change programmes begin with Project Fusion. There are focused attraction pieces within Dentistry to increase qualified staff in these teams, as well as recruitment fairs for Health Care Support Workers. The fair held in Southampton recently has filled outstanding vacancies for this service. Any continued use of temporary staffing for these roles in this area will be monitored. Exit interview data is reported to People Committee and reviewed for specific organisational development interventions to support retention, also triangulated with the NHS Staff Survey results. An example of this is a review of job plans for medics in particular services, and a focus generally on the experience of our people through onboarding.

Temporary Staffing

We continue to push our programme of work in Temporary Staffing, most recently to permit substantive staff with bank worker agreements to receive weekly pay for additional shifts they pick up. Supporting with cost-of-living opportunities, flexibility and reducing reliance on agency bookings. Ensuring our clinical areas can be staffed with those familiar with the environment and teams is also positive towards patient quality and safety. We continue to work closely with the South-East Temporary Staffing Collaborative to manage our rates towards cap compliance, with a plan to bring us to this with agenda for change in August. The Trust is not reporting any off-framework agency use at the time of writing this report.

6. Finance

a. Performance Summary

	Indicator Description	Internal /External Target	Target	Apr-24 Current Performance	Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance	Mar-24 Trending Performance	Mar-24 Variance
Finance	Year to date surplus/(deficit) Actual v budget	-	-	-1.5%			0.0%		
	Agency spend % pay	I	3.5%	2.5%			2.7%		
	Cash balance (£m)	-	-	£3.60			£6.70		
	Aged debt (over 90 days) (£k)	-	-	£2,046			£3,134		
	Use of Resources Score	-	-	0			0		

b. Spotlight On: Month 1 Results

The Trust has a surplus plan of £7m for 2024-25. Included in the plan is £5m of additional income linked to ICB dental services and £30.4m CIP programme of which £5.5m is unidentified.

The ICS has a deficit plan of £70m with work still outstanding to finalise how partners will contribute towards its achievement. Included in the system plan is a target reduction in corporate WTE of 2,000. Corporate WTEs are defined as any WTE not directly delivering patient care. Solent's proportion of this WTE reduction is 220.

The month 1 position is an adjusted deficit of £267k, £286k worse than the planned adjusted surplus of £19k. The main driver of the adverse variance is under delivery of CIP, offset with one off benefit in Goods Received Not Invoiced (GRNI) accrual.

Cost Improvement Plans (CIP)

The Trust has an internal efficiency programme of £30.4m. M1 CIPs underperformed by £1.3m, £0.3m of which is unidentified. Other underperformance is offset against various benefits recognised in M1.
The finance team are working closely with services and corporate teams to understand what is driving the under delivery of CIP and actions required to bring these back in line with plan. The Finance Recovery Board will focus on actions required when it resumes in June.

Capital

The Capital plan for 24/25 is £12m, consisting of £5m Internally Funded and £7m Public Dividend Capital (nationally) Funded. M01 capital spend totalled £0.6m, consisting of £0.2m internally funded spend, £0.4m PDC spend. The M01 capital plan totalled £1.8m, the £1.2m underspend is mainly due to: £0.7m underspend on the WCH project, £0.4m on Highclere, and £0.1m on Oakley Road resulting from the profiling of planned spend vs actuals.

Cash

The cash balance £3.6m at the 30 April, a decrease of £3.1m from March. The decrease in the cash balance is due primarily to a payment to NHS Properties for £3.5m.

Aged Debt

Total debt at the end of April was £4.5m, a decrease of £4.4m in month largely due to high value invoices paid in the 1-30 day overdue bracket.

Aged Creditors

The Trust aims to pay its creditors on receipt of undisputed, valid invoices within 30 days or payment terms, whichever is later. Performance against this metric is monitored nationally by NHS England against a target of 95% achievement. For April 2024 the Trust paid 93.5% of volume of invoices within target and 97.2% of value. Scan date to payment date was 29.1 days, 9.8 days longer than March.

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 - 2024/25 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	Apr-24 Current Performance		Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance		Mar-24 Trending Performance	Mar-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%	140.2%		P		122.7%		P	
	S009d: Patients waiting more than 65 weeks to start consultant-led treatment	E	0	0		?		0		?	
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	E	100.0%	56.8%		F	H	56.8%		F	H
	S121a: NHS Staff Survey compassionate culture people promise element sub-score		0	Annual Metric							
	S121b: NHS Staff Survey raising concerns people promise element sub-score	I	0.0%	Annual Metric							
	S124a: Percentage of occupied adult beds occupied by patients who no longer meet the criteria to reside	-	-	Metric under development							
	S125a: Long length of stay for adult acute mental health (discharges with LOS over 60 days / all discharges)	E	0.0%	8.3%		?		21.0%		?	
	S125b: Long length of stay for older adult mental health (discharges with LOS over 60 days / all discharges)	E	0.0%	10.0%		F	H	18.2%		F	H
	S126a: Diagnostic activity waiting times – percentage of patients who have been waiting more than 6 weeks	E	95.0%	39.4%		F		39.0%		F	
	S128a: Virtual wards – percentage occupied	I	100%	130%		F	H	142%		F	H
	S038a: Potential under-reporting of patient safety incidents	E	100.0%	100.0%		?	H	100.0%		?	H
	S039a: National Patient Safety Alerts not completed by deadline	E	0	0		?	L	0		?	L
	S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	E	0	0		?		0		?	
	S041a: Clostridium difficile infections	E	0	0		?		0		?	
	S042a: E. coli blood stream infections	E	0	0		?		0		?	
	S081a: Talking Therapies access (total numbers accessing services)	E	542	485		?		436		?	
	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	63		?		49		?	
	S107a. Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	E	70.0%	65.9%		?		64.9%		?	

	Indicator Description	Internal /External Target	Target	Apr-24 Current Performance		Apr-24 Trending Performance	Apr-24 Variance	Mar-24 Current Performance		Mar-24 Trending Performance	Mar-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%	12.4%		P		12.8%		P	
	S068a: Sickness absence (working days lost to sickness)	I	5.0%	50.3%		F	H	5.4%		F	L
	S071a: Proportion of staff in senior leadership roles who are from a BME background	I	12.0%	7.2%		F		7.5%		F	
	S071b: Proportion of staff in senior leadership roles who are women	I	62.0%	72.3%		P		74.2%		P	
	S071c: Proportion of staff in senior leadership roles who are disabled	I	3.2%	9.6%		P	H	9.7%		P	H
	S133a: Staff Survey – We Are Compassionate and Inclusive People Promise element score	I	0.0%	Annual Metric							
Finance and Use of Resources	S119a: Financial Efficiency	E	-	3.0%				6.0%			H

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.

Item 10

NHS Solent NHS Trust

Title of Paper	Code of Governance for NHS Provider Trusts			
Date of paper	3 June 2024			
Presentation to	In-Public Trust Board			
Item No.	10			
Executive Summary	The aim of this paper is to advise the Board of compliance with the provisions of the *Code of Governance for NHS Provider Trusts,* as part of the disclosure of corporate governance arrangements in the annual report. Each of the provisions is assessed for its compliance with the requirements of the Code and referenced against the relevant section of the Annual Report			
Action Required	For decision?		For assurance?	Y
Summary of Recommendations	In Public Trust Board is asked to discuss and note the report.			
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	 Mike Wats, Chair							

Code of Governance for NHS Provider Trusts

1. Introduction

The aim of this paper is to advise the Board of compliance with the provisions of the Code of Governance for NHS Provider Trusts, as part of the disclosure of corporate governance arrangements in the annual report.

Each of the provisions is assessed for its compliance with the requirements of the Code and referenced against the relevant section of the Annual Report

2. Code of Governance for NHS Provider Trusts

The code (2023) sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems. For the first time, the Code of Governance applies to NHS Trusts, as well as to NHS Foundation Trusts.

To meet the requirements of the 'comply or explain' basis of the Code, Trusts must comply with each of the provisions of the code (which in some cases will require a statement or information in the annual report, or provision of information to the public) or, where appropriate, explain in each case why the trust has departed from the code.

Some provisions require a statement or information in the annual report, which is referenced in the appended document. Where information would otherwise be duplicated, trusts need only provide a clear reference to the location of the information within their annual report.

Other provisions require a trust to make information publicly available.

3. Recommendation

The Board is asked to discuss and note the report.

Dominic Ford
Governance Programme Lead
May 2024

Code of Governance for NHS Provider Trust

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for foundation trusts and for NHS trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a trust's annual report, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

Pg. item ref	Requirement	Compliance – do we comply already? If not – what do we need to do?			
		Yes	Evidence	No	Actions Required
Section A 2.1	The board of directors should assess the basis on which the trust ensures it effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long-term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering in partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed and how its governance is contributing to the delivery of its strategy.	✓	• Detailed in Great Value for Money, Great Care (73) and Annual Governance Statement (193) sections of annual report, including Going Concern (224) assessment • Work with Fusion partners (20) and broader system partners integral to Trust strategy, including Board approval of FBC for new organisation • Principal risks (22), including strategic provision of services, and uncertainties detailed in annual report, and risk management system (186) within the annual governance statement.		No further action identified
Section A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report	✓	• Positive assurance received through staff survey (126) • Regular reporting through Freedom to Speak Up Guardian (129)		No further action identified

	should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	✓	• Trust values (13) are embedded in our culture and underpin everything we do • Extensive wellbeing package available to staff (130)		
Section A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners have been considered in their discussions and decision-making and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effectives. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	✓	• Working with people and communities section of the report describes progress in delivery of *Alongside Communities,* the Solent approach to engagement and inclusion (82)		No further action identified
Section B 2.6	The board of directors should identify in the annual report each nonexecutive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a Non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees	✓	• Declarations are published on public website and included within the director's report (169) • Status of directors and independence included in director's report (169)		No further action identified

	• holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment3 • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the Non-executive director is independent, it needs to be clearly explained why				
Section B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	✓	• Detailed in Director's report (172)		No further action identified
Section C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	✓	• Detailed in Directors' report (161)		No further action identified
Section C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors	✓	• Detailed in annual governance statement and monitored by Audit and Risk Committee		No further action identified
Section C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors	✓	• Detailed in Director's report (180) and remuneration report (203) • Composition, balance of skills and experience of the Board, together with succession planning is reviewed regularly		No further action identified

	and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	✓ ✓ ✓	by the Remuneration and Nomination Committee • Comprehensive section of the annual report on Equality, Diversity and Inclusion (106) • Information contained within the EDI Annual Report and WRES section of annual report (118) • Detailed in EDIB annual report		
Section D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit	✓ ✓ ✓	• No significant issues were raised. • Detailed in *Our Auditors* section of annual report (177, 181) • Not applicable • No non-audit services were conducted in-year		No further action identified

	• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.				
Section D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy	✓	• Statement of Directors' responsibilities in respect of the accounts (202)		No further action identified
Section D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	✓	• Board and Board Committees routinely review Board Assurance Framework • Risk management system detailed in Annual Governance Statement (186) • Principal risks and uncertainties facing the organisation detailed in report (22)		No further action identified
Section D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	✓	• Board and Board Committees routinely review Board Assurance Framework • Risk management system detailed in Annual Governance Statement (186) • Audit and Risk Committee monitors effectiveness of internal control system, including through internal audit programme (181) • No significant issues identified in control system (200)		No further action identified
Section D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going	✓	• Going Concern basis detailed in annual report (224)		No further action identified

	concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.				
Section E 2.3	Where a trust releases an executive director, eg to serve as a nonexecutive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	✓	• Not applicable		No further action identified
Section A 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	✓	• HEART values explained and detailed throughout the annual report (13)		No further action identified
Section A 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	✓	• Detailed in performance analysis (142), Great Care (73), and Great Value for Money sections of annual report • Board reviews Integrated Performance Report at each of its meetings • Executive Performance Review system		No further action identified

Section A 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	✓	• Board reviews Integrated Performance Report at each of its meetings • Detailed in performance analysis (142) • Risk-based internal audit programme		No further action identified
Section A 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered	✓	• Described in Great Care section of annual report (25)		No further action identified
Section A 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners.	✓	• Community engagement detailed within annual report (82). Board engagement includes with patient safety partners, patient and staff stories, Board visits, Fusion engagement, development of quality priorities and annual general meeting		No further action identified
Section A 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	✓	• Freedom to Speak Up Team in place and provides regular verbal updates and six-monthly written reports to the Board (129).		No further action identified
Section A 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of	✓	• Register of Interests process explained as required by the		No further action identified

	third parties does not compromise or override independent judgement.		'Managing Conflicts of Interest in the NHS' guidance (169).		
Section A 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	✓	• Routinely record individual Board members concerns and comments. Also on request, specifically reference matters attributable to them for the public record.		No further action identified
Section B 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues	✓	• Regular meetings held with Chair, CEO, and corporate governance team to agree Board agendas.		No further action identified
Section B 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively.	✓	• Detailed in Board Standing Orders and standards for report writing. Actions taken forward through well-led action plan		No further action identified
Section B 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of Non-executive directors in particular and ensuring a constructive relationship between executive and Non-executive directors.	✓	• Board and Committee meetings undertaken in line with Trust values and active reflection on culture of meetings		No further action identified
Section B 2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 on page 16. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	✓	• Trust compliant. Detailed in composition of Board Committees (169)		No further action identified

Section B 2.7	At least half the board of directors, excluding the chair, should be nonexecutive directors whom the board considers to be independent.	✓	• Detailed in directors' report. Composition of board directors reflects requirement for majority of non-executive directors (169)		No further action identified
Section B 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	✓	• Not applicable		No further action identified
Section B 2.9	The value of ensuring that committee membership is refreshed, and that no undue reliance is placed on particular individuals should be taken into account in deciding chair ship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a Non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse Non-executive directors with a range of skill sets, backgrounds and lived experience.	✓	• Board members' balance of skills and experience is reviewed regularly by the Remuneration and Nominations Committee. Variety of NED skills. 1 NED with clinical background in post		No further action identified
Section B 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	✓	• Detailed in terms of reference		No further action identified
Section B 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	✓	• NEDs invited to sit on interview panels • The CEO conducts appraisals of execs. The Chair appraises the CEO. • Performance evaluation of Executives included in Remuneration and Nomination Committee cycle of business • NED meetings held after main Board on a regular basis		
Section B 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to	✓	• Upon appointment, individuals are required to inform the Trust		No further action identified

	appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Fulltime executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chair ship of such an organisation.		and appointing manager any additional appointments and offices held. On an annual basis all Board members declare their interest (169) and any matters of concern would be dealt with via the CEO, Chair and with the support of the CPO.		
Section B 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	✓	• Board has access to Company Secretary and whole Board approved appointment		No further action identified
Section B 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	✓	• The Board is appraised with any key quality and safety matters, including through Quality Assurance Committee and via comprehensive reporting in the Integrated Performance Report.		No further action identified
Section B 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	✓	• Board conducted as set out in ToRs and underpinned by the Scheme of Delegation and Reservation of Powers.		No further action identified
Section B 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as	✓	• Board challenge/proposals and approvals are documented within minutes of the meetings. The Board receives relevant reports to cover the monitoring of performance, financial, clinical and other information to ensure financial and clinical		No further action identified

	to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.		quality controls and risk are implemented.		
Section B 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	✓	• Board meet formally every other month and for workshops every other month, with additional meetings as required		No further action identified
Section C 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	✓	• Fit and Proper Person's requirements undertaken on appointment and through annual review		No further action identified
Section C 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing Non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England	✓	• Tenure log maintained. Succession planning process in place. Chair tenures have not extended beyond 9 years.		No further action identified

Section C 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. NHS England lead the evaluation of the chair and Non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	✓	• Board director appraisal processes in place • Committee effectiveness reviews undertaken annually • Comprehensive well-led review undertaken and actions monitored		No further action identified
Section C 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	✓	• The Board collectively review results and consider recommendations made for improvements and areas to address.		No further action identified
Section C 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	✓	• The Rem & Nom Committee is responsible for recommending Board development activities from skill mix analysis, appraisals of committees and the Board and other feedback mechanisms. Stated within the Terms of Reference		No further action identified
Section C 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	✓	• The Remuneration and Nominations Committee ensures contractual terms are carried out on termination and payments are fair to the individual and NHS. Detailed in Remuneration report (203)		No further action identified
Section C 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors	✓	• Robust Director induction programme in place with documentation and meeting activity filed for each new		No further action identified

	and, for foundation trusts, governors should make every effort to participate in training that is offered.		member of staff for information.		
Section C 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias	✓	• Mandatory training is closely monitored and completed as necessary. Records are kept on the LMS system. • In addition, Board members are offered external opportunities for training eg via HMFA, NHS Providers and alternatives.		No further action identified
Section C 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	✓	• Regularly reviewed by the Remuneration and Nominations Committee (203). • Values are widely displayed and all up to date policies are available on SolNet (13).		No further action identified
Section C 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	✓	• Thorough induction programme in place for all execs and non-execs on appointment.		No further action identified
Section C 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	✓	• The Chair conducts the CEO appraisal of which there may be training needs identified. The CEO conducts the executive team appraisal of which training		No further action identified

			needs maybe identified. Anything of particular escalation or concern would be raised with the chair accordingly.		
Section C 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	✓	• Refer to B2.2		No further action identified
Section C 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	✓	• Refer to B 2.2		No further action identified
Section C 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	✓	• Board report templates are provided to assist in ensuring the correct information is reported. Effective report writing instruction is also available.		No further action identified
Section C 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances	✓	• Reports shared with the Board contain comprehensive		No further action identified

	received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.		information for challenge and appropriate decisions to be made. Board reports are approved by the executive sponso. Further information requested during meetings would be logged as an action for completion.		
Section C 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	✓	• Advice obtained as required e.g. through Fusion process		No further action identified
Section C 5.13	Committees should be provided with sufficient resources to undertake their duties	✓	• Requirement duly noted. No issues with compliance to date.		No further action identified
Section C 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles	✓	• Supporting papers for the Board and reporting committees are shared 5 working days prior to the meeting to allow time to read and digest papers.		No further action identified
Section C 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance	✓	• Insurance cover in place. Copy of policy available.		No further action identified

	with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.				
Section C 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	✓	• Audit Committee meetings are held quarterly and chaired by a nonexecutive who has a financial background (162). Trust Chair is not a member of the committee. Vice chair does not chair the meeting. • As set out in the committee Terms of Reference.		No further action identified
Section C 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy	✓	• Compliant in all areas as specified within the committee Terms of Reference		No further action identified

	• reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent nonexecutive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.				
Section D 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.	✓	• Procurement undertaken either by full tender or mini competition through official framework. • Mini competition held 2022 and preferred bidder given new contract for 2 years with possible 12-month extension. Contract start date 01/08/2022		
Section D 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and	✓	• The Audit Committee approves any non-audit services conducted including acceptable thresholds and safeguards. Any		No further action identified

	implement a policy on the engagement of the external auditor to supply non-audit services.		work is disclosed within the Annual Report.		
Section E 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	✓ ✓ ✓	• Detailed in remuneration report (203) .		No further action identified

Section E 2.2	Levels of remuneration for the chair and other Non-executive directors should reflect the Chair and Non-executive director remuneration structure.	✓	• Remuneration aligned with national framework. Appointments made by NHSE		No further action identified
Section E 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate clawback provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	✓	• Payments made are to be fair to the individual and NHS, aligned with the interest of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised in line with national guidance.		No further action identified
Section E 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity	✓	• Detailed in remuneration report		No further action identified
Section E 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	✓	• Detailed within the Committee terms of reference and remuneration report		No further action identified
Section E 2.8	Trusts should wait for notification and instruction from NHS England before implementing any cost-of-living increases.	✓	• Trust approach in line with national arrangements		No further action identified
Section B 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available	✓	• Detailed in directors report		No further action identified

Section C 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	✓	• Detailed in directors report and annual governance statement		No further action identified
Section E 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	✓	• Described in Committee terms of reference		No further action identified
Section B 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	✓	• The role of Board and its Committees are set out within the annual report.		No further action identified
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	✓	• Detailed in directors report		No further action identified
Section E 2.6	The board of directors should establish a remumuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	✓	• Details of the Remuneration and Nominations Committee are included within the Annual Report page 137 • The Chief People Officer attends the meeting as required		

Title of Paper	Information Governance & Data Security Compliance Report 2023/24 End of Year Report and DSPR Submission Report
Date of paper	17 May 2024
Presentation to	In-Public Trust Board
Item No.	11
Author(s)	Sadie Bell, Head of Information Governance & Digital Security / Data Protection Officer
Executive Sponsor	Nicola Burnett – Chief Finance Officer / SIRO
Executive Summary	The aim of this paper is to inform the Trust Board on the Trust's end of year compliance with Information Governance & Digital Security Practices, inclusive of Mandatory Requirements. To present the Trust's closing position for 2023/24 Data Security and Protection Toolkit (DSPT), for sign off and approval and to share the learning and areas for improvement including the priorities that will move into Hampshire and IoW Healthcare NHS Foundation Trust.

