Bundle Trust Board Public 7 April 2022

1	OPENING BUSINESS
1.1	10:00 - March SOX of the Month Awards *March Patient Centred SOX* *March Staff SOX*
1.2	10:05 - Patient Story
1.3	10:15 - Welcome and Apologies *Apologies received from -* *Michael von Bertele* *Peter Collins, Duncan Murray attending*
1.4	Declaration of Interests
1.5	10:20 - Minutes of the previous meeting *Minutes attached from Public Meeting held on 10th March 2022* 1.5 Draft Public Board mins 10 March 2022.docx
1.6	10:25 - Matters Arising and Action Log 1.6 Public Board Action Log.pdf
1.7	10:30 - Chairman's Business *Presented by Nick Marsden* *For information*
1.8	10:35 - Chief Executive Report *Presented by Stacey Hunter* *For information* 1.8 CEO Board Report - March for April Meeting.docx 1.8b AHA_March_Briefing_310322_V1.0.docx 1.8c B1523 - Ockenden Final report letter 1 April 2022.pdf
1.9	10:45 - Public and Private Trust Board Cycle of Business *For approval* 1.9a DRAFT Public Trust Board Annual Business Cycle 22_23.pdf 1.9b DRAFT Private Trust Board Annual Business Cycle 2022-23.pdf
2	ASSURANCE AND REPORTS OF COMMITTEES
2.1	10:50 - Clinical Governance Committee - 29 March *Presented by Eiri Jones* *For assurance* 2.1 Escalation report - from March 2022 CGC to April Board 2022 final.docx
2.2	10:55 - Finance and Performance Committee - 29 March *Presented by Paul Miller* *For assurance* 2.2 Finance and Performance Committee escalation paper 29th March 2022.docx
2.3	Trust Management Committee - 23 March - condensed meeting no report this month
2.4	11:00 - People and Culture Committee - 31 March *Presented by Michael von Bertele* *For assurance* 2.4 People and Culture Escalation report 31 March 2022.docx
2.5	11:05 - Audit Committee - 24 March *Presented by Paul Kemp* *For assurance* 2.5 Escalation report from Committee to Board - Audit Committee 24th March 2022.docx
2.6	11:10 - Charitable Funds Committee - 24 March *Verbal update by Nick Marsden* *For assurance*
2.7	11:15 - Integrated Performance Report to include exception reports

Presented by Judy Dyos
For assurance

2.7a 070422 Trust Board cover sheet.docx

2.7b IPR April.pdf

3 QUALITY AND RISK

3.1 11:45 - Patient Experience Report Q3

Presented by Judy Dyos
For assurance

3.1 Patient Experience Report Q3 a.docx

3.2 11:55 - Learning from Deaths Report Q3

Presented by Peter Collins
For assurance

3.2a Cover Sheet Quarterly Learning from Deaths Report - Q3.docx

3.2b Quarterly Learning from Deaths Report - Q3.pdf

4 STRATEGY AND DEVELOPMENT

4.1 12:05 - Improving Together Quarterly Update Report

Presented by Esther Provins
For assurance

4.1a Improving together quarterly report for Trust Board - April 2022.docx

4.1b Appendix A Improving Together Indicative Implementation Timeline.pdf

4.1c Appendix B KPMG expenditure report Q4.pptx

5 FINANCIAL AND OPERATIONAL PERFORMANCE

5.1 12:20 - Standing Financial Instructions

Presented by Lisa Thomas
For approval

5.1a SFI review Mar22.docx

5.1b Appendix 1 - current SFI limits.docx

5.1c Appendix 2 - recommended approval limits.pdf

5.1d Appendix 3 - Standing Financial Instructions Mar22.docx

6 PEOPLE AND CULTURE

6.1 12:30 - Medical Education Performance Report - deferred from January

Presented by Peter Collins
For assurance

6.1a Medical Education Cover sheet.docx

6.1b Annual Medical Education Report 2020-2021.docx

6.2 12:40 - National Staff Survey Results

Presented by Melanie Whitfield
For assurance

6.2a Public Board - staff survey paper March 22 (2) a.docx

6.2b SFT staff survey presentation Trust board 7 April DRAFT.pptx

7 GOVERNANCE

7.1 12:50 - 2022 Annual Review of Directors Interests/Annual Review Fit and Proper Persons Test

Presented by Fiona McNeight
For assurance

7.1a Trust Board Annual Declaration of Interests and FPPR cover sheet.docx

7.1b Public Board Register of Interests Decision Making Staff.pdf

7.2 13:00 - Integrated Governance Framework including Board Committee Terms of Reference

Presented by Fiona McNeight
For approval

7.2a Trust Board Integrated Governance Framework Cover Sheet.docx

7.2b DRAFT Integrated Governance Framework 2022 V1.docx

7.3 Accountability Framework - deferred to May

Presented by Andy Hyett

7.5 Register of Seals Q4 - no updates since last report in January

8 CLOSING BUSINESS

8.1 13:10 - Agreement of Principle Actions and Items for Escalation

8.2 13:15 - Any Other Business

8.3 13:20 - Public Questions

8.4 Date next meeting

5 May 2022

9 RESOLUTION

Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 10th March 2022, MS Teams Salisbury NHS Foundation Trust The Rugby Club, Salisbury

Board Members:

Nick Marsden (NM)	Chairman (via teams)
Paul Kemp (PK)	Non-Executive Director
Paul Miller (PM)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
David Buckle (DB)	Non-Executive Director
Michael von Bertele (MvB)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
Lisa Thomas (LT)	Chief Finance Officer
Judy Dyos (JD)	Chief Nursing Officer
Andy Hyett (AH)	Chief Operating Officer
Stacey Hunter (SH)	Chief Executive
Melanie Whitfield (MW)	Chief People Officer
Peter Collins (PC)	Chief Medical Officer

In Attendance:

Esther Provins (EP)	Director of Improvement and Partnerships
Naginder Dhanoa (ND)	Chief Digital Officer
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
John Mangan (JM)	Governor (observer)
Lucinda Herklots (LH)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Antonio Pinna (AP)	Healthcare Support Worker Theatres (item TB1 10/3/1.2)
Mariana Garro-Olivares (MG)	KPMG (observer)
Felicity Pullan (FP)	KPMG (observer)
Amila Maduragoda (AM)	Clinical Fellow (observer)

ACTION

TB1 10/3/1 **OPENING BUSINESS**

TB1 10/3/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

NM noted the following members of staff who had been awarded a SOX Certificate and details of the nominations were given:

- **January SOX of the month –** Paul Straughair and team, Catering
- **January Patient-centered and Safe SOX –** Wessex Rehabilitation
- **February SOX of the month –** Nick Goodman & Maria Baylis, Central Booking
- **February Patient-centered and Safe SOX -** Day Surgery and Sarum