Action Required	For decision?	Y – DSPT only	For assurance?	Y

Summary of Recommendations	In-Public Trust Board is asked to receive the report and in doing so: • Note assurance of the Trust's compliance levels / status • Note the risks identified and priority areas of focus moving Hampshire and IoW Healthcare NHS Foundation Trust. • Approval the Trust's closing position for the 2023/24 Data Security and Protection Toolkit (DSPT)

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

Positive / negative inequalities	n/a
Previously considered at	Review by the Trust's SIRO

Strategic Priority this paper relates to

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

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	 Nikki Burnett, CFO

Information Governance & Data Security Compliance Report 2023/24 – End of Year Report

1. Purpose

1.1 The purpose of this report is to provide the Trust with a summary of the Trust's current Information Governance Compliance with Law, National Requirements and Mandatory NHS Requirements.

1.2 Information Governance covers; Data Protection Legislation, Freedom of Information Act, Information Management, Information Security, and Cyber Security.

1.3 Solent NHS Trust believes that it is essential to the delivery of the highest quality of health care for all relevant information to be accurate, complete, timely and secure. As such, it is the responsibility of all staff and contractors working on our behalf to ensure and promote a high quality of reliable information to underpin decision making.

1.4 Information Governance promotes good practice requirements and guidance to ensure information is handled by organisations and staff legally, securely, efficiently, and effectively to deliver the highest care standards. Information Governance also plays a key role as the foundation for all governance areas, supporting integrated governance within Solent NHS Trust.

1.5 This report covers Solent NHS Trust's Information Governance's activity concerning;

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

2. Data Protection and Security Toolkit

2.1 The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool, mandated by the Department of Health and provided by NHS Digital, which enables Health and Social Care organisations to measure their performance against Data Security and Information Governance standards and legislation.

The ten Data Security Standards were a result of the NDG review and therefore the focus of the new Toolkit, which is then split into three categories:

- **Leadership Obligation 1 – People:** *Ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles*.
- **Leadership Obligation 2 – Process:** *Ensure the organisation proactively prevent data security breaches and responds appropriately to incidents or near misses*
- **Leadership Obligation 3 – Technology:** *Ensure technology is secure and up to date*

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Organisations are mandated to meet all mandatory requirements, in order to be classified as Compliant & Assurance Met.

2.2 **2023/24 Toolkit:** The publication of the 2023/24 DSPT, operates for the period July 2023 – June 2024. The Trust was also required to submit its baseline submission on the 28th February 2024, which it did do.

Change Summary: This year's DSPT consists of

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

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

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

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

Breakdown of the work required:

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

Focus: The Trust focused its attention on the mandatory requirements and assertions; the Head of IG & Digital Security would like to offer the board an assurance statement that the Trust has achieved full compliance on all mandatory requirements. The Trust also undertook an independent audit of its DSPT, in February 2024 and received a "moderate" outcome to the audit, supporting the Trust's compliance.

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

Compliance Status	**No. Requirements**
Compliant	104
Compliant (non-mandatory)	10
Non-mandatory or N/A	14

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

Concerning	Summary
SARS	• There was a 21.5% increase in the number of requests received by the Trust, when comparing 2022/23 to 2023/24 • Overall compliance in 2023/24 to date: 98.2%, which is above the mandatory compliance rate of 95% and an increase compliance rate of 1.5% when compared to 2022/23 • Overall, 91.3% of requests were released within the best practice timeframe of 21 days, whish is and increase of 10.7% when compared to 2022/23 • There are currently 12 requests (Q4) that have not been released, however they are also currently not due to be released (legal deadline) or are on hold; therefore, figures are subject to change.
FOIs	• There was a 13.5% increase in the number of requests received by the Trust, when comparing 2022/23 to 2023/24 • Overall compliance in 2023/24 to date: 98.6%, which is above the mandatory compliance rate of 95% and an increase compliance rate of 4.3% when compared to 2022/23 • Q4 saw the Trust achieve 100% compliance for the quarter • There are currently 4 requests (Q4) that have not been released, as they are currently on hold; therefore, figures are subject to change. • Sessions continue to be held with services, who receive frequent FOI's, to assess how we can proactively address FOIs, with a number of the actions from this session now in place, reducing the impact of FOI's on the Trust.
Overall support	• The Trust continues to see a year-on-year increase in the number of requests received. The increase rate is also growing each year. For example, the 2022/23 increase was 11% and this year's increase rate is 13.5%. • The Trust is maintaining compliance above the 95% mandatory compliance rate. • Despite the increase in the number of requests received, the Trust has increased its compliance rates, both overall and in best practice, with regards to SARs, through continuous service and process reflections, training and efficiencies.

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

4. Information Governance/Security Incidents 2023/24 Deep Dive

4.1 ***IG Incident Summary 2023/24***

Concerning	Summary 2023/24
No. Incidents reported	• 690 Information Governance Incidents were reported in 2023/24 • 291 (42.2% of the reported incidents) were deemed to be either "Out of Our Control" e.g., breaches by third parties or "No IG Breach" e.g., near miss or the information was considered to not be identifiable and therefore no breach. • 399 incidents, within Solent NHS Trust's control were reported within this reporting period

Most Common type of reported incidents	• Top two most common reported IG incidents, make up 71.9% of the Trust's total IG Incidents (within our control)
	  ○ PID sent to wrong person / address (148)
	  ○ PID in wrong record / record error (139)
	• A deep dive report into these incidents was undertaken in February 2024.
	  ○ The findings indicated that the root cause of incidents is not predominantly to do with the processes in place currently within the Trust, but the human elements of working practices. Actions were identified to address the human elements and have been included in Appendix C of this report.

Important to note	• The Trust reported four IG incidents to the ICO in 2023/24, all relating to staff accessing their own or family members information (at their request). The ICO has not taken any action against the Trust and appropriate HR processes were followed. The Trust takes such incidents very seriously and provide continuous education and training to staff, with regards to appropriate access of information.

Type of Incident	No of Incidents Report April 23 – March 24
PID Sent to Wrong Person / Address	148
PID in Wrong Record / Record Error	139
Inappropriate Access / Disclosure (Includes accidental internal disclosures)	35
PID Saved / Stored Insecurely	33
Non-Encrypted Email Used for PID	15
PID Found in Public Place (includes Trust areas open to the public)	15
Other IG	10
Lost / Missing PID	4
Cyber Security	0 *this type of incident is reported as "No IG Breach"
Lost Smart Card / ID Badge	0 *this type of incident is reported as "No IG Breach"

5. Information Management & Cyber Security Assurance

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

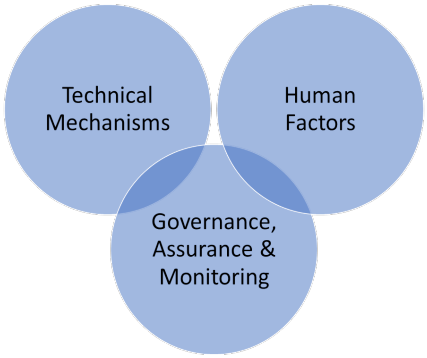
5.2 As part of this journey the Trust has established an Information Management & Cyber Security Strategy, which is a sub-strategy of the Trust's Digital Strategy. This strategy has outlined several key deliverables and achievements.

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

Cyber Security Assurance, Assessment and Monitoring	Training and Education	Culture: Creating an Environment of Digital Ownership & Accountability
➢ Understanding of technology dependency and governance of technology risk ➢ Cyber security strategy (understanding of cyber security risks) ➢ Ransomware-specific assessments ➢ Effective cyber security monitoring and response ➢ Testing of cyber security capability through simulated attacks ➢ Cyber security incident response and crisis management plans ➢ BCP and disaster recovery – planning for a ransomware scenario	➢ Staff education reference Cyber Security ➢ Evaluation of staff's understanding of Cyber Security ➢ Staff education reference information management standards and requirements ➢ Monitoring and assessment of staff's understanding and adherence to information standards and requirements ➢ Develop a Trust-wide knowledge bank and the sharing of best-practice	➢ Develop a culture of individual and service ownership of data; ensuring the confidentiality, integrity, and availability of data ➢ Develop a culture of individual ownership over the security and safeguarding of the Trust's information security and awareness ➢ Develop a culture of reporting and learning from information related incidents ➢ Develop a culture of information and digital maturity; as well as an understanding of the value of digital information.

5.4 This strategy is underpinned by the Trust's new Cyber Security Model, which requires the Trust to look at cyber security through three lenses, instead of the standard "technical" lens. The benefit of this model is that it allows the Trust to protect, defend and asses its cyber security position from multiple mechanisms, meaning that the Trust is not reliant on one approach nor vulnerable by not assessing other mechanisms: providing greater protection against cyber security

Cyber Security Model



What have we achieved to date: Since the Boards last Cyber Security Update in November 2023, the following elements have been implemented and / or commenced.

Technical	Human Factors	Governance & Assurance
• Updating of Window's Operating Model from 20H2 to 22H2 – all outstanding non-InTune laptops and desktops are to be updated to the latest operating model, to bring all devices back into full security patching support. ***Completed*** • InTune project will continue to swap out old devices, with new devices, improving software and patching compliance. ***Ongoing, but drawing to an end*** • Remaining firewalls, not currently in security support and to be addressed by Atos. ***Completed*** • Implementation of the remaining IT Health Check recommendations and Pen Test Vulnerability actions (pending risk assessments). ***Ongoing, but drawing to an end*** • Turning NAC from monitoring mode to preventative mode. ***Commenced – in monitoring mode***	• The Information Governance Team produced a cyber security communication plan, which will increase staff communications and learning being cascaded to staff, advising of common cyber-attacks and counter fraud alerts; with a clear process now in place to communicate such alerts efficiently and effectively. It is planned to both supports, educate can protect staff in both their professional and personal life against cyber security attacks and fraud. Bringing learning into all aspects of their lives, with the intention of making this learning part of their lives and not something they only have to think about at work. ***Completed, with education ongoing*** • Trust is currently working with NHS England to utilise a phishing simulation tool provided by them. ***Commenced – due to be rolled in June 2024***	• Continual vulnerability management assessments to be undertaken by the Trust's Cyber Security Manager and managed / monitored until resolved. Inclusive of monthly cyber security dashboard assessment. ***Ongoing, with significant decreases to vulnerability and increases in security compliance rates*** • Cyber Essentials Plus Gap Analysis is to be completed in September 2023. ***Commenced*** • Continual progression of the Trust's access control projects. ***Ongoing, but drawing to an end*** • Continual in-depth assessment of the cyber dashboard to understand Solent's 'exposure' score has commenced. ***Ongoing piece of work***

In addition, in June 2023, the Trust appointed a Cyber Security Manager. A review of the Trust's cyber security performance between June 2023 and March 2024 shows significant improvement in key cyber security metrics of risk preventions, detections, monitoring and recovery, enabling the Trust to deliver health care services safely and securely to patients.

		June 2023	March 2024
1	**Microsoft Defender for Endpoint (MDE)**	**High (70+)**	**Medium (40)**

Microsoft Defender for Endpoint (MDE) is an endpoint security solution deployed to enable NHS England's CSOC to spot potential threats on endpoint devices and servers. The Trust has improved from a **High risk rating** with an over 70/100 Exposure Score to **Medium risk rating** at an average of less than 40/100 between June 2023 and March 2024. This MDE Exposure Score is an indication of the strength of cyber security control in the Trust's internal environment.

2	**Antivirus Compliance**	**64.0%**	**87.0%**

Antivirus compliance measures the compliance of Endpoints and Servers with the latest released antivirus patch. The Trust's systems show an improvement from 64% in June 2023 to 87.0% in March 2023.

3	**Patching Compliance**	**65.8%**	**94.4%**

Patching compliance of Endpoints and Servers to the latest patches improved from 65.8% in June 2023 to 94.4% in March 2024.

4	**Bitsight & VMS – External Vulnerabilities**	**790/100 (Advanced)**	**790/100 (Advanced)**

Bitsight and Vulnerability Monitoring Service are the two solutions that are deployed to monitor and scan the external interfaces of the Trust for vulnerabilities and security configuration weaknesses. Bitsight runs real-time 24/7 while VMS scans the interfaces once monthly. At one point, the Trust score dropped to 770/100 due to scope expansion to cover previously excluded external Ips, identified by the Trust's Cyber Security Manager. The vulnerabilities were escalated and mitigated restoring the risk to Advanced Security position which is an indication of implementation of strong security controls. VMS was initiated in Feb 2024 and scans monthly since then.

5	**Cyber Security Operations Centre (CSOC)**	**Nil**	**Implemented**

Cyber Security Operations Centre (CSOC) monitors the Trust's Servers for the for the first signs of cyber vulnerabilities. This was fully implemented in March 2024. It now provides visibility into security incidents on Servers and the management of such incidents to resolution. In addition, the CSOC scans vulnerabilities on Servers for proactive mitigation.

6	**Multifactor Authentication (MFA)**	**98.9%**	**99.9%**

Implementation of MFA on user accounts improved from 98.9% in June 2023 (59 non-compliant accounts) to 99.9% (13 accounts) in March 2024. Non-compliant accounts have been risk-assessed and accepted due to business requirements.

7	**Software & Apps Groups**	**Nil**	**Implemented**

The Software & Apps Group oversees the safe and secure use of applications across the Trust. Cyber security assessment is a key approval requirement and has improved the awareness of cyber security as a critical process for service activation across the organisation.

8	**IT Estates**	**Nil**	**Implemented**

There is now improved oversight on the Trust's IT Estate through the identification, documentation and monitoring of Endpoints (Laptops/Desktops), Mobile Devices, Servers, and Network Devices.

9	**Overseas Working Policy & Process**	**Nil**	**Implemented**

Overseas Working enables Staff that are not physically present in the United Kingdom deliver safe and secure health care service to our patients. The policy and process ensure staff are dully approved for overseas working following organisational rules and technical assessment of staff and system to prevent cyber incidents.

10	**Vulnerability Management**	**Nil**	**Implemented**

The Vulnerability Management Policy and Process are implemented to ensure proactive identification and remediation of security weaknesses on the Trust IT Estates.

11	**Software Vulnerability Reporting**	**Nil**	**Implemented**

The Software Vulnerability Reporting enables the identification of vulnerable software, awareness of vulnerabilities as published by Vendors, and tracking of remediations.

12	**Cyber Essential Plus – Readiness Assessment**	**Nil**	**Completed (87.5%)**

An assessment of the readiness of the Trust for the Cyber Essential Plus (CE+) certification was conducted. The result shows the Trust is 87.5% compliant with improvements required in mitigation software vulnerabilities and non-compliance to MFA of remotely accessed applications.

In the next 12 months, we are looking at leveraging these achievements to improve on all these cyber security metrics, and especially:

- Adoption of the National Cyber Security Centre's Cyber Assessment Framework (CAF) as the new basis for cyber security and IG assurance replacing DSPT.
- Improve Antivirus compliance benchmark from current state to Endpoint/Server 90%/95%.
- Improve patching compliance benchmark from current state to Endpoint/Server 90%/95%.
- Influence the improvement of Bitsight Score to over 800/900.
- Influence the mitigation of software vulnerabilities through software cyber security assessment, application of patches or service deactivation.
- Improve MDE Score through configuration review and activation of necessary Attack Surface Reduction rules.
- Oversee Business Continuity activities of ICT Vendors and ensuring 100% compliance to BCP testing schedules.
- Influence actions and initiatives to enable 100% readiness for the CE+ certification.

6. Top Three Security Risks (Taken from the May 2024 SIRO Risk Register (Cyber security, IG, ICT and Information Management))

1. **Risk 2635: Public website (Score 12 – Active Risk):** There is a risk that as a result of the Trust's website (solent.nhs.uk) currently running on a piece of software that ran out of support in September 2023, that the website could be exploited.

   Action: Website will be decommissioned in July 2024.

2. **Risk 2258: Multi-Factor Authentication SMS Text Message Option. (Score 10 – Active Risk):** There is a risk that the temporary SMS (text messaging) MFA solution that was implemented, to support the rapid rollout of the Citrix VPN solution (allowing staff to work remotely) is not as secure as the Trust's Microsoft Authenticator MFA Solution that the Trust is wanting all staff to utilise. As the SMS solution is less secure, it can leave the Trust vulnerable to inappropriate access and data breaches, the consequence of which is loss of data, fines and loss of public / patient trust, in the Trust.

   Action: A more secure alternative option is currently being rolled out.

3. **Patching & Cyber Security (Score 10 – Active Risk):** The Trust has a number of risks associated with the Trust's network and software patching, which is actively being addressed by the Trust's new ICT suppliers. There is a risk that the Trust is vulnerable to a cyber-attack, as its security exposure score is above 29 (recommended level). The consequence is that the Trust could have a cyber-attack, impacting its network and infrastructure and access to critical systems. The Trust Cyber Security Manager is focused on assessing, monitoring and addressing the Trust's Cyber Exposure Score.

   Action: The Trust's score is now very close to reaching 29 and continuous daily monitoring of vulnerabilities and threats is being undertaken to achieve this.

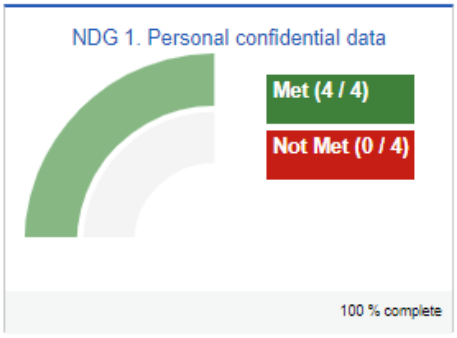
7. Summary

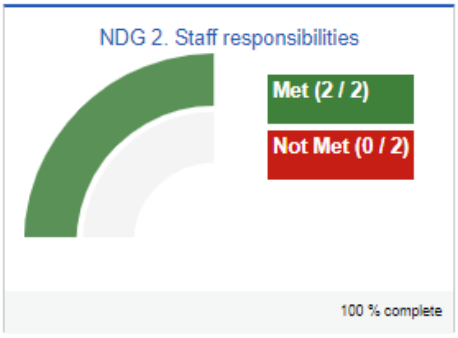
Solent NHS Trust continues to strive for excellent Information Governance compliance and awareness, providing and operating a culture of transparency and openness, as well as continual improvement and learning. This supports the Trust's values and strategies, as well as the foundations of the Data Protection Legislation.

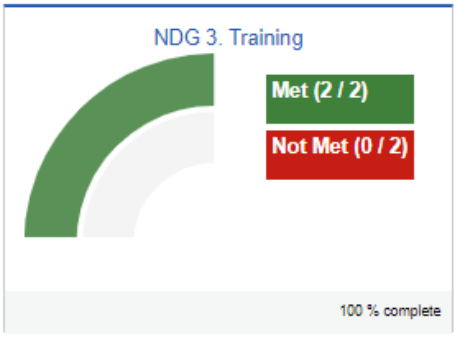
The Information Governance Team continue to focus on improving compliance, creating a learning culture and working collaboratively, going into Hampshire & IoW Healthcare NHS Foundation Trust and are already working extremely closely with all parties to identify best practice across the organisations, in order to implement strengthened practices going forward.

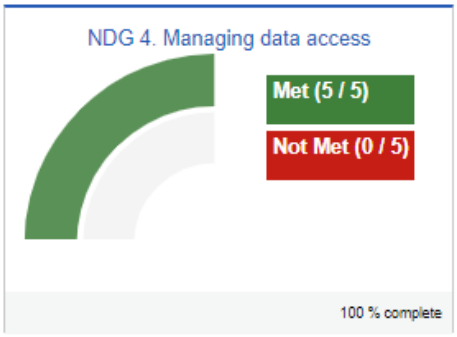
Appendix A: Data Security and Protection Toolkit Submission 2023/24 and Completed Action Plan

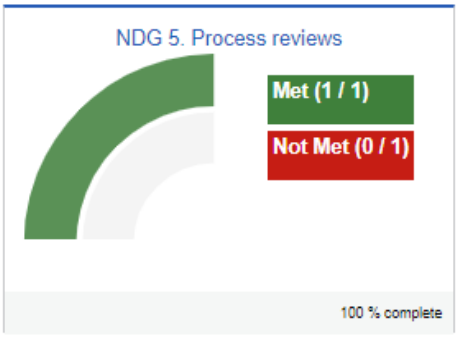
Please note that NDG 9: IT Protection currently shows one “not met”, as we are awaiting the auditors to update that they have completed a satisfactory audit. The audit report has been provided to demonstrate this, but we are awaiting the DSPT to be updated.

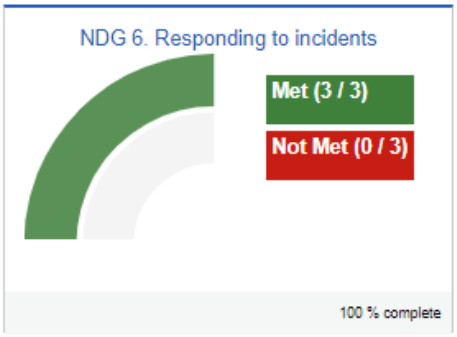


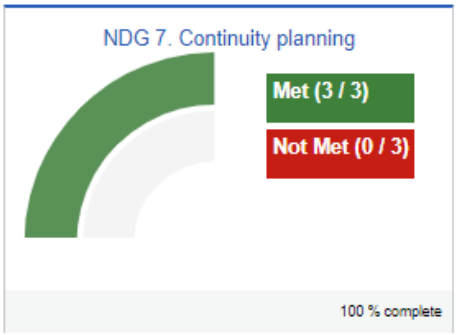


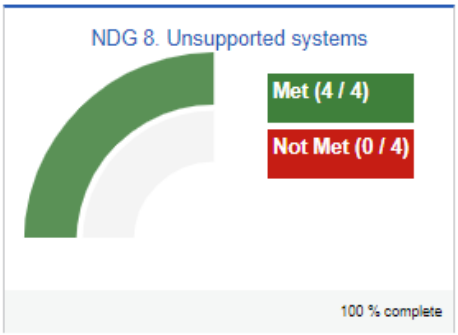


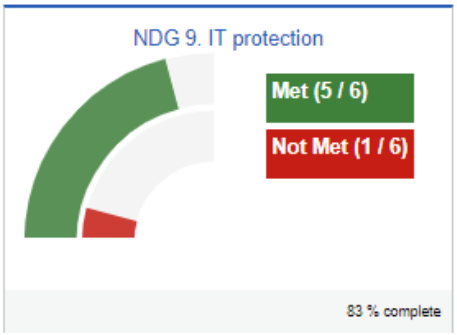












Req.	Status 2023/24	Evidence Text - NHS Trusts	Person Responsible for Signing Off Evidence	Evidence Obtained 2023/24	Evidence Located (Link) 2023/24
NDG Standard 1: Personal Confidential Data **All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.**					
1.1	**The organisation has a framework in place to support Lawfulness, Fairness and Transparency**				
1.1.1	Compliant	State your organisation's Information Commissioner's Office (ICO) registration number.	Sadie Bell, Data Protection Officer	https://ico.org.uk/ESDWebPages/Entry/Z2659626	https://ico.org.uk/ESDWebPages/Entry/Z2659627
1.1.2	Compliant	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Sadie Bell, Data Protection Officer	Data Flow Mapping and ROPA Log Data Protection by Design Procedure Information Asset Register (ICT Register)	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies
1.1.3	Compliant - Non-mandatory	Transparency information (e.g. your Privacy Notice and Rights for individuals) is published and available to the public.	Sadie Bell, Data Protection Officer	Privacy Notices published	https://www.solent.nhs.uk/our-story/publication-scheme/your-information-your-rights/
1.1.4	Compliant	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Sadie Bell, Data Protection Officer	Information Asset Register (ICT Register)	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies
1.1.5	Compliant	List the names and job titles of your organisation's key staff with responsibility for data protection and data security.	Sadie Bell, Data Protection Officer	Nicola Burnett– SIRO Daniel Baylis – Caldicott Guardian Sadie Bell – DPO & Head of Information Governance & Digital Security Dawn Day – Head of Digital Service Delivery Wal Micaiah – Cyber Security Manager Karen McCarthy - Information Governance Assurance & Compliance Operational Manager Caroline Beebee – Information Assurance & Compliance Team Manager JenYong Khor – Information Assurance Officer Sarah Abbott – Information Assurance Officer Marika Bulgajewska – Information Assurance Officer Chanté Nadgie - Information Assurance Officer Margaret Gilbertson - Digital Security Business Support Officer	\\v-dfs-001\Data10\IG Solent\IG Structure \\v-dfs-001\Data10\IG Solent\IG Structure\Other Leads Job Descriptions \\v-dfs-001\Data10\IG Solent\IG Structure\IG Team\Job Descriptions
1.1.6	Compliant	Your organisation has reviewed how it asks for and records consent to share personal data.	Sadie Bell, Data Protection Officer	Data Protection and compliance policy Information Sharing Agreement Template	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Policies\Data Protection Compliance Policy \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.In Progress\1.Templates
1.1.7	Compliant	Data quality metrics and reports are used to assess and improve data quality.	Sadie Bell, Data Protection Officer	Contracts DQMI Board Report MHSDS - DQMI Waiting Times Data Assurance Report - Awaiting Updated Version - Reminder sent 19/01/2024	Additiontional Evidence\1.1.7
1.1.8	Compliant	A data quality forum monitors the effectiveness of data quality assurance processes.	Sadie Bell, Data Protection Officer	Evidence to obtain Advised that ToR and minutes for the group Data Quality would be required - Email sent 19/01/2024	Additiontional Evidence\1.1.8
1.2	**Individuals' rights are respected and supported**				
1.2.2	Compliant	Your organisation has processes in place to deliver individuals rights including to handle an individual's objection to the processing of their personal data.	Sadie Bell, Data Protection Officer	Data Subject Rights Procedure Right of access guidance Right of erasure guidance National Opt Out Guidance DPO Request Cases	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies
1.2.3	Compliant	Your organisation has a process to recognise and respond to individuals' requests to access their personal data.	Sadie Bell, Data Protection Officer	Subject Access Request Processes published Information Request Policy SAR Requests	Subject Access Request Processes published: https://www.solent.nhs.uk/our-story/publication-scheme/your-information-your-rights/ Information Request Policy: R:\IG Solent\DP Documents & Policies\1.Policies\Information Request Policy
1.2.4	Compliant	Your organisation is compliant with the national data opt-out policy.	Sadie Bell, Data Protection Officer	IG23.4 Opt In Out O-SOP V2	Additiontional Evidence\1.2.4
1.3	**Accountability and Governance in place for data protection and data security**				
1.3.1	Compliant	There are board-approved data security and protection policies in place that follow relevant guidance.	Policy Steering Group	Data Protection Compliance Policy - Review Date 05/2025 Information Request Policy - Review Date 05/2025 Records Management Policy - Review Date 05/2025 Registration Authority Policy - - Review Date 04/2023 Data Quality Policy - Review Date 05/2025	https://www.solent.nhs.uk/about-us/trust-information/publication-scheme/our-policies-and-procedures/
1.3.2	Compliant	Your organisation monitors your own	Sadie Bell, Data	Spotcheck Audit Reports	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Procedures\Data Protection

		compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.	Protection Officer	Data Protection Compliance Audit Procedure Emails to senior manager following audits Evidence of last years audit rpeorts and action plan updates	Compliance Audit Procedure
1.3.3	Compliant	SIRO responsibility for data security has been assigned.	Sadie Bell, Data Protection Officer	Nicola Burnett is assinged as SIRO	N/A
1.3.4	Compliant	There are clear documented lines of responsibility and accountability to named individuals for data security and data protection.	Nikki Burnett, SIRO	Nicola Burnett – SIRO Sadie Bell – DPO & Head of Information Governance & Security Dawn Day – Head of ICT Service Delivery Atos & Expo-e – Outsourced ICT Security Trust Data Protection & Security Structure	Obtain extract from Risk Management Team prior to submission \\solnhs.local\storagepool\Data10\IG Solent\Reports & Meetings\SIRO Report \\solnhs.local\storagepool\Data10\IG Solent\IG Structure
1.3.5	Compliant	Your organisation operates and maintains a data security and protection risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility.	Nikki Burnett, SIRO	Data security and protection risk management framework and risk register (SIRO Risk Register) Corporate risk management framework and risk register. Monthly risk register is discussed in SIRO Report Quarterly reviewed at DIG Third Party Suppliers Data Protection & Security Assurance Policy	Obtain extract from Risk Management Team prior to submission \\solnhs.local\storagepool\Data10\IG Solent\Reports & Meetings\SIRO Report \\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\1.3.5Third Party Suppliers Data Protection & Security Assurance Policy
1.3.6	Compliant	List your organisation's top three data security and protection risks.	Nikki Burnett, SIRO	Data Protection Policy to outline Risk Management Assessment Responsibility Trust Risk Management Framework SIRO Report demonstrating monthly review of risks DIG Agenda & Minutes when risks are discussed	\\v-dfs-001\Data10\IG Solent\DP Documents & Policies\1.Processes\Data Protection Risk Management Procedure \\v-dfs-001\Data10\IG Solent\Data Security & Protection Toolkit\2021-22\Additional Evidence\1.3.6 \\v-dfs-001\Data10\IG Solent\Reports & Meetings\SIRO Report https://solenttrust.sharepoint.com/:f:/t/SolentDigitalGovernance-DigitalInformationGroup/EsNcL9n5GlhEnLwql2Lrg-sBfzIWbfqdlIZbebkjphxM4g?e=SZHxhr
1.3.7	Compliant	Your organisation has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.	Sadie Bell, Data Protection Officer	Data Protection by Design Procedure Privacy by Design Compliance Report CEG Minutes (May 2022)	\\v-dfs-001\Data10\IG Solent\DP Documents & Policies\1.Processes\Data Protection by Design Procedure \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Procedures\Data Protection by Design Procedure\Audit Assessments \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Policies
1.3.8	Compliant	Your organisation understands when you must conduct a Data Protection Impact Assessment and has processes in place, which links to your existing risk management and project management, to action this.	Sadie Bell, Data Protection Officer	Data Protection by Design SoP, inclusive of DPIA Process and Template	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.In Progress\1.Templates \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Procedures\Data Protection by Design Procedure \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Policies
1.3.9	Compliant	Data security and protection direction is set at board level and translated into effective organisational practices.	Nikki Burnett, SIRO	Board Reports DIG ToR inclusive of responsibility to monitor Data Protection	\\solnhs.local\storagepool\Data10\IG Solent\Reports & Meetings\Assurance & Board Reports https://solenttrust.sharepoint.com/:f:/t/SolentDigitalGovernance-DigitalInformationGroup/ErVNV2CtTsxAjzrzvHrLYeIBm-pyvHnZRh-K3W9Ci-ZC-w?e=DBpSt9
1.4	**Records are maintained appropriately**				
1.4.1	Compliant	The organisation has a records management policy including a records retention schedule.	Sadie Bell, Data Protection Officer	Records Management Policy We have adopted the NHS Records Management Code of Practice,, with regards to Record Retention	..\..\DP Documents & Policies\1.Policies\Records Management Policy
NDG Standard 2: Staff Responsibilities **All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.**					
2.1	**Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards**				
2.1.1	Compliant	The organisation has a nominated member of the Cyber Associates Network.	Sadie Bell, Data Protection Officer	Registration confirmation email	\\v-dfs-001\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\3.3.3
2.2.1	**Staff contracts set out responsibilities for data security**				
2.2.1	Compliant	All employment contracts contain data security requirements.	Sadie Bell, Data Protection Officer	Copy of HR contract/ assurance from HR	\\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\2.2.1
NDG Standard 3: Training **All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit**					
3.1	**Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training and awareness**				
3.1.1	Compliant	Training and awareness activities form part of organisational mandatory training requirements, with a training and awareness needs analysis (covering all staff roles) that is formally endorsed and resourced by senior leadership.	Nikki Burnett, SIRO	Training Plan and approval by SIRO	..\..\Training\2023-24_Training_IG & Cyber\Training Plan
3.1.2	Compliant	Your organisation's defined training and awareness activities are implemented for and followed by all staff.	Nikki Burnett, SIRO	Training Plan and Training Reports	\\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber\Training Plan \\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber
3.1.3	Compliant	Provide details of how you evaluate your training and awareness activities.	Nikki Burnett, SIRO	Training Plan and revised Training Tools	\\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber\Training Plan \\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber\2023_24_Mandatory

					Training Tools
3.2	**Your organisation engages proactively and widely to improve information governance and cyber security, and has an open and just culture for information incidents.**				
3.2.1	Compliant	Information governance and cyber security matters are prioritised by the board or equivalent senior leaders.	Sadie Bell, Data Protection Officer	Training Report - Overall complaince	..\..\Training\2023-24_Training_IG & Cyber\2023-24_Overall_Compliance Report.xlsx
3.2.2	Non-Mandatory	Actions are taken openly and consistently in response to information governance and cyber securityconcerns.	Sadie Bell, Data Protection Officer		
3.2.3	Non-Mandatory	Your information governance and cyber security programme is informed by wide and representative engagement with staff.	Sadie Bell, Data Protection Officer		
NDG Standard 4: Managing Data Access **Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.**					
4.1	**The organisation maintains a current record of staff and their roles**				
4.1.1	Compliant	Your organisation understands who has access to personal and confidential data through your systems, including any systems which do not support individual logins.	Sadie Bell, Data Protection Officer	Organisational Chart Trust Data Protection & Security Structure IG Team Job Descriptions ICT Security Leads Job Descriptions Starters Leavers Process Starers / Leavers Report Recipients	https://www.solent.nhs.uk/about-us/corporate-documents/ \\v-dfs-001\Data10\IG Solent\IG Structure \\v-dfs-001\Data10\IG Solent\IG Structure\IG Team\Job Descriptions \\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additional Evidence\4.1.1
4.1.2	Non-Mandatory	Users in your organisation are only given the minimum access to sensitive information or systems necessary for their role.	Sadie Bell, Data Protection Officer		
4.2	**The organisation assures good management and maintenance of identity and access control for it's networks and information systems**				
4.2.1	Complaint	When was the last audit of user accounts with access to the organisation's systems held?	Sadie Bell, Data Protection Officer	Confirmation emails as evidence of the completion of user access audits of applications	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\Req 4
4.2.2	Compliant - Non-mandatory	Provide a summary of data security incidents in the last 12 months caused by a mismatch between user role and system accesses granted.	Sadie Bell, Data Protection Officer	Incident Report IG & Cyber Newsletter - Bi-Monthly Incidents Shared Learning Incidents - Guidance	..\..\Risks & Incidents\Incident\2023-24\Reports\2023_24_Monthly Incident_Reporting.xlsx \\solnhs.local\storagepool\Data10\IG Solent\Communications\Cyber\News Letters \\solnhs.local\storagepool\Data10\IG Solent\Communications\Incident Shared Learning\2023 - 2024 \\solnhs.local\storagepool\Data10\IG Solent\Communications\Guidance\2023 - 2024
4.2.3	Compliant	Logs are retained for a sufficient period, managed securely, reviewed regularly and can be searched to identify malicious activity.	Sadie Bell, Data Protection Officer	SIEM Log Retention Setting Raw Log Export file	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.2.3 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.4.1
4.2.4	Compliant	Unnecessary user accounts are removed or disabled.	Sadie Bell, Data Protection Officer	IT Security Policy NHS Solent - User review call - Q4 2023 Removal of unnecessary accounts - Email	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.2.4
4.3	**You closely manage privileged user access to networks and information systems supporting the essential service**				
4.3.1	Compliant	All system administrators have signed an agreement which holds them accountable to the highest standards of use.	Sadie Bell, Data Protection Officer	Acceptable Use Policy (Atos) Sample Contract of Employment (Expo-e) Cyber Security Awareness attendance (Expo-e)	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.3.1 Security Awareness: 2024.01.22_DPST Toolkit 2023_24 - Requirement No - 4_3.1 (Expo-e)
4.3.2	Compliant	Users, systems and (where appropriate) devices are identified and authenticated prior to being permitted access to information or systems.	Sadie Bell, Data Protection Officer	NHS Solent O365 Modular High-Level Design Authentication (Password) configuration setting (Screenshot) AB 2023-12-12 - all Solent EUDs are either AD or AAD joined, and identification and authentication is built-in and enforced functionality for both. Users of AAD joined systems are also MFA enabled and enforced. Servers are AD joined and benefit from the same identification and authorisation policies as AD joined EUDs.	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.5.3 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.2.3
4.3.3	Compliant - Non-mandatory	All staff have been notified that their system use could be monitored.	Sadie Bell, Data Protection Officer	Staff are advised through IG Training Data Protection Compliance Policy	\\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber\2023_24_Mandatory Training Tools \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Policies\Data Protection Compliance Policy

4.4	**You closely manage privileged user access to networks and information systems supporting the essential service**				
4.4.1	Compliant	The organisation ensures that logs, including privileged account use, are kept securely and only accessible to appropriate personnel. They are stored in a read only format, tamper proof and managed according to the organisation information life cycle policy with disposal as appropriate.	Sadie Bell, Data Protection Officer	SIEM Log Retention Setting List of users with access to logs (screenshot) RE: DSPT Evidence Collection: CSOC (Email)	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.4.1
4.4.2	Compliant	The organisation does not allow users with wide ranging or extensive system privilege to use their highly privileged accounts for high-risk functions, in particular email and web browsing.	Sadie Bell, Data Protection Officer	AB 2023-06-08 - end users don't have elevated permissions. Elevated prmissions require a separate admin account. Admin accounts are not mail enabled	
4.4.3	Non-Mandatory	The organisation only allows privileged access to be initiated from devices owned and managed or assured by your organisation.	Sadie Bell, Data Protection Officer		
4.5	**You ensure your passwords are suitable for the information you are protecting**				
4.5.1	Compliant	Your organisation has a password policy giving staff advice on managing their passwords.	Sadie Bell, Data Protection Officer	ICT Password Policy Data Protection Compliance Policy Evidence of network password implementation	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Policies\Password Policy \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Policies\Data Protection Compliance Policy \\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2021-22\Additional Evidence\4.5.1
4.5.2	Compliant	Technical controls enforce password policy and mitigate against password-guessing attacks.	Sadie Bell, Data Protection Officer	Evidence of network password implementation	\\v-dfs-001\Data10\IG Solent\Data Security & Protection Toolkit\2021-22\Additional Evidence\4.5.2
4.5.3	Compliant	Multifactor authentication is used wherever technically feasible.	Sadie Bell, Data Protection Officer	453 - authentication strategy - part of the O365 HLD.pdf	\\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\4.5.3
4.5.4	Complaint	Passwords for highly privileged system accounts, social media accounts and infrastructure components shall be changed from default values and should have high strength.	Sadie Bell, Data Protection Officer	Password Policy Password Settings	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.5.1
4.5.5	Non-Mandatory	Your organisation, or your supply chain with access to your systems, grant limited privileged access and third party access only for a limited time period, or is planning to do so.	Sadie Bell, Data Protection Officer		
NDG Standard 5: Process Reviews **Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.**					
5.1	**Process reviews are held at least once per year where data security is put at risk following data security incidents**				
5.1.1	Compliant	Root cause analysis is conducted routinely as a key part of your lessons learned activities following a data security or protection incident, with findings acted upon.	Sadie Bell, Data Protection Officer	Data Protection Incident Management Procedure Incident Reports Incident Log Incident Deep Dive Report Actions taking / Lessons Learnt (service engagement)	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Procedures\Data Protection Risk Management Procedure \\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\HRI_SI\2023-2024 \\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\Reports\Cyber Reports \\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\Incident\2023-24 \\solnhs.local\storagepool\Data10\IG Solent\Communications\Service Engagement
5.2	**Action is taken to address problem processes as a result of feedback at meetings or in year**				
5.2.1	Compliant - Non-mandatory	Actions to address problem processes are being monitored, and assurance is given to the board or equivalent senior team.	Sadie Bell, Data Protection Officer	Incident Deep Dive Report 2023/24 Evidence that actions have been completed for 2022/23 - Included in Incident Deep Dive Report 2023/24	\\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\Reports
NDG Standard 6: Responding to Incidents **Cyber-attacks against services are identified and resisted and security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.**					
6.1	**A confidential system for reporting data security and protection breaches and near misses is in place and actively used**				

6.1.1	Compliant	Data security and protection incidents are reported appropriately and by a full range of staff groups.	Policy Steering Group	Data Protection Risk Management Procedure Commercial contract template IG Training Tools	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Procedures\Data Protection Risk Management Procedure \\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber\2023_24_Mandatory Training Tools
6.1.2	Compliant	The board or equivalent have been informed of the action plan for all data security and protection breaches reported to the ICO and/or the DHSC in the last twelve months.	Nikki Burnett, SIRO	HRI/SI Reports Incident Log Board Report (to be completed)	\\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\HRI_SI \\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\Incident \\solnhs.local\storagepool\Data10\IG Solent\Reports & Meetings\Assurance & Board Reports
6.1.3	Compliant	Individuals affected by a breach where there is high risk to their right's and freedoms are appropriately informed.	Sadie Bell, Data Protection Officer	Data Protection Risk Management Procedure IG Training Tools Duty of Candour Training Duty of Candour is a standard requirement under all HRI / SI Reports	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Procedures\Data Protection Risk Management Procedure \\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber\2023_24_Mandatory Training Tools \\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.1.3 \\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\HRI_SI
6.2	**All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway**				
6.2.1	Compliant	Antivirus/anti-malware software has been installed on all computers that are connected to, or are capable of connecting to the Internet.	Sadie Bell, Data Protection Officer	Micrsoft MDE (ATP) and Mcafee Virusscan. AV reports provided monthly from MDE Security Reports, within the Information Security Committee Agendas MDE Reports Device Health MDAV Details Export for: --- 01 Dec 2023 --- 05 Dec 2023 --- 04 Jan 2024 Security Reports, within the Information Security Committee Agendas NHS Solent Intune HLD v0.3	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings\Part A \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.1
6.2.3	Compliant	Antivirus/anti-malware is kept continually up to date.	Sadie Bell, Data Protection Officer	The organisation antivirus solution is designed to automatically scan files Antivirus Policy Procedure Solent Antimalware Polices .docx	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.3
6.2.4	Compliant	Antivirus/anti-malware software scans files automatically upon access.	Sadie Bell, Data Protection Officer	Solent Antimalware configurations Antivirus Policy Procedure MDE Computers and Servers Logs of updates made to Antivirus software virus signatures	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.3 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.4
6.2.5	Compliant	Connections to malicious websites on the Internet are prevented.	Sadie Bell, Data Protection Officer	UKTSOL0002 NHS Solent iBoss Secure Cloud Gateway HLD v2.0 - first 3 pages.pdf Monthly iBoss report is evidence	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.5
6.2.6	Compliant - Non-mandatory	Number of phishing emails reported by staff per month.	Sadie Bell, Data Protection Officer	Cyber Training, inclusive of reporting process Phishing report Phishing Awareness Comms IG & Cyber Security Newsletter - Bi-Montly	\\solnhs.local\storagepool\Data10\IG Solent\Training\2023-24_Training_IG & Cyber\2023_24_Mandatory Training Tools \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Report \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings\Part A \\solnhs.local\storagepool\Data10\IG Solent\Communications\Guidance\2023 - 2024 \\solnhs.local\storagepool\Data10\IG Solent\Communications\Cyber\News Letters\2023-2024 http://intranet.solent.nhs.uk/TeamCentre/QualityAndProfessionalStandards/InformationGovernance/Pages/IG-and-Cyber-Security-Newsletter---November-2023.aspx
6.2.8	Compliant	You have implemented on your email, Domain-based Message Authentication Reporting and Conformance (DMARC), Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) for your organisation's domains to make email spoofing difficult.	Sadie Bell, Data Protection Officer	Email_DKIM_DMARC_SPF_mail_header_validation (Screenshot)	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.8
6.2.9	Compliant	You have implemented spam and malware filtering, and enforce DMARC on inbound email.	Sadie Bell, Data Protection Officer	E-mail_DKIM_DMARC_SPF_DNS_records (screenshot) Technical documentation to prevent malicious emails	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.8 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional

				Mail_filtering_DMARC_anti-spam	Evidence\6.2.9
6.3	**Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses**				
6.3.1	Compliant	If you have had a data security incident, was it caused by a known vulnerability?	Sadie Bell, Data Protection Officer	Incident Details (PDF pages 1 - 5) Incident List (PDF Pages 1 - 10) CareCERT alerts records	2024.01.22_DPST Toolkit 2023_24 - Requirement No - 6_3_1 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.3.1
6.3.2	Compliant	The organisation acknowledges all 'high severity' cyber alerts within 48 hours using the respond to an NHS cyber alert service.	Sadie Bell, Data Protection Officer	Sec+K47:L53urity Reports, within the Information Security Committee Agendas (includes CareCERT Register) Atos & Expo-e Security Incident Example	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings \\v-dfs-001\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\6.3.2
6.3.3	Complaint	The organisation has a proportionate monitoring solution to detect cyber events on systems and services.	Sadie Bell, Data Protection Officer	Security Reports, within the Information Security Committee Agendas (includes CareCERT Register) Azure monitoring DCS Alert Report Example Network Diagram MDE Monitoring SEIM Monitoring (Screenshot) SEIM covers this Atos Security Management Plans	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings\Part A \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.3.8 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.3.3 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\4.5.2
6.3.4	N/A	All new digital services that are attractive to cyber criminals (such as for fraud) are implementing transactional monitoring techniques from the outset.	Sadie Bell, Data Protection Officer		
6.3.5	Compliant - Non-mandatory	Have you had any repeat data security incidents within the organisation during the past twelve months?	Sadie Bell, Data Protection Officer	Data security incident management procedure. Incident Reports	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Procedures\Data Protection Risk Management Procedure \\solnhs.local\storagepool\Data10\IG Solent\Risks & Incidents\Incident\2023-24\Reports
NDG Standard 7: Continuity Planning **A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.**					
7.1	**Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services**				
7.1.1	Compliant	Your organisation understands the health and care services it provides.	Nikki Burnett, SIRO	Trustwide BCP ICT & Infrastructure BCP Critical Application List	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.1.1
7.1.2	Compliant	Your organisation has well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise.	Nikki Burnett, SIRO	Trustwide BCP ICT & Infrastructure BCP	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.1.1
7.1.3	Non-Mandatory	You understand the resources and information that will likely be needed to carry out any required response activities, and arrangements are in place to make these resources available.	Sadie Bell, Data Protection Officer		
7.1.4	Non-Mandatory	You use your security awareness, e.g. threat intelligence sources, to make temporary security changes in response to new threats, e.g. a widespread outbreak of very damaging malware.	Sadie Bell, Data Protection Officer		
7.2	**There is an effective test of the continuity plan and disaster recovery plan for data security incidents**				
7.2.1	Compliant	Explain how your data security incident response and management plan has been tested to ensure all parties understand their roles and responsibilities as part of the plan.	Nikki Burnett, SIRO	Incident response and management plan Exercise Report Minutes of Information & Cyber Security (June 23)	\\solnhs.local\storagepool\Data10\IG Solent\Information Security Assurance\Cyber Security Incident Response & Management Plan \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Assurance\202304_Cyber Security Exercise \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings\Part B
7.2.2	Compliant	From the business continuity exercise, explain what issues and actions were documented, with names of actionees listed against each item.	Nikki Burnett, SIRO	Exercise report	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Assurance\202304_Cyber Security Exercise \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.2.2
7.3	**You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions**				
7.3.1	Compliant	On discovery of an incident, mitigating measures shall be assessed and applied at the earliest opportunity, drawing on	Sadie Bell, Data Protection Officer	Cyber Security Incident Response Plan (CSIRP). List of Participants for Continuity Plan training, Backup Restore Test Report, DR Test Plan, and Report WalkthThrough	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.2.1 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional

		expert advice where necessary.			Evidence\7.3.1
7.3.2	Compliant	All emergency contacts are kept securely, in hardcopy and are up-to-date.	Sadie Bell, Data Protection Officer	Cyber Security Incident Response Plan (CSIRP).	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.2.1
7.3.3	Non-Mandatory	Draft press materials for data security incidents are ready.	Sadie Bell, Data Protection Officer		
7.3.4	Compliant	Suitable backups of all important data and information needed to recover the essential service are made, tested, documented and routinely reviewed.	Sadie Bell, Data Protection Officer	Recovery Procedure for NHS Solent Azure IAAS Services	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.3.4
7.3.5	Compliant	Your organisation tests its backups regularly to ensure it can restore from a backup.	Sadie Bell, Data Protection Officer	Solent Azure VM Restore from Backup Test - Runbook	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.3.5
7.3.6	Compliant	Your organisation's backups are kept securely and separate from your network ('offline'), or in a cloud service designed for this purpose.	Sadie Bell, Data Protection Officer	Backup centre (Screenshoot) NHS Solent - Azure Infrastructure HLD	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\7.3.6
NDG Standatd 8: Unsupported Systems **No unsupported operating systems, software or internet browsers are used within the IT estate.**					
8.1	**All software and hardware has been surveyed to understand if it is supported and up to date**				
8.1.1	Compliant	Provide evidence of how the organisation tracks and records all software assets and their configuration.	Sadie Bell, Data Protection Officer	Evidence of Software Asset in MDE NHS Solent Intune HLD MDE software inventory Approved Software Inventory	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.1.1 2024.01.17_DPST Toolkit 2023_24 - Requirement No - 8_2_2c \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.2.2 2024.01.17_DPST Toolkit 2023_24 - Requirement No - 8_2_2d \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.2.2 2024.01.17_DPST Toolkit 2023_24 - Requirement No - 8_1_1d \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.1.1
8.1.2	Compliant	The organisation tracks and records all end user devices and removable media assets.	Sadie Bell, Data Protection Officer	Evidence of Asset on MDE IT asset management process. End User Systems	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.7 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.1.2
8.1.4	Compliant - Non-mandatory	The organisation ensures that software that is no longer within support or receiving security updates is uninstalled. Where this is impractical, the endpoint should be isolated and have limited connectivity to the network.	Sadie Bell, Data Protection Officer	MDE software inventory Cyber Security Vulnerability management Policy Cyber Security Vulnerability management process. Cyber Security Reports for monitoring Risk Register SIRO Reports	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.2.1 \\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\8.4.3 \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Report\Cyber Security Position Report \\solnhs.local\storagepool\Data10\IG Solent\Reports & Meetings\SIRO Report
8.2	**Unsupported software and hardware is categorised and documented, and data security risks are identified and managed**				
8.2.1	Compliant	List any unsupported software prioritised according to business risk, with remediation plan against each item.	Sadie Bell, Data Protection Officer	MDE software inventory	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.2.1
8.2.2	Compliant	The SIRO confirms that the overall risks of using unsupported systems are being managed and the scale of unsupported software is reported to your board along with the plans to address.	Nikki Burnett, SIRO	Vulnerability Tracker Report and Unsupported-Unknown Software Report SIRO to review and signoff Evidence of unsupported systems (Screenshot) MDE software inventory	2024.01.22_DPST Toolkit 2023_24 - Requirement No - 8_2_1 & 8_2_1a \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.2.1 2024.01.22_DPST Toolkit 2023_24 - Requirement No - 8_2_2b \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.2.2 \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings\Part A
8.3	**Supported systems are kept up-to-date with the latest security patches**				
8.3.1	Compliant	How do your systems receive updates and how often?	Sadie Bell, Data Protection Officer	Patch management reporting, presented to Information & Cyber Security Committee Monthly Atos & Expo-e Patching Procedure	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings \\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\8.3.1 \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings\Part A
8.3.2	Compliant	How often, in days, is automatic patching typically being pushed out to remote endpoints?	Sadie Bell, Data Protection Officer	Patch management reporting, presented to Information & Cyber Security Committee Monthly Patch management procedure and/or strategy/policy. Patch management technology configurations. Microsoft Configuration Manager Patch Management Guide	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.2 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.3
8.3.3	Compliant	There is a documented approach to	Nikki Burnett,	Patch management reporting, presented to Information & Cyber Security Committee Monthly	2023.01.19_DPST Toolkit 2023_24 - Requirement No_ 8_3_3 and 8_3_3a

		applying security updates (patches) agreed by the SIRO.	SIRO	Patch management procedure and/or strategy/policy. Microsoft Configuration Manager Patch Management Guide	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.3
8.3.4	Compliant	Where a security patch has been classed as critical or high-risk vulnerability it is applied within 14 days, or the risk has been assessed, documented, accepted, reviewed regularly and signed off by the SIRO with an auditor agreeing a robust risk management process has been applied.	Sadie Bell, Data Protection Officer	Email evidence of Patch Management schedule to address timeline requirement	2023.01.19_DPST Toolkit 2023_24 - Requirement No_ 8_3_4 - \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.4 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.4.1
8.3.5	Compliant	Where a security patch has been classed as critical or high-risk vulnerability has not been applied, explain the technical remediation and risk management that has been undertaken.	Sadie Bell, Data Protection Officer	Email evidence of Patch Management schedule to address timeline requirement Patch management reporting, presented to Information & Cyber Security Committee Monthly Patch process treatment procedure or process	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.5 \\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings
8.3.6	Compliant	Your organisation is actively using and managing Advanced Threat Protection (ATP) and regularly reviewing alerts from Microsoft defender for endpoint.	Sadie Bell, Data Protection Officer	Evidence of implementation of ATP solution and IT security strategy for references to ATP solution.	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.6
8.3.7	Compliant	95% of your organisation's server estate and 98% of your desktop estate are on supported versions of operating systems. Where this is not possible, there is a SIRO approved plan to achieve 95% of your server estate and 98% of your desktop estate on supported versions of operating systems.	Sadie Bell, Data Protection Officer	Monthly Cyber Security Meeting Inventory of System on MDE	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Meetings \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.7
8.3.8	Compliant	Your organisation is registered for and actively using the NCSC early warning service.	Sadie Bell, Data Protection Officer	Evidence associated with the early warning systems and outputs.	\\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\8.3.8
8.4	**You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service**				
8.4.1	Compliant	Your organisation's infrastructure is protected from common cyber-attacks through secure configuration and patching?	Sadie Bell, Data Protection Officer	Patching Practice Email evidence of Patch Management schedule to address timeline requirement The following TI sources are used byt the Atos CSM for Solent: - built-in MDE - NHS CareCERTs - Atos internal TI - public TI	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.4.1
8.4.2	Compliant	All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted, regularly reviewed and signed off by the SIRO.	Sadie Bell, Data Protection Officer	Atos & Expo-e Patching Procedure Patch management reporting, presented to Information & Cyber Security Committee Monthly Patch management procedure and/or strategy/policy. Patch management technology configurations. Email evidence of Patch Management schedule to address timeline requirement Patch Management status report	AB 2024-01-04 - the following constitute evidence to support the patching compliance: \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.1.4 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.1 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.2 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\8.3.3
8.4.3	Compliant	You maintain a current understanding of the exposure of your hardware and software to publicly-known vulnerabilities.	Sadie Bell, Data Protection Officer	Vulnerability management process. Sample of vulnerability scanning reports. List of the organisation's security vulnerabilities.	\\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\8.4.3
Standard 9: IT Protection **A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.**					
9.1	**All networking components have had their default passwords changed**				
9.1.1	Compliant	The Head of IT, or equivalent role, confirms all networking components have had their default passwords changed to a high strength password.	Sadie Bell, Data Protection Officer	Password settings Email showing steps followed for configuration Password settings NHS Solent - Azure Security Controls Low-Level Design 2023/24 Pen Testing report	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.1.1
9.1.2	Compliant	The Head of IT, or equivalent role,	Sadie Bell, Data	Password Policy and email evidence obtained from Expo-e	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional

		confirms all organisational devices have had their default passwords changed.	Protection Officer	End user device password configurations.	Evidence\9.1.1 \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.Policies\Password Policy
9.2	**A penetration test has been scoped and undertaken**				
9.2.1	Compliant	The annual IT penetration testing is scoped in negotiation between the SIRO, business and testing team including a vulnerability scan and checking that all networking components have had their default passwords changed to a high strength password.	Sadie Bell, Data Protection Officer	Pen Test Scope & SIRO Approval	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Assurance\Pen Test\Pen Test 2023-24
9.2.3	Compliant	The SIRO or equivalent senior role has reviewed the results of latest penetration testing, with an action plan for its findings.	Nikki Burnett, SIRO	Pen Test Report and action plan approved by SIRO	\\solnhs.local\storagepool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Assurance\Pen Test\Pen Test 2023-24
9.3	**Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities**				
9.3.1	N/A	All web applications are protected and not susceptible to common security vulnerabilities, such as described in the top ten Open Web Application Security Project (OWASP) vulnerabilities.	Sadie Bell, Data Protection Officer		
9.3.3	Compliant	The organisation has a technology solution or service that prevents users from accessing potentially malicious websites, reducing the risk of the organisation's infrastructure being infected with malware.	Sadie Bell, Data Protection Officer	UKTSOL0002 NHS Solent iBoss Secure Cloud Gateway HLD v2.0 - first 3 pages. iBoss web security Solent Public IP Addresses	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\6.2.5 \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.3.3
9.3.4	Compliant	The organisation ensures that changes to its authoritative DNS entries can only be made by strongly authenticated and authorised administrators.	Sadie Bell, Data Protection Officer	Internal DNS is integrated with the Domain Controllers and is managed by a small number of AD adminstrators. Some DNS entries are automatically updated by service accounts but any manually configured DNS entries can only be added by the AD administrators. External DNS (Internet/HSCN) is managed by Solent through NHS Digital.	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.3.4
9.3.5	Compliant	The organisation understands and records all IP ranges in use across the organisation.	Sadie Bell, Data Protection Officer	NHS Solent IP Addressing (Screenshot) Evidence of IP range reviews (automated or manual).	https://solenttrust.sharepoint.com/teams/SOLENTExpo-Esharedspace/Shared%20Documents/Forms/AllItems.aspx?csf=1&web=1&e=0PikfR&cid=44591174%2D6235%2D428f%2D9a8f%2Da18d070374df&FolderCTID=0x0120008B1288CB1CFBD9438921D8E7CCD5C0C1&id=%2Fteams%2FSOLENTExpo%2DEsharedspace%2FShared%20Documents%2FGeneral%2FShared%20space%2FDesigns%2FIP%20Addressing&viewid=b9fcdf91%2Dc440%2D432b%2Db2d5%2D11ca79a4e9cf \\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.3.5
9.3.6	Compliant	The organisation protects its data in transit (including email) using appropriate technical controls, such as encryption.	Sadie Bell, Data Protection Officer	Solent_e-mail_header_sample_with_TLS_communication_encryption Internet Explorer TLS 1.2 Internet Explorer TLS 1.2 User Guide	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.3.6
9.3.7	Compliant	The organisation has registered and uses the National Cyber Security Centre (NCSC) Web Check service, or equivalent web check service, for its publicly-visible applications.	Sadie Bell, Data Protection Officer	NSCS Webcheck Dashboard	\\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\9.3.6
9.3.8	Compliant	The organisation maintains a register of medical devices connected to its network.	Sadie Bell, Data Protection Officer	Medical Devices Register	..\..\DP Documents & Policies\1.Projects\Medical Devices
9.3.9	Compliant	What is the organisation's data security assurance process for medical devices connected to the network.	Sadie Bell, Data Protection Officer	Medical Devises Policy	Additiontional Evidence\9.3.9
9.4	**You have demonstrable confidence in the effectiveness of the security of your technology, people, and processes relevant to essential services**				
9.4.1	Compliant - Non-mandatory	You validate that the security measures in place to protect the networks and information systems are effective, and remain effective for the lifetime over which they are needed.	Sadie Bell, Data Protection Officer	UKTSOL0001 NHS Solent Atos Security Management Plan - Final v1.0	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.4.1
9.4.4	Compliant	Security deficiencies uncovered by assurance activities are assessed,	Sadie Bell, Data Protection Officer	Pen Test Report and action plan	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.4.4

		prioritised and remedied when necessary in a timely and effective way.			
9.4.5	Compliant	Your organisation has completed an independent audit of your Data Security and Protection Toolkit and has reported the results to the Board.	Nikki Burnett, SIRO	DSPT Audit Report	\\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Audit
9.5	**You securely configure the network and information systems that support the delivery of essential services**				
9.5.1	Compliant	All devices in your organisation have technical controls that manage the installation of software on the device.	Sadie Bell, Data Protection Officer	Evidence of Microsoft Apps Store configuration settings List of allowed Applications Local Admin POC (Screenshoot)	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.5.1
9.5.2	Compliant	Confirm all data are encrypted at rest on all mobile devices and removable media and you have the ability to remotely wipe and/or revoke access from an end user device.	Sadie Bell, Data Protection Officer	Endpoint security disk encryption setting (PDF) IT Security Policy Mobile device encryption (PDF) Endpoint security disk encryption setting (PDF)	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.5.2
9.5.3	Compliant	You closely and effectively manage changes in your environment, ensuring that network and system configurations are secure and documented.	Sadie Bell, Data Protection Officer	Solent NHT Trust - Network Software Patching Schedule Change Process Overiew Change tickets - CHG20008005, CHG20004035, CHG20018649, CHG20022688, CHG20022567 Neowrk Diagram Email: CHG20022688 - Fix routing issue for PHU VLAN 801 One Compliance Penetration Testing - Azure queries	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.5.3
9.5.5	Compliant	End user devices are built from a consistent and approved base image.	Sadie Bell, Data Protection Officer	NHS Solent - Windows 10 Intune Build Low Level Design	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.5.5
9.5.6	Compliant	End user device security settings are managed and deployed centrally.	Sadie Bell, Data Protection Officer	Atos Client Deployment Toolkit (Image Deployment) Build Installation Guide FW Intune HLD	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.5.6
9.5.7	Compliant	AutoRun is disabled.	Sadie Bell, Data Protection Officer	Windows Components/AutoPlay Policies Auto run configuration - Screenshot Autorun configurations.	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.5.7
9.5.8	Compliant	All remote access is authenticated.	Sadie Bell, Data Protection Officer	Citrix ADC Remote Access Sercuxe - Low Level Design Remote Access Technology Configurations	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.5.8
9.5.9	N/A	You have a plan for protecting devices that are natively unable to connect to the Internet, and the risk has been assessed, documented, accepted, reviewed regularly and signed off by the SIRO.	Sadie Bell, Data Protection Officer		
9.5.10	Compliant - Non-Mandatory	Your organisation meets the secure email standard.	Sadie Bell, Data Protection Officer	Accredited	
9.6	**The organisation is protected by a well managed firewall**				
9.6.1	Compliant	One or more firewalls (or similar network device) have been installed on all the boundaries of the organisation's internal network(s). -	Sadie Bell, Data Protection Officer	Network diagrams	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.6.1
9.6.2	Compliant	The administrative interface used to manage the boundary firewall has been configured such that; it is not accessible from the Internet, it requires second factor authentication or is access limited to a specific address.	Sadie Bell, Data Protection Officer	Access to the Solent firewall is via a dedicated managemtn interface on a dedicated management network, a jumpbox accessable only via Logic Monitor is required to access the management network and this requires two factor authenticaion using OKTA along with an Expo-e engineering AD account. Admin access to devices are via a dedicated management network, this network is accessible via our Logic Monitor platform that uses expo-e SSO, then via a MFA protected Jump Box and each user has unique credentials for accountability screenshots in email.	N/A
9.6.3	Compliant	The organisation has checked and verified that firewall rules ensure that all unauthenticated inbound connections are blocked by default.	Sadie Bell, Data Protection Officer	Firewall Rule (Screenshot) Pen Testing Report and Action Plan	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.6.3 \\solnhs.local\StoragePool\Data10\IG Solent\Cyber Security Assurance\Cyber Security Assurance\Pen Test
9.6.4	Compliant	All inbound firewall rules (other than default deny) are documented with business justification and approval by the change management process.	Sadie Bell, Data Protection Officer	Firewall Rule change request record Sample of Firewall Ruleset	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.6.4

9.6.5	Compliant	Firewall rulesets are reviewed on a regular basis. Rulesets are removed/disabled when they are no longer required.	Sadie Bell, Data Protection Officer	Firewall Rule change request record	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.6.4
9.6.6	Compliant	All of your organisation's desktop and laptop computers have personal firewalls (or equivalent) enabled and configured to block unapproved connections by default.	Sadie Bell, Data Protection Officer	Personal firewall configurations and evidence associated with implementation of personal firewalls. Evidence associated with implementation of personal firewalls.	\\solnhs.local\StoragePool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\9.6.6
NDG Standard 10: Accountable Suppliers **IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.**					
10.1	**The organisation can name its suppliers, the products and services they deliver and the contract durations**				
10.1.1	Compliant	The organisation has an up to date list of its suppliers, which enables it to identify suppliers that could potentially pose a data security or data protection risk to the organisation. The list includes which suppliers process personal data or provide IT services on which critical services rely, details on the product and services they deliver, contact details and contract duration.	Sadie Bell, Data Protection Officer	Third Party Security Audit Policy Supplier list.	\\v-dfs-001\Data10\IG Solent\DP Documents & Policies\1.Policies\Third Party Suppliers Data Protection & Security Assurance Policy
10.1.2	Non-Mandatory	Contracts with all third parties that handle personal information are compliant with ICO guidance.	Sadie Bell, Data Protection Officer		
10.2	**Basic due diligence has been undertaken against each supplier that handles personal information**				
10.2.1	Compliant	Your organisation ensures that any supplier of IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification.	Sadie Bell, Data Protection Officer	All relevant contracts ensure appropriate certificates are valid and maintained (refer to Schedule 2, Page 25, Section 10 - Warranties in the NHS T&Cs Provision of Services contract template) to include Contract Review meetings held between Solent Contract Manager and Contractor. Additionally, the Trust's Data Protection Impact Assessment (DPIA) process includes the checking of certification relevant to the supply of service being provided • List of contracts • System DPIAs	\\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2022-23\Additional Evidence\10.1.1 \\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.DPIA's_Completed
10.2.3	Non-Mandatory	Percentage of suppliers with data security contract clauses in place.	Sadie Bell, Data Protection Officer		
10.2.4	Compliant	Where services are outsourced (for example by use of cloud infrastructure or services), the organisation understands and accurately records which security related responsibilities remain with the organisation and which are the supplier's responsibility.	Sadie Bell, Data Protection Officer	Supplier contracts include clauses relevant to the responsibilities of both the third Party and our Organisation. In addition to this the contract specification document contains the responsibilities and expectations. DPIAs are also completed to assess the risk to privacy. Refer to our DSPT evidence portfolio for documented evidence. • System DPIAs	\\solnhs.local\storagepool\Data10\IG Solent\DP Documents & Policies\1.DPIA's_Completed
10.2.5	Non-Mandatory	All suppliers that process or have access to health or care personal confidential information have completed a Data Security and Protection Toolkit, or equivalent.	Sadie Bell, Data Protection Officer		
10.3	**All disputes between the organisation and its suppliers have been recorded and any risks posed to data security have been documented**				
10.3.1	Compliant - Non-mandatory	List of data security incidents – past or present – with current suppliers who handle personal information.	Sadie Bell, Data Protection Officer	Incident Report Data Protection Risk Management Procedure Sample of incident documentation	..\..\Risks & Incidents\Incident\2023-24\Reports ..\..\DP Documents & Policies\1.Procedures\Data Protection Risk Management Procedure \\solnhs.local\storagepool\Data10\IG Solent\Data Security & Protection Toolkit\2023-24\Additiontional Evidence\10.3.1

Appendix B: Information Request Compliance Breakdown * as of 17th May 2024

Subject Access Requests – Quarterly Breakdown and Comparison to 2022/23

	2022/23				2023/24			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
No. requests received	287	315	252	317	304	369	359	391
No. requests responded to within 21 days (best practice)	221	245	208	270	262	341	338	347
No. requests responded to within mandated timescale (one calendar month)	51	62	33	42	29	21	20	28
No. breaches within (legal deadline)	15	8	11	5	13	7	1	4
% Compliance – Legal Requirement (approx. 30 days)	94.8%	97.5%	95.6%	98.4%	95.7%	98.1%	99.7%	98.9%
Not Due	-	-	-	-	-	-	-	12

Subject Access Requests – Annual Breakdown and Comparison to 2022/23

	2022/23	
	2022/23	**2023/24**
No. requests received	1171	1423
No. requests responded to within 21 days (best practice)	944	1288
No. requests responded to within mandated timescale (one calendar month)	188	98
No. breaches within (legal deadline)	39	25
% Compliance – Legal Requirement (approx. 30 days)	96.7%	98.2%
Not Due	-	12

Freedom of Information Requests – Quarterly Breakdown and Comparison to 2022/23

	2022/23				2023/24			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
No. Requests	83	118	107	127	110	115	126	143
No. Responded within 20 working days	82	112	97	119	108	112	124	139
No. Breaches	1	6	10	8	2	3	2	0
% Compliance – Legal Requirement (21 days)	98.8%	94.9%	90.7%	93.7%	98.2%	97.4%	98.4%	100%
Not Due	-	-	-	-	-	-	-	4

Freedom of Information Requests – Annual Breakdown and Comparison to 2022/23

	2022/23	
	2022/23	**2023/24**
No. Requests	435	494
No. Responded within 20 working days	410	483
No. Breaches	25	7
% Compliance – Legal Requirement (21 days)	94.3%	98.6%
Not Due	-	4

Information Governance Incident Deep Dive Report 2023/24
In Relation to PID in Wrong Record and PID Sent to Wrong Person/Address
Summary of Initial Findings

1) Introduction / Purpose:

The Information Assurance & Compliance Team Manager (Interim) has undertaken a deep dive into the top two most reported Information Governance (IG) Incidents; PID in Wrong Record and PID Sent to Wrong Person/Address. The report covers incidents reported in the last 18 months, (July 2022 – December 2023). The purpose of this deep dive is to establish the following;

- Common root causes
- Analysis of best practice
- Assessment of the impact of Human Error on these IG incidents
- Identify future learning and actions to reduce the number of reportable IG incidents

2) Initial Findings

Please note that all data is reflected of incident reporting July 2022 – December 2023

Between these 18 months, a total of 575 Information Governance Incidents were reported due to PID in Wrong Record or PID Sent to Wrong Person/Address. ***A breakdown for every half-year is also available in Appendix i.***

Out of the 575 incidents, 133 were deemed to be either "No IG Breach" e.g. near miss or the information was considered to not be identifiable and therefore no breach or deemed "Out of Our Control" e.g. breaches by third parties. This accounts for 23.1% of the reported incidents.

With regards to the remaining 442 incidents (76.9% of incidents), these were determined to be in connection with Human Error (69.6%), Processes (Failure to follow, Lack of and Unaware of) (5.7%) and ICT – System Issues (1.6%). The breakdown is as follows:

Cause Group	PID in Wrong Record/Record Error	PID Sent to Wrong Person/Address)
"No IG Breach" or "Out of Control"	48	85
Human Error	219	181
Process	8	25
ICT – System Issues	3	6

Total	**278**	**297**

No IG Breach / Out of Our Control

- 17.2% of PID in Wrong Record incidents were in connection with No IG Breach / Out of Our Control
- 28.6% of PID Sent to Wrong Person/Address incidents were in connection with No IG Breach / Out of Our Control

The assessment above demonstrates;

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

Human Error vs Process

- **Human Error:** 78.8% of ***PID in Wrong Record*** incidents reported were in connection with Human Error, with 60.9% of ***PID Sent to Wrong Person/Address*** incidents reported also in connection with Human Error
- **Process:** 2.9% of ***PID in Wrong Record*** incidents reported were in connection with Processes (Failure to follow, Lack of and Unaware of), with 8.4% of ***PID Sent to Wrong Person/Address*** incidents reported were in connection with Processes (Failure to follow, Lack of and Unaware of)

These findings indicated that the root cause of incidents is not predominantly to do with the processes in place currently within the Trust, but the human elements of working practices. That being said, Human Error should not be dismissed as something we cannot reduce, but something we need to understand, assess, and ask the question "so what can we do". If we can get a better understand of these types of incidents and put mechanisms in place to reduce just half of the IG incidents, relating to Human Error, this will reduce IG incidents by at least 30%.

3) <u>Service Engagement</u>

One way in which we can get a better understand of the human error element is through service engagement. This allows us to better understand the human element and work with services on how we can then bring human elements into our processes and hopefully reduce the number of incidents reported.

PID in Wrong Record

In the first five months of 2023/24 (Apr – Aug 2023), PID in Wrong Record has been identified as one of the most reported incidents, with 40% of incidents reported to happen within Child & Family Services. We have carried out a service engagement session with the Governance Lead and Head of Service on 20th Sept 2023 which focused on what has worked or needs improvement, and how IG could further assist the service in preventing similar incidents from happening going forward. Our finding from this service engagement session is most errors occur because of loss of signal which caused S1 records to be saved incorrectly and distraction due to busy or noisy working environment. From this session, a learning outcome poster was designed to reflect changes in practice and cascaded to the whole Trust.

Following the service engagement, there has been a reduction of 40% in the number of reported incidents in the following 5 months (please refer to ***Breakdown of PID in Wrong Record Incidents by Service Lines in Appendix i(b).*** This demonstrates the effectiveness of service engagement as services are involved in establishing clear processes which they can connect with. This is critical as the IG team can better understand how the implementation of processes will impact how services operate.

In addition to service engagement, the IG Team has also recently implemented a number of new processes to address IG incidents, implement preventative measures and cascading of learning across the Trust;

- ***Re-occurring incidents***
  - Each month the IG Team will assess the most common type of reported incident, over the last three months and then connect with the services who have reported these type of incidents; working with services to assess the incident, what the business needs are that led to or were being addressed at the time of the incidents and the IG best practices / mandates in place. By doing this the service(s) and the IG Team look at building new processes at service level, that will allow them to meet the requirements of their service / treatment of patients, whilst ensuring the IG practices there to safeguard data are still met – as opposed to IG directing what should be happening and this unintentionally impacting on services and clinical needs. The process also recognises the diverse services within the Trust and that one solution is not always practical in every setting, therefore this service engagement aims to identify 3 – 4 options/processes that services can follow, depending on their service circumstances, to safeguard data.
- ***Rapid Learning Posters***
  - When incidents occur that recognise a gap in the Trust's IG practice, that needs to be addressed ASAP, Rapid Learning Posters are cascaded to all staff, via multiple routes. The communication is short and pointed, "what has happened", "what the Trust / IG Team have done to address the incident", "what we need staff to learn from this incident".
- ***SolNet***
  - The IG Team add all new processes and learning to the IG Team SolNet page, alongside additional FAQ's that will help staff tackle questions, that will prevent IG incidents and ensure best practice.

4) **<u>Common Themes / Findings</u>**

a) PID in Wrong Record / Record Error:

This type of incident is most commonly reported due to human error.

Specific service engagement is required to work with services and staff to assess the human elements of this type of incident and assess new processes and practices that can be proposed. As above, a service engagement session was carried out for the service with the highest number of PID in Wrong Record incidents.

b) PID Sent to Wrong Person / Address:

The three most common root causes for this type of incident were;

- 53% of incidents relating to the selecting of the wrong email address when sending emails (mainly internally)

- 30% of incidents relating to sending information to patients, but including information of other patients; although the number of these incidents have reduced since last year, following on from the Trust's service engagement around bulk printing
- Sending information to the incorrect GP Practice.

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

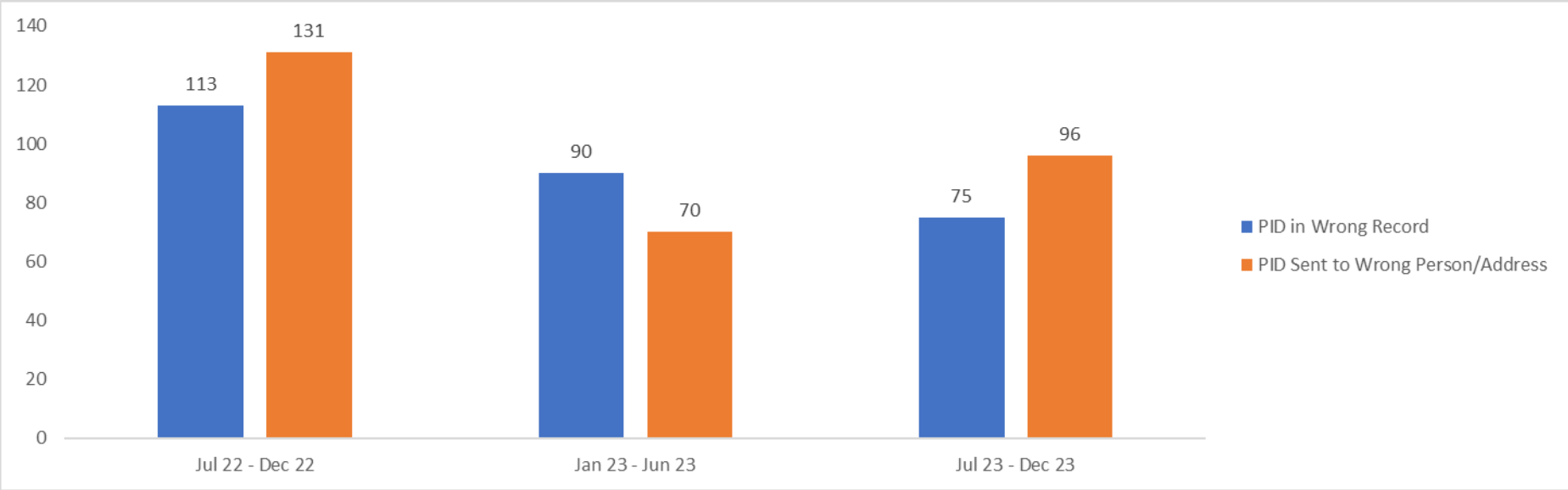
High Risk Incidents / Serious Incidents: There are no IG High Risk or Serious Incidents that have been reported in relation to PID in Wrong Record or PID Sent to Wrong Person/Address in July 2022 – December 2023.

5) <u>Next Steps:</u>

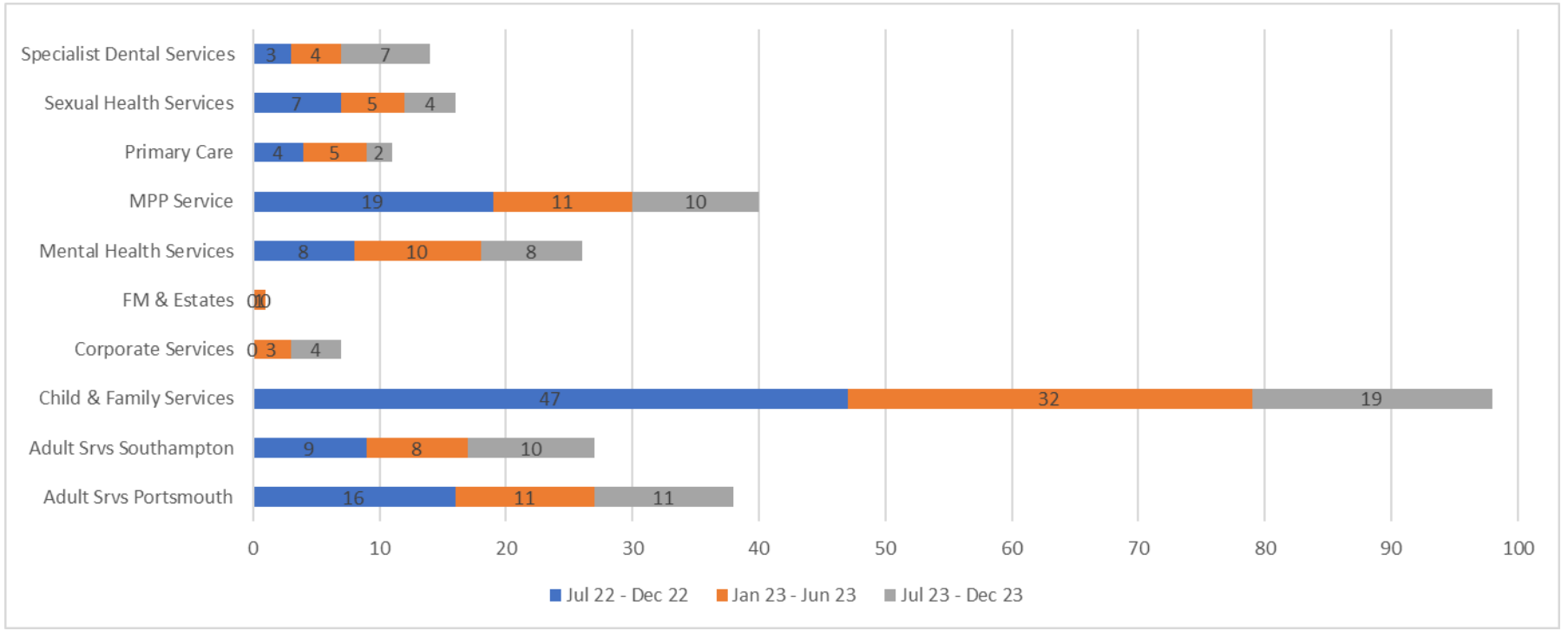
- IG Team to ensure that best practice / reminders of processes, for all incidents reported with a Root Cause of Process (Failure to follow, Lack of and Unaware of) are cascaded to staff as "IG Learning"
- Revision of IG Training (alongside bespoke IG Training), to include and address the most common types of reported IG incidents that impact Solent NHS Trust and the learning that has been identified as a result of these incidents.
- IG Team to participate in Child & Family bi-monthly learning events where possible to present on any learning identified from incidents reported from their service. These events invite staff from within Childrens and from outside to share learning, projects, audits and feedback.
- Each IG incident will be continued to be look at in-depth, by the IG Officer(s), so that IG Learning can be identified and cascaded where applicable.
- Continue with IG Rapid Learning Communications
- Undertake a monthly assessment of reported IG incidents, undertaking service engagement on the most common themed incident, working with services to assess new practices
- IG Team to undertake further service engagement, to assess how improvements / changes to practices can assist in reducing the number of incidents relating to PID in wrong record and PID sent to wrong person / address
- Undertake 3 month, 6 month and annual reviews of service engagement vs impact / change in practice (reduction in incidents)

Breakdown of Incidents by Half-year

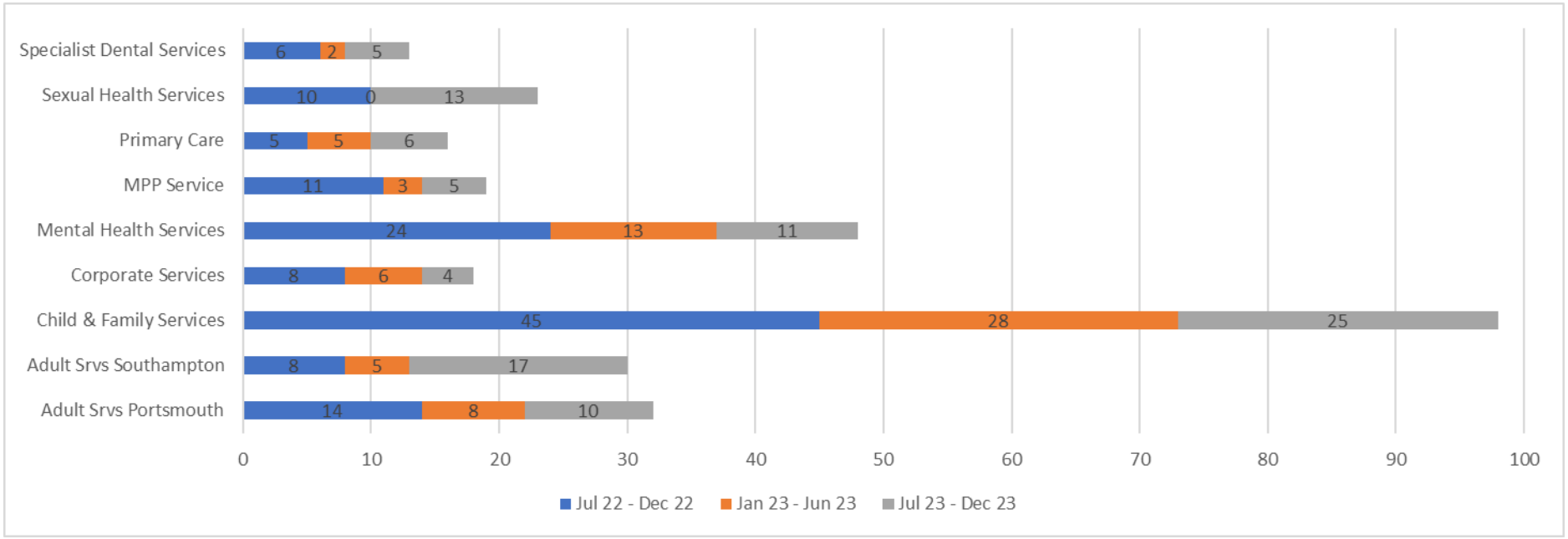
a) Breakdown of incidents by months



b) ***Breakdown of PID in Wrong Record Incidents by Service Lines***



c) Breakdown of PID Sent to Wrong Person/Address Incidents by Service Lines



Board and Committee Summary Report

Title of Paper	Academy of Research & Improvement Annual Report 2023-24					
Date of paper	14/05/2024					
Presentation to	In-Public Trust Board					
Item No.	12					
Author(s)	Sarah Williams, Director of Research & Improvement					
Executive Sponsor	Dan Baylis, Chief Medical Officer					
Executive Summary	The purpose of the report is to provide an overview of the Academy's activity between April 2023 and March 2024.					
Action Required	For decision?	N	For assurance?	Y		
Summary of Recommendations	In-Public Trust Board is asked to: • Note the scope and range of work across the organisation in respect of ongoing research, improvement and participation • Receive assurance about maturity of Solent as a learning organisation, with plans to extend this into the new organisation strategy and structures					
Statement on impact on inequalities	Positive impact (inc. details below)	x	Negative Impact (inc. details below)		No impact (neutral)	
Previously considered at	QIR					

Strategic Priority this paper relates to

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

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

Level of Assurance *(tick one)*	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)							
Executive Sponsor Signature	 Dan Baylis, Chief Medical Officer							

The Academy of Research and Improvement

2023/ 2024

ANNUAL REPORT

NHS Solent NHS Trust

Table of Contents

WELCOME *to the* ACADEMY!

Foreward

Thank you for taking the time to share the achievements of our Academy over the past 12 months. The journey we are on to deliver innovative community based research and improvement methodology that asks questions, evaluates and transforms healthcare really is incredible.

I'd like to thank all our staff, our partners and our communities for their engagement, enthusiasm and energy especially as we look to draw on the considerable opportunities of being part of a much larger organisation, HIOW Healthcare, in 2024; exciting times!

Dr Dan Baylis
Chief Medical Officer

Introduction

Welcome to an overview of our activity between April 2023 and March 2024 – for more information and our resources, head to our website: www.academy.solent.nhs.uk.

By way of a quick introduction, we are an integrated Academy, supporting our teams to get involved and lead their own programmes of continuous improvement. We offer training, coaching and facilitation in research, quality improvement, clinical effectiveness, innovation and library services.

We're here to make it easy for our staff to learn how to use tools for continuous improvement, and to build an evidence base for health and care across community settings. As such, we work closely with colleagues across our voluntary and local authority services; and most importantly we place the experience and voice of those who use our services at the centre of all our improvement work.

It's been a busy and productive year, with our organisational improvement culture thriving and maturing- we've extended our Quality Improvement Programme to include Demand, Capacity and Flow training; we've co-designed a programme to support Co-Production for Improvement; we've developed tool kits in partnership with service users, and grown our networks of research and improvement leaders across the Trust.

We've grown a network of community peer researchers and been asked to provide training to a number of organisations across Hampshire - and finally, we've launched our Co-Lab, our collaborative, community-focused rapid evaluation hub which carries out commissioned pieces of work for both internal and external initiatives.

If you'd like to get involved, please do get in touch – we'd love to hear from you.

608
research participants

42
studies

59
people joined the Research Development Programme

8
externally commissioned projects

15
peer researchers

135
clinical audit and evaluations

777
people trained in Quality Improvement

53
specialist evidence searches

21
SBS members

773
hours of SBS involvement

sidebyside

98
workshops

388
attendees

SOLENT DRAGONS' DEN

19
funded Dragon's Den initiatives

Research

Solent's Research Team was one of the top three most research active care Trusts in England in 23/24. In total, we recruited 608 participants to 42 studies.

We have a strong focus on building skills and confidence in research across our teams, and supporting them to both develop and use best evidence for community based care. To help with this we work closely with organisations in our communities.

www.academy.solent.nhs.uk/research

Community peer researcher network

This year we have launched our peer researcher programme, training people in our communities to research the areas affecting them the most.

We have worked, in collaboration with the Young Foundation, Portsmouth City Council, HIVE Portsmouth, Community Action Isle of Wight, Communicare and other community groups to recruit and train peer researchers across Portsmouth, Southampton and the Isle of Wight.

They have employed creative methods and inclusive approaches to engage their communities in research. Topics have included cultural understanding of faith-based needs, suicide risk among local young adults, challenges in accessing respite care for families with children with Special Educational Needs and oral healthcare for older adults.

We are learning about better methods for carrying our research in communities and innovative approaches to inclusion. There are currently 15 people in the network.

In October, we co-facilitated a research workshop facilitated by the Portsmouth-based charity, URBOND. The interactive session was delivered jointly with Portsmouth Hospitals with the aim of breaking down barriers and building better relationships with communities that are currently under-served by health and care research.

We discussed what research meant to them and what would encourage them to take part in it.

> "I think it is positive thing to do in the community, because there is many misconceptions about health research in the BAME community, people don't have the right information... for me it was very informative , and I will be very happy to take part as long as it not something going into my body."

Care Home Research Partnership

Another community research partnership involves collaborating with care homes.

Currently, we are working with 39 homes to facilitate their participation in research. Here are some examples of the studies we have conducted within care homes:

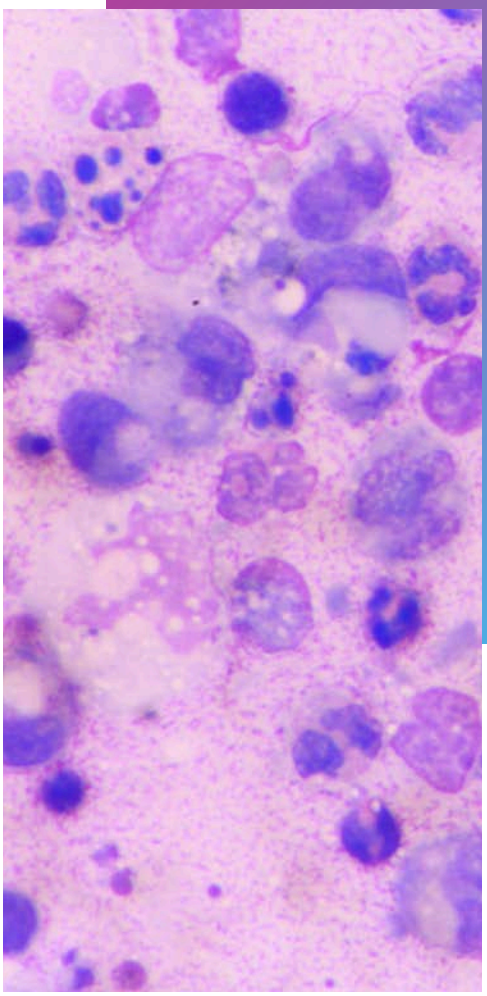
Urinary Tract Infection – Treatment and Prevention

The DISCO-UTI study aims to identify infection markers in residents' urine to enable early detection and more effective treatment. Currently, 48 residents from partner homes have participated, making Solent the leading recruitment site. The average age of participants is 85.7 years old!

The Prevent IAD project is creating and testing a care package to prevent and manage incontinence-associated skin damage. Led by King's College London and the University of Southampton, this initiative involves collaborating with Harry Sotnick House, a care home in Portsmouth, to facilitate the study. To date, 23 residents have been recruited.

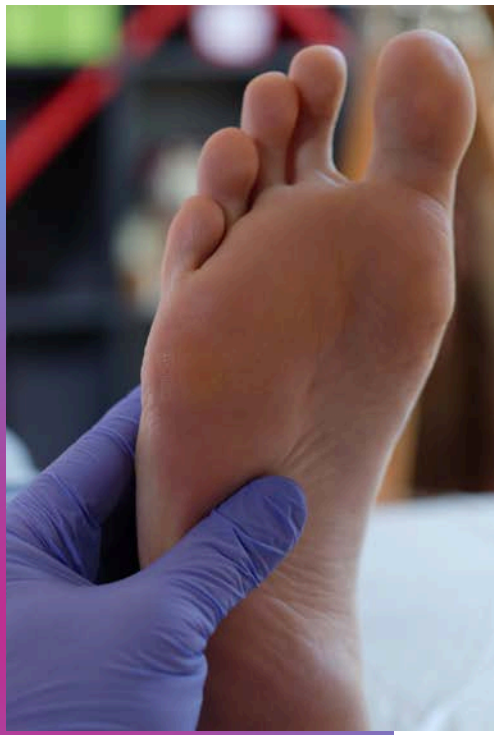
Research in Solent services

We also carry out research within our core clinical services. There are a wide range of studies, so head to the website for more information. Examples are:



Immunotherapy for the treatment of Herpes

Solent has taken part in its first Phase 2 study, with Consultant Dr Raj Patel from our Southampton team selected as the Chief Investigator for the UK. This is led by the pharmaceutical company GSK. Genital herpes is a lifelong condition. The treatment options that are currently available (i.e., antivirals) cannot cure the infection. GSK have developed an immunotherapy (a drug that activates your immune system) against genital herpes. They are looking to see if it is well tolerated and whether it reduces the number, severity and duration of recurrences.



Prevention of Diabetic Foot Ulcers

The REDUCE-DFU study provides patients with diabetic foot ulcers with an educational package that aims to decrease the number of patients who re-ulcerate after healing. 20 patients have taken part in this trial.

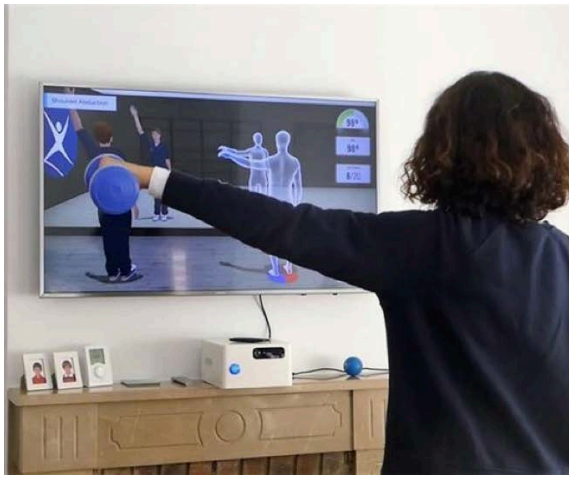
"The podiatry team have been excited to be part of this clinical trial. It has been a great opportunity to include patients we treat in Solent as part of this research study to support/improve patient care. A large group of the podiatry team have been involved in this trial and have been recruiting appropriate patients in clinical appointments."

Georgia Lane, Podiatrist

Home devices for rehabilitation post stroke

The EvolvRehab – MoveWell study provides stroke survivors with at home rehabilitation service through a device that plugs into their TV. This is programmed remotely by the patient's clinician with exercises for them to follow, then a camera in the device creates an avatar of the patient on their TV to follow the on-screen guide and give real-time feedback on their technique.

Patients have reported that this feedback is so important to encourage them in their progress between their usual clinical appointments; and the fun exergaming aspect has turned the activity from a chore into something exciting they are more likely to remember each day. To date four patients have enrolled in this trial, with more to follow.



Diabetes Screening for Children

Solent is part of a national research project (ELSA) that aims to explore the feasibility and benefits of screening for Type 1 diabetes in children aged between 3 and 13 years.

3 in 1000 children are at high risk of developing type 1 diabetes in the future. Screening allows type 1 diabetes to be picked up sooner. This stops children from becoming too unwell and prevents children from needing to go into hospital as an emergency admission for type 1 diabetes.

We are working with schools, sports clubs and community centres to recruit to this study. So far, 94 children have taken part.

Psychosis and physical activity

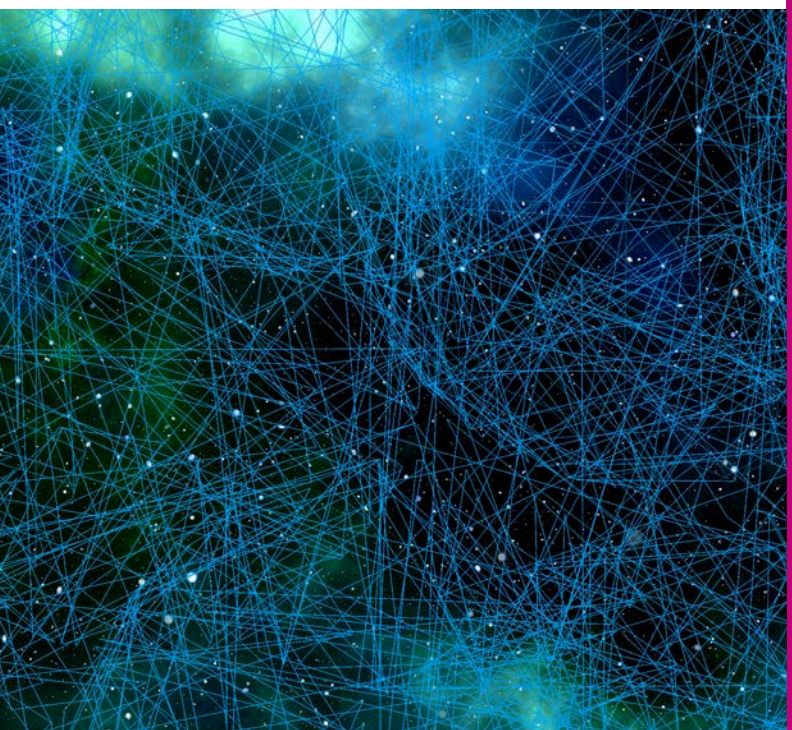
This questionnaire study is looking to understand what helps and hinders physical activity for those who experience psychosis (to help the design of effective interventions). 10 participants from our Adult Mental Health services have taken part so far.

Psychosis links with the immune system

There is evidence that some cases of psychosis may be caused by a specific problem with the immune system.

The PPiP2 study aims to see how many people with psychosis may have this specific issue with their immune system. The study involves taking a blood sample to test for specific antibodies.

We have recruited to this study on in our inpatient Mental Health units in Portsmouth and so far have worked with 7 participants.



> "Without the research team our service would not have been involved in 3 research projects. They work with you to make you believe you can, guide you through the research documentation and work with the clinical team to support you to take part if you decide participation in the trial is right".

Surgical treatment for Chronic Pain

Radiofrequency "denervation" is a surgical procedure offered to people with moderate to severe lower back pain.

The RADICAL study aims to find out if denervation reduces low back pain and is value for money. It is a complex study is being led by Dr Cathy Price. Consulant in Pain and is a collaboration with University Hospital Southampton and Spire Healthcare.

We are the highest recruiting site in the UK, with 11 patients having taken part to date.

Computerised Cognitive Behaviour Therapy for young adults

The SPARX-UK study is testing the effectiveness of a new digital computerised Cognitive Behaviour Therapy intervention. The intervention is aimed at adolescents with low mood, it was originally tested in New Zealand and found to reduce depression symptoms. The game is designed to be a serious, fantasy game.

“The research nurses and the wider team are generous with both their knowledge and time when supporting clinical teams with involvement in research trials. They are incredibly approachable and make taking part in trials easy and less overwhelming. “

Building research skills and capacity

Researcher Development Programme

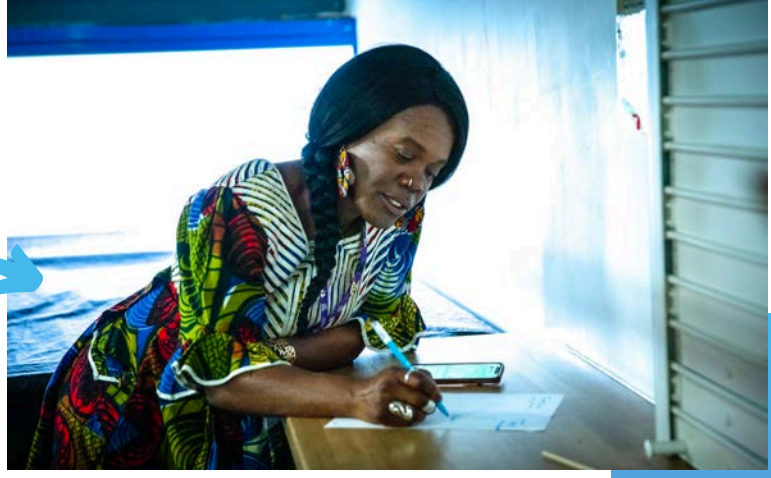
Our Researcher Development programme supports clinical and non clinical colleagues to understand more about health and care research, develop skills and maximise research career opportunities. It also helps to promote growing evidence-based working in their teams and services.

During 2023-24 we continued this new programme - 59 members staff across Solent, Southern and the Isle of Wight have taken part.

All sessions are supported by patient and public representatives from our Side-by-Side group and our community peer researchers. Each session also includes guest speakers who share examples of their work and opportunities they have had.

"The programme has been brilliant. It has given me breathing days between clinical work. The team have been incredibly supportive, patient and understanding. I have really felt heard and supported in the NHS. "

Outcomes following the programme include:



Ophelia

Solent's Head of Experience of Care has gone on to undertake a Masters in Clinical Research at Bournemouth University. She also won an underserved communities grant from the NIHR Clinical Research network to explore creative methods to increase engagement between the NHS and African migrant families.

Harriet

Is an Occupational Therapist who has been awarded an NIHR ARC Wessex research internship, and is exploring long term sickness in the armed forces. Harriet is now developing her PhD application.

Elle

A Clinical Associate Specialist, who is looking at the feasibility of delivering a self compassion programme for staff in UK mental health teams. After the programme she successfully applied for an ARC Wessex initiation award and is now preparing for the NIHR internship award.

Catherine

An Eating Disorders Practitioner is looking specifically at the Dove 'Confident Me Body Image' programme. She is completing an evaluation of the programme and is also training to be a Principal Investigator for a national eating disorders research study. She would like to develop her work into a PhD in the future.

Blue

A Senior Recovery Psychological Therapist with a specific interest in psychosis, has secured an NIHR internship and is developing her application for the NIHR Doctoral Fellowship award. Blue has recently published an article describing her work in "CBT Today" and shared a poster of her work at the National Rehabilitation conference.

"I feel empowered professionally and that I have a network to support me. The course has helped me unlock the "research curtain" and navigate the acronyms, pathways and reality of research careers. "

Research Discovery Award

This year we have also introduced a research discovery internship in Solent.

This funds time for developing research ideas and funding applications. For example, Emily (podiatrist) is looking at consistency in foot orthosis prescription to improve alleviation of foot pain; and Ellie (speech and language therapist) is looking at co-producing a resource for people with more severe aphasia to express their psychological needs

PhD submissions:

Two clinical academics have recently submitted their PhDs.

Chantel Ostler's (Clinical Lead for Research) PhD has explored meaningful outcome measurement following lower limb prosthetic rehabilitation.

Clare Ryan (Clinical Physiotherapy Specialist) has explored why people attend the emergency department (ED) for low back pain (LBP) and how this situation might be best or alternatively managed in community settings.

Prestigious Award for Consultant Psychiatrist in Child and Adolescent Mental Health

In November, Professor Samuele Cortese was awarded a prestigious National Institute for Health Research (NIHR) Research Professorship. This flagship award for the NIHR was only awarded to six outstanding researchers this year. The award will enable Prof. Cortese to lead a team of researchers on a project aimed at personalising treatment for children with ADHD, the most common neurodevelopmental condition.

"As a practicing clinician in our Child and Adult Mental Health Service (CAMHS), Samuele knows first-hand how children and families are impacted by this condition. His programme of work will seek a personalised approach to treatments - excitingly this will be designed for easy use by clinicians, and will also enable patients and families to set their own preferences. It's a special example of truly applied clinically-led research."

Quality Improvement

Solent has developed a mature improvement culture over the past few years. This is underpinned by a quality improvement training programme, which combines skills development with project facilitation. The programme is broad, aimed at supporting all staff at all levels, and helps them progress from beginner to leader.

- What is QI?
- Patient & Community Participation
- Co-Producing Improvement
- Improvement Leaders
- Happier Working Lives
- Preceptorship & other professional pathways
- Demand, Capacity & Flow

www.academy.solent.nhs.uk/improvement

QI in career pathways

We support our clinical staff to build improvement into their careers – this starts with Quality Improvement training and projects for all our Preceptees (newly qualified nursing and allied health professional staff), and continues with Advanced Clinical and Consultant Practitioners (linked with research). Advice and support to anyone that would like to be involved is given via coaching or through our regular lunchtime online QI Café's.

Preceptorship

Over the last year, 94 preceptees have participated in the improvement training and carried out projects. Examples are:

Freya Kunst (Physiotherapist) – better footwear for older adults on a ward:

Patients admitted to the Older Persons Mental Health ward, the Limes, may have a pro-longed stay without access to appropriate footwear. Many of these patients are at high risk of falls and without footwear and they are unable to access the outdoor areas available to them. The League of Friends have provided funding for suitable slippers – this is being evaluated for evidence of enhanced experience of stay.

Emily Jordan (Nursing Associate), Community Nursing in Southampton:

There are currently 449 catheter patients across the Community Nursing Caseload (Solent NHS Trust Data, December 2023).

Community Teams are experiencing an increase in emergency callouts to patients with catheters. Many of these patients have little information around safely managing their catheter, reason for insertion, how to source supplies or removal (TWOC) plans. An Awareness Guide has been developed for new catheter patients to the Community Nursing service to empower patients, reduce risks and readmissions. It is hoped that this will decrease patient harm, including reconditioning of the bladder, infections risks and readmission.

Ella McNicoll (Nursing Associate) – Oxygen provision on a rehabilitation ward:

Oxygen is one of the most used medications in medical emergencies. It was highlighted that there was a potential barrier to prompt implementation of oxygen delivery to patients requiring supplementary oxygen whilst on Lower Brambles Ward (RSH), due to the location of oxygen device storage and ward design. Equipment was re-located to within patient bays and the change was communicated to staff. This led to a 50% reduction in the time taken to implement oxygen on the ward.

Shantel Matogo (Occupational Therapist) – fatigue for those receiving specialist palliative care:

One of the most common symptoms experienced by palliative patients is fatigue which can impact quality of life and make activities of daily living challenging. It was identified that the Specialist Palliative Care Team were handing out a booklet about fatigue, but patients were finding it very taxing to read. A new fatigue management leaflet, which was smaller and easier to read, was developed. The leaflet has been peer reviewed will be piloted with 10 patients. The preceptee also presented their initiative at the Academy of Research and Improvement's annual conference in February 2024.

Trainee Advanced Clinical Practitioners

The Trainee Advanced Clinical Practice leads devised a pre-course training programme to support the TACP's and provide greater insight into their pillars of clinical practice. TPrior to their ACP training, we equipped participants with skills in Improvement methodology and tools to support their improvement initiatives. They carried out small projects, such as:

Roz Lankford – Community Services – documentation process

Restructuring the Complex Care (CC) documentation process: this improvement has streamlined the documentation process, by developing a template to document live on SystmOne (S1). This has saved time and enhanced patient safety.

"QI is not scary!! There is always someone from the academy to provide help and support. It is important to work out the cause of the problem before coming up with the solution!"

QI Practitioner

The QI practitioner programme runs over four days, and supports teams to deliver service improvement initiatives, providing them with skills and tools to aid them throughout the process.

This year saw us deliver two cohorts, each hosting 8 teams. Initiatives include:

Fybromyalgia Service

The Fibromyalgia service (FMS) took part in a national pilot providing group interventions for the successful management of FMS. The pilot saw 56% of DNA's (did not attend) in session one and 59% not attending follow up sessions. The FMS service sent a survey to patients, showing that they either felt to anxious or to unwell to attend and that the timings of the sessions did not work. During their first PDSA cycle patients were offered an opt in approach to sessions which has thus far shown a 100% conversion rate.

Portsmouth City Council & the ICB

Cold homes are a major risk factor for death and illness in winter, with older people particularly at risk. They analysed their data and targeted 133 patients who are over 65 with a respiratory condition, sending text messages, letters and arranging social prescribers appointments, providing information on where they can receive help to make their homes warmer. From this they had a response rate of 8-12% compared to 3% on previous years from general marketing.

Community Paediatric Medical Service

The Community Paediatric Medical service (CPMS) aimed to ensure that all children have the same length of wait for an Autism Spectrum Disorder assessment, there were longer waits in certain areas than other. With a sample of 20, families were offered the next available appointed regardless of locality. All families have accepted their appointments.

> I felt coming away from there every time that my whole team were beaming. We just felt a sense of 'Someone's really thought about us'. It felt really, really important to our team and we were really glad of the opportunity and we would just encourage any other teams to do it.

Co-Producing Improvement

The Co-production for Improvement programme was co-designed and co-delivered by a working group of four service users, Academy staff and service participation leads over the past year. The programme provides the knowledge, skills, and tools to enable teams to make service improvements by working in partnership with patients and communities. This is achieved by combining co-production and quality improvement approaches. You can find more about the programme and the learning so far- blog.

To date, we've had 8 teams participate, with a further 12 signed up for the new cohort. Outcomes from our first cohort include:

Two Saints Oakdene House

Found that services users who 'move-on' struggled in their new accommodation and community, often meaning they return. They worked alongside current and former clients to understand how they can support them to move-on successfully. They established weekly meetings, shared learning with Senior leads and other Two Saints locations and built better connections with community services to aid community support.

Integrated Specialist Dental Service

This team wanted to implement communication aids in receptions. They engaged with service users, learning that they had no concerns around existing communication strategies but alternative improvements were suggested (such as removing Perspex screens and sourcing wall-mounted play equipment) This changed the project, and they have since linked up with local SEN schools, play therapists, and visited a hospital's sensory room and asked service users what they would like.

"It's really good to think about all the different people that we can be engaging with and involving when we're developing our services. It is about making sure that people's voices are really heard, and we are actually including everybody at every part of the process"

Demand, capacity and flow programme

This year has seen further growth and development of, our demand, capacity and flow programme. This programme supports teams to understand the demand on their services, and how this is matched by the capacity to deliver.

The overarching aim is to empower teams address their waiting lists - to explore and understand data on how patients come into and progress through services, where there are waiting lists or 'pinch points' and gives them tools and skills to make improvements.

The programme has featured on a national podcast, in conjunction with the National NHS E/I Demand and Capacity team:

Spotify: Episode 11: We didn't know that about our service! - Demand and Capacity Team Podcasts | Podcast on Spotify

Demand for the workshops has been high and over 300 people have taken part this year. Participants have reported the days provide a valuable opportunity to develop new skills with the potential to enhance service performance. There are different options for participation – either a one-day introduction, a four-day course that includes project facilitation or bespoke support and coaching.

Teams participating are undertaking multifaceted and wide-ranging activities to improve their demand and capacity management. These include job planning and reviewing staffing skill mix (Access to Intervention), implementing a new tool to improve triage/discharge decision-making and exploring approaches to reducing variation in care provided (Specialist Dental), and improving data quality to accurately understand service demand (Child and Family Therapies).

Other participating services include Speech and Language Therapy (Adults Portsmouth), Pulmonary Rehabilitation (Adults Portsmouth), Public Health (Child and Family) and the Persistent Pain team (Portsmouth and South East Hants) who said: "People are coming to these (operational) roles as clinicians and we do not have naturally the skills to tackle waiting lists. It is really necessary to have a robust programme like this".

"Our mindset of looking at demand and capacity has changed our way of working: we are looking at processes, challenging what is done etc. We have improved confidence to question and challenge"
Pulmonary Rehabilitation Team

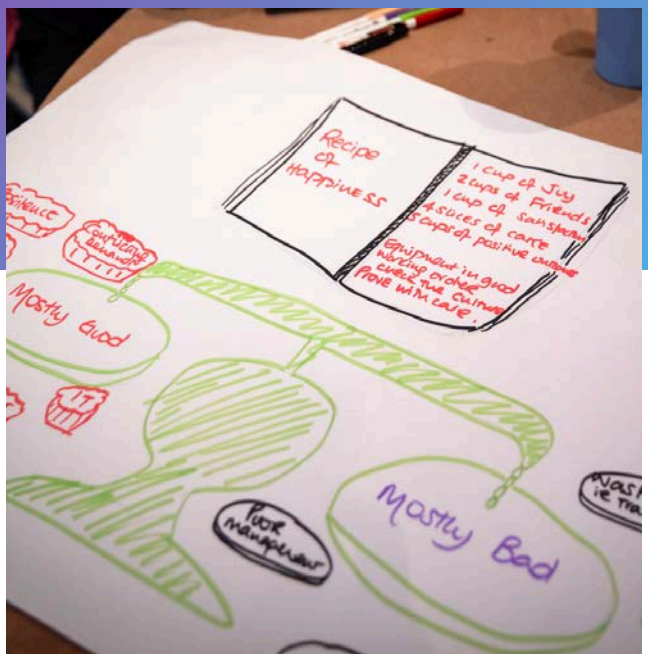
"One of biggest things we've taken away is the number of quick fixes we've tried over the years and that we need to focus on things for longer"
Speech & Language Therapy team

Our new programme is also generating external interest with enquiries being received from healthcare improvement professionals in Northern Ireland, delivery of a workshop on patient pathways and flow for the Chartered Society of Physiotherapy South Central Regional Network. In April, this work was showcased at the IHI International Forum on Safety and Quality in London.

Happier Working Lives

Our Happier Working Lives programme focuses on how we use improvement principles to create happier, healthier, and more productive teams. It aims to lay the groundwork for sustained improvement and a commitment to creating lasting positive change that benefits both staff and patients.

This programme is delivered in partnership with NHS Elect, and to date has had 40 teams from across Solent (and some partner organisations) participate.



Investing in people and culture is a key component of the NHS IMPACT systematic approach to continuous improvement. The HWL programme focuses on improving the well-being and satisfaction of NHS staff, which directly contributes to enhancing the organisation's culture and employee engagement.

An evaluation has demonstrated that teams who have taken part can tangibly demonstrate how what they have learnt has enabled value and appreciation of their wider team members. Gestures like gratitude cards and recognition of achievements helped to strengthen bonds and boost morale. It also helped build resilience, enabling teams to overcome obstacles and maintain a positive outlook, even in difficult circumstances.

Some individuals felt a new sense of responsibility to ensure that their wider team members felt listened to. They wanted to create a supportive environment where people could freely share ideas and address concerns. Some team members found the learning opportunities provided by the programme to be profound gaining valuable insights into themselves and their team dynamics.

> People on the work stream felt empowered by the models that we were given ... it's not to tell you how to improve your well-being, but instead it's to get the team to think about how they want to improve their well-being, make it meaningful to them".

Case Study: Learning Disability Team

The team have reflected that they are now more proactive in team well-being - Since attending have implemented the following:

- Email headings that state either "for information or for action" so staff can prioritise their work.
- Buddy groups (5 members of staff) have been created to support health & wellbeing.
- Procedures are being reviewed to ensure staff don't have to work over their contracted hours.
- Each week, staff share one highlight during "Peak of the Week"

"Asking curious questions .. I've asked more people about improvements! I hope this has given patients more confidence in sharing feedback."

"Continue to ask, keep going on changes QI is never tick and done!'

QI Leaders

The QI leader programme provides experienced staff and patients with a comprehensive understanding of improvement approaches and an opportunity to enhance their skills and confidence in improvement implementation. QI Leaders is also a network that brings together individuals with a passion for improving services by leading and supporting others through QI activity.

Many of the service improvements we see have QI Leaders help to form the idea, implement the project strategically within the service line, and support staff to access training and skills.

This year a further 13 people joined, to form a network of 30, which includes three patient representatives.

Commissioned Training

Over the last year we've also been commissioned to deliver improvement training for external partners that include:

- University of Winchester
- Dental Deanery
- ICB Fellowships
- Wessex Cancer Alliance

> "It has given me the confidence to proceed with my project. It has been a bit of a reset for me!"

Introducing

Solent has led the initiation of an annual Quality Improvement week, working alongside regional colleagues, The theme of this first week was to demystify quality improvement, with myth-busting, roadshows, virtual workshops, and keynote speakers.

This week has led to close regional work on collaborative improvement approaches and has been picked up across the country. This year (September 2024) it will be a national event.

Come and join us for #QIWEEK2024 on the 9th - 13th September, or to see what happened last year please visit our website QI Week 2023 | Academy of Research and Improvement (solent.nhs.uk)

In 2023-24, 135 local clinical audit and service evaluation reports were received, along with participation in over 30 trust-wide audits and 15 national audits and confidential enquiries.

Clinical Effectiveness

Our clinical audit and evaluation year started with detailed plans prepared after a trust-wide improvement planning event. The themes and ideas from this event were influenced by a staff survey, the involvement of the trust Chief Medical Officer, Quality and Safety teams, Directors of Engagement, Operational Development, Transformation and Five patients and public members.

We conduct audits and evaluations to provide assurance of effectiveness and quantify concerns but primarily to drive improvement in safety, quality and patient experience through action plans and re-auditing and to share learning across the organisation.

Our audit and evaluation activity is supported by a lead person in each service line who coordinates a local audit, research and quality improvement network.

Many of our initiatives were presented at lunchtime learning events, at our patient panel and as posters and presentations at our annual conference.

The following examples illustrate some of the learning and improvement from projects conducted this year:

Adult services

Audits for pressure ulcer risk, malnutrition and the assessment and diagnosis of lower leg wounds in Southampton.

These all showed significant improvement. For pressure ulcers, the recording of recommendations had increased from 83% to 94%. There was also significant improvement for 3 standards for patients who were malnourished or at risk: e.g., the standard about personalising care plans improved from 63% to 90%. This followed an action in the last audit to remind staff to personalise care plans for nutritional needs. For the lower leg wound audit, compliance had increased to 77% for completion of a Lower Limb Assessment from 43%.

Inpatient and community urinary catheter insertion and care

50 cases were audited from 3 inpatient units and 3 Community Nursing teams. There was an increase in the number of patients with a urinary care plan in place at 85% (78% in Jan-23, 33% in Mar-22). Forms originating in Solent care were more likely to have it completed than outside of Solent care, but these also showed an increase (76% from 67%). 100% of the 46 appropriate patients were aware of their catheter plan.

Portsmouth rehabilitation and reablement team re-audits of medication and general documentation

These audits identified a significant improvement in nurse reviews documenting how the patient was managing and listing their current medication on the template (from 25% to 90%). This was mostly attributed to a new paper care plan introduced since the last audit. The general documentation audit also identified several areas of improvement including recording of visit departure time in the patient held record and recording patients' priorities discussed which increased from 72% to 83% compliance.

An evaluation comparing clinically guided versus patient choice for pulmonary rehab

The Portsmouth pulmonary rehabilitation team intervention, whether carried out once or twice a week, demonstrated clinically significant results, but with potentially higher results in the clinically guided group. Both groups demonstrated clinically significant improvement in their health-related quality of life scores.

Child and Family

Evaluation of the OLIVE Programme

The cases of 18 families were reviewed, which showed that the OLIVE programme has started to become effective at identifying children and families at risk of an unhealthy weight and engaging them with early intervention and preventative lifestyle measures. The ethos of OLIVE is to shift the focus from weight and attempt to realign to a wider emphasis on the whole family and the need for healthier lifestyles.

Delivering review appointments for patients in the care of the children's podiatry service remotely during the covid-19 pandemic

Findings showed that insoles can be reviewed and replaced safely with a remote consultation in many instances. Providing insoles by post did not lead to any safety concerns in the way or complaints, most patients had their insoles sent out within 5.5 days. There was a delay in receiving photos from some parents though no patient said they could not provide photos to us. We received positive verbal feedback from guardians around the provision of insoles by post.

Evaluation of the melatonin review questionnaire

An online questionnaire for 12 monthly reviews of patients prescribed melatonin was trialled. 21/26 parents returned questionnaires. Of these, 7 were at satisfactory status (33%) and a letter was sent to their GP requesting repeat prescription of melatonin; the remaining 14 patients (66%) required a telephone or face-to-face review by their usual clinician. 6 parents gave feedback: 5 parents agreed that the questionnaire was easy to navigate; 2 parents strongly agreed or agreed that using the questionnaire was more convenient for the family than attending a face to face review; 2 parents agreed that the questionnaire was preferable to having a face to face clinic review. However, some parents commented on the advantages of face-to-face appointments.

Mental Health

Evaluation of appointment cost messages to reduce missed hospital appointments

Aiming to reduce the do not attend (DNA) rate in the community mental health outpatient services, appointment costs were included in appointment letters and SMS reminders. There was a significant reduction in DNA rates. Over 60% was noted during the evaluation period. As the evaluation took place during the time of the Covid pandemic, this would have an impact on the results though the service has continued to see reduced DNA rates.

Re-audit of Physical Health Monitoring

29/30 patients had clear documentation of annual physical health blood monitoring in accordance with NICE guidance. All examined patients have received annual and regular routine reviews. All patients had a review of side effects before drug administration.

Sexual Health

Re-audit of emergency contraception (EC) prescribing at treetops SARC

In the first audit, 45 females were eligible for and were prescribed EC but 3 (7%) were given a second-choice contraceptive - this provision of ineffective EC was discussed in clinical supervision sessions and training sessions were held. In the 2nd Audit, 48 females were eligible for EC of which all were given the correct prescription.

MSK Pain and Podiatry

An evaluation of demands for podiatry domiciliary visits by review of eligibility criteria

The current caseload was reviewed to ensure that patients met the criteria for Podiatry care at home and to address the 100% increase in podiatry home visits over the last 2 years. 179 patients completed the eligibility questions - 39 in Portsmouth and 140 in Southampton. Replies were similar for both areas: between 50 and 55% said they were able to leave the house with or without assistance; between 60 and 65% said they could get in a car or transport bus with wheelchair availability/access; 5% or less attended a hairdresser/day centre/social group; around 45% attended medical appointments such as doctors/hospital/dentist. Around 30 - 35% could not leave the house i.e., were truly housebound. Actions included education for the team and support for patients to return to clinic-based care.

Teen gym group evaluation

60 Adolescents attended. 18 responded to a questionnaire. Overall, 83% (14) felt that the teen gym class changed the way they felt about exercise somewhat or very much and 95% (17) reported that the class had encouraged them to exercise more.

Evaluation of the impact of ex-service users presenting at the introduction to pain management session

33 patients who attended the introduction sessions completed a survey, with the majority of the feedback being positive about the impact of having ex-service users attending; most people found them relatable & encouraging and felt the timing/length of their presentations were good, with the main feedback being that more practical examples and more information about their history would be useful. Responses also highlighted the need for a more diverse volunteer demographic to increase relatability for all patients.

Evaluation of physiotherapy knowledge of exercise prescription in the management of non-traumatic rotator cuff (RT) tendinopathy

26 physiotherapists were each given a clinical scenario and survey to assess their understanding of exercise prescription for Rotator Cuff Tendinopathy (RT).

The results showed that Solent physiotherapists align their management of RT patients with evidence-based guidelines. They exhibit sound knowledge of exercise prescription, tailor rehabilitation programs to individual patients, consider pain levels, and adjust and progress exercises over a suitable timeframe.

Dental

Re-audit of mandatory dental posters in Solent NHS Trust dental clinics

There was an immediate improvement following the initial audit as the act of checking resulted in missing posters being found and displayed - compliance then ranged from 81% to 100% for individual clinics.

The previous audit showed 72% compliance overall; this audit showed 86% initial compliance for mandatory posters which rose to 91% after missing ones were found.

Re-audit of sedation monitoring

The records of 60 patients were audited; overall compliance was excellent with 5 out of the 8 standards being met; there was 100% compliance with taking pulse oximetry readings at assessment and 98% pre and intra-operatively - compliance was lower for readings post-operatively at 87% but still a large improvement from the previous result.

Dragons Den

Teams can apply for up to £10,000 to test and implement an innovation in their service. Submissions are judged and then supported by a team of corporate service leads (IT, Estates, Procurement, Quality, Academy).
24 projects were submitted to Dragon's Den in 2023/24, of which 19 were approved.

Paediatric Occupational Therapy (OT) Video project

Five paediatric OT's from across Solent joined a Quality Improvement group with a parent representative to look at the needs of children and parents on the waiting list for difficulties with coordination and daily living skills.

Initially they trialled live virtual workshops for parents, but attendance was low and feedback suggested recorded (video) content would be preferred. A more detailed survey to parents on the waiting list identified specific content and format for videos.

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They applied to the Dragons Den for funding to make a series of videos. They were supported to identify a local company to produce these and worked with colleagues to produce a series of scripts.

Filming, using a parent and child actor, started in March 2024.

SOLENT DRAGONS' DEN

www.academy.solent.nhs.uk/innovation

Virtual Reality to enhance rehabilitation for people with a brain injury

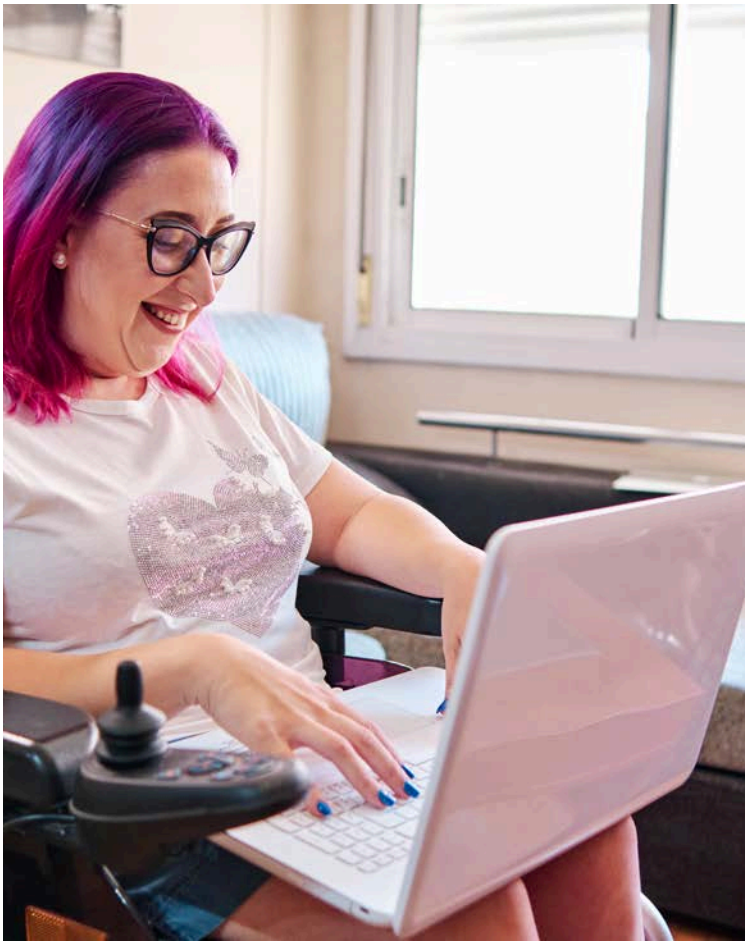
Virtual Reality headsets will replace an old Nintendo Wii to enhance rehabilitation via exercise for patients in the rehabilitation wards in the new South of England Rehabilitation Unit in Southampton. This allows patients to exercise to regain functional and motor skills.

Expansion of the EMDR offer for Talking Therapies

Trained therapists in our Talking Therapies have demonstrated improvement in patient outcomes with the use of Eye Movement Desensitization And Reprocessing Devices (EMDR) during therapy. This award will allow the service to purchase additional units and offer the therapy to more patients.

Enhancing speech and language therapy for adults with technology

Speech and Language Therapists in Southampton bid successfully for the investment in technology to support patients in their therapy. They have invested in specialist devices, headphones and software which invest in technology to support patients to independently communicate, and improve their communication skills. In doing so the service is modernising its therapy and assessment resources promoting equity and enhancing efficient working practice.



Co-Lab

Co-Lab is the Academy's service that runs internal and external rapid evaluations and training, exploring research methods that better fit community settings.

We have had a busy year delivering evaluations to our growing client base as well as launching our new peer researcher programme which trains people in our communities to research the areas affecting them the most.

Our work 2023-2024

Rapid Evaluation of the Enhanced Occupational Health and Wellbeing (OHWB) Programme across Hampshire and the Isle of Wight (HIOW)

In this evaluation, we completed 45 interviews with people who work in health organisations across Hampshire and the Isle of Wight about their experiences of the enhanced occupational health and wellbeing services.

The main findings highlighted that having one system across all areas ensures equity and increased efficiency by avoiding duplication. The findings also showed the benefits of a proactive approach aimed at keeping the workforce well and happy.

A rapid evaluation of Hampshire and Isle of Wight 350+ NHS Careers Programme

The Hampshire and Isle of Wight 350 programme is an educational outreach programme aimed at inspiring the NHS workforce of the future. In our evaluation, we completed observations and interviews by attending the sessions that are conducted at schools, colleges, and other educational settings. The evaluation showed how the programme empowers individuals from a range of backgrounds increasing diversity and inclusion.

A rapid evaluation of the Happier Working Lives (HWL) Programme

The Happier Working Lives programme is a programme run by NHS Elect to help create happier, healthier, and more productive teams in the NHS. This evaluation used snapshot ethnography and interviews to evaluate the impact of the programme. The evaluation highlighted the importance of empowering teams to initiate positive changes with the support of leadership teams.

"We were expertly guided from the beginning... everyone worked incredibly quickly to capture a moment in time, collecting an incredible amount of data"

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

" Our evaluation is full of new perspectives and data, presented in a clear and concise way with graphs and pictures to entice the reader"

Library Services

Engagement with library services continues to rise. This year, our knowledge specialist has carried out 53 expert evidence searches. These have been carried out for seven out of Solent's nine clinical service lines and saved approximately 320 hours, or 8.4 weeks WTE, of staff time. People who might not always have felt comfortable in health libraries have started to come along to events, training sessions and drop-ins, including Level 2 and 3 apprenticeship students and our colleagues in administrative roles. This is a good sign that we are helping to make finding and using the evidence less daunting.

320 hours of staff time saved

In November 2023, Kerry, our Knowledge Specialist presented at the International Clinical Librarians' Conference (ICLC) in Leicester, on our first three years in operation and the unique way we've built and run our service. This proved popular, with subsequent invitations to meet teams from other libraries to pass on our learning with speaking slots at the NHS Libraries Celebration event in January 2024 and the South of England Searching and Training meeting in February.

We currently have 507 OpenAthens accounts in the trust, more than ten percent of the current staff number. Our partnership with Portsmouth Hospitals has come to an end with the closing of the financial year, and reader services have transferred to our new colleagues in Southern Health. Over the last year, Portsmouth Hospitals has dealt with 163 interlibrary loan requests for journal articles from Solent staff, as well as 21 book requests.

User stories:

"On attending the Academy researcher development programme, I was supported to develop my own research career trajectory and develop a funding application to the NIHR internship awards…This included some initial scoping searches which, due to the complexity of my topic having very little research and being a niche population, were daunting. Kerry gave me extra support and 1:1 tuition to develop my confidence in searching the literature from accessing key databases, through to the use of natural language and MeSH headings."

Harriet Wilding

"After discussions with my team, I was supported in developing a Trans+ clinic for our Southampton community. I needed some research to explore how other services delivered theirs and evidence to prove my idea is worthwhile. I was directed to Kerry who was able to help me out a great deal, they did a comprehensive search and checked in with me throughout to update me on their progress."

Hunter Livingstone

"The work Kerry did exploring the evidence for dialectical behaviour therapy and neurodiversity underpinned our project, which was summarised in a poster. This was accepted for display at the Academy Conference recently and featured in our Mental Health Service Roadshow on Audit, Research, Quality Improvement."

Toni King

sidebyside

> "You have given me some really good ideas. The idea that to start small makes it feel more manageable and something that I can fit into my workload ."
>
> Nathan Clifford, Co-production Workshop

Side-by-Side is a dedicated group of individuals that give a patient and public perspective and work in partnership with us in the Academy. The network meets up regularly to support each other, share each other's involvement, and help us embed the patient perspective in the work we do together.

This involves co-designing and co-delivering workshops and programmes, being involved in recruitment and interviews, planning our conference, and promoting people participation across research and improvement activities.

A patient voice and service user involvement is a fundamental part of all training that we do at the Academy, whether it is Side by Side or patient partners that work alongside services.

www.academy.solent.nhs.uk/side-by-side

Participation Workshops

Side-by-Side members collaborate with the Academy team to design and deliver content and support teams attending a range of participation workshops. This includes Experience Based Design, co-production, and introduction to working with Patients and People to improve services.

Also, as a network we have been involved in supporting bespoke training and programme for the Transformation Team, University of Winchester Advanced Practice module and Trainee Advanced Clinical Practitioner.

Having Side-by-Side members involved provides a patient perspective and offers encouragement and advice to teams on how they can engage with their own patients, to ensure research and improvement activity is important and central to what matters to patients, people and our communities.

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

Involving patients and people in recruitment and interviews

Several teams in Solent (for example, Academy of Research & Improvement, Learning Disabilities and Child and Family Services) involve patients as part of all their recruitment processes.

Last year, to help other services to do the same, we designed a toolkit with the Voluntary organisation ReMinds and patient representatives. The toolkit includes methods, resources, and videos to help others involve patients and service users in recruitment and interviews.

This has now been adopted by our People Services and Equality, Diversity and Inclusion leads who are integrating the toolkit into a new inclusive recruitment strategy. People Services will now support managers in recruiting staff for band 7 and above positions, to involve service users in recruitment and interviews .

International Forum on Quality and Safety in Healthcare

Alongside University Hospital Southampton NHS Foundation Trust, Southampton Sight and the Braintrust we ran an interactive workshop for 150 delegates at the International Forum on Quality and Safety in Healthcare 2023.

We shared our integrated approach to research and improvement, how we work alongside and support co-production with services.

Patient Review Panel

This year we introduced a patient review panel to promote patient and public involvement in various improvement projects. The panel is comprised of Side-by-Side members, where project authors share a summary of their methods, findings and future plans with the panel before a virtual session takes place. During the session, panel members ask questions, provide insights from their lived experience and make recommendations. Project authors receive a summary of the panel's feedback and are encouraged to implement improvements and feedback to the panel.

This panel initiative was recognised and awarded the Patient and Public Hero award as part of Clinical Audit Awareness Week 2023.

"Side-by-Side is a fantastic, constantly evolving, team with each person highly valued in bringing their skills, strengths, and experiences to a variety of settings. How wonderful to receive an award that recognises the importance of people participation, I hope it will encourage other organisations to do the same."

Academy Workshops

This year we have provided 98 workshops, attended by 388 people.

Our introductory sessions are always popular covering topics such as library and evidence searches, clinical audit, service evaluation, outcome measures, quality improvement and people participation.

98 WORKSHOPS

388 ATTENDEES

Other popular topics have included:

- Social Media in the NHS
- Blogging
- Poster production
- Project Management
- Writing for publication
- QI Café – the fear of change
- Film making
- Co-production for improvement
- How to involve patients and people in staff recruitment and interviews

"Great day - Thank you for a really inspiring day thinking about how we can use a quality improvement approach in our work".
Suzanni AHP workforce fellow

"I just wanted to say how helpful and enjoyable yesterday's poster workshop was. I have come away feeling really excited about completing this and it feels very achievable as previously was feeling slightly overwhelmed".
Michelle Vincent, Tissue Viability Sister

Solent Awards 2023

"Thank you all for welcoming me to the Academy and giving me the opportunity to be involved in the QI and Side-by-Side projects during the last four years. I was bowled over just to receive a nomination for an award and to receive it was very poignant. I look forward to continuing my involvement with you for as long as I have value to add"

Penny Reid, Side-by-Side member

The Heart of Solent Awards were held in July 2023, including prizes for research and improvement. Amanda Barfield, a Side-by-Side member was part of the judging panel and presented one of the awards.

A big congratulations to the winners and all of those nominated for the outstanding contributions and differences they have made through their work. For the:

People Partnership Award

Won by Penny Reid, member of Side-by-Side and QI Leader, for her work supporting patient involvement in improvement across the Trust.

Improvement Award

Won by Lower Brambles and Fanshaw Wards, who were recognised for their efforts in relieving post covid pressures on community beds.

Research Award

Won by Podiatrist, Emily Leach, who received acknowledgement for her research on orthotics supported by a National Institute for Health and Care Research Initiation Award.

Academy Conference

We held our annual conference, with 130 delegates. Our Side-by-Side members opened the conference and co-delivered two workshops. The day was an accredited #PatientsIncluded event, designed to be interactive and celebrate the story of the Academy so far.

We had three zones (working in partnership, creative methods, improvement in action) which were interactive with sharing of learning, connection opportunities, and a celebration, and included over 40 posters showcasing research and improvement activities from across services.

Our keynote speakers were Professor Samuele Cortese, an NIHR Professor who works in our Child and Adolescent Mental Health Services as a Consultant Psychiatrist; and our current and past Chief Medical Officers, Dr Dan Baylis and Prof Daniel Meron who reflected on the importance of improvement culture.

Please find out more via social media #SolentConf24

This is our last Academy Annual Report as Solent NHS Trust - in just a few weeks we will become Hampshire & Isle of Wight Healthcare NHS Foundation Trust. We're all ready and raring to go, excited about all the opportunities ahead.

A massive thank you for all those who, (since the story started and Solent was formed in 2010) have worked alongside us, taken part in training and projects, guided us, challenged and inspired us, and always strived to learn, innovate and improve. We've been fantastically supported by our Trust Board, our Side by Side network and everyone across Solent. The story so far for us has been incredibly fulfilling and lots of fun.

The team are very much looking forward to our next chapter. Keep an eye out for news and updates and please come forward with any requests or suggestions.

See you soon,

Sarah.

WWW.ACADEMY.SOLENT.NHS.UK

Board and Committee Summary Report

Title of Paper	Charitable Funds Committee Exception Report
Date of paper	23 May 2024
Presentation to	Solent NHS In-Public Trust Board
Item No.	18
Author(s)	Belinda Brown, Executive Assistant to Chief Executive
Executive Sponsor	Gaurav Kumar, NED – Committee Chair Debbie James – Executive Sponsor
Summary of key issues/messages	To summarise the key business transacted at the Charitable Funds Committee meeting, 09 May 24. The Committee: - • **Received** the Finance Report for Quarter 4, covering the period from 01 January 2024 to 31 March 2024. • was **informed** that the charity had a surplus position of **£90, 429** within Q4 and a surplus position of **£171,757** YTD. • was **informed** of receipt of legacy donation **£64,627**, with a further remaining 25% of the legacy donation to be received in due course. • The committee was **updated** on the NHS Charities Together development grant **£30,000.00** to be used to drive improvements in charity reporting across Solent and Southern Health NHS Foundation Trust (SHNHSFT) and to fund shared resource across Solent and SHNHSFT. • **Received** an update on donations received within Q4, including a donation of **£1,000.00** following care provided by the St Mary's Community Nursing Team and two other donations totalling **£55.00.** • **Received** an update on charity expenditure within the quarter, including (i) staff welfare totalling **£1,729.00,** including expenditure on team wellbeing events of the Occupational Health, Commercial and Cardiac teams totalling **£746.00**, staff thank you cards and hampers totalling **£781.00** and funding for tea and coffee consumables for 0-19 totalling **£202.00**, and (ii) patient welfare expenditure totalling **£2,177.00**, including **£725.00** spend used to make the Occupational Health team's new premises at Woolston House, more appealing, **£900.00** used for musical entertainment at Spinnaker Ward and **£72.00** spend on Horizon (CAMHS) clinical rooms, to provide sensory lighting, furniture and toys. • **Received** an update on the Covid-19 appeal grants, (i) NHSCT Charity Development and (ii) the Stage 3 Recovery grant. • **Received** an update on the use of charity funds to redesign gardens at Falcon House. • **Received** an update on the use of the charity funds for the development of an outside gym area for Jubilee House. • **Received** an update on the use of funds to support the Trust's 'Celebration Event', arranged for Wednesday 05 June 2024. • **Received** an update on the closure and transition of the charity committee work to the new organisation. The committee **agreed** that all existing Solent charity projects will be ring-fenced moving into the new organisation. • 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 receive the above summary of business transacted.			

Statement on impact on inequalities	Positive impact (inc. details below)		Negative Impact (inc. details below)		No impact (neutral) X
Previously considered at	*N/A*				

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

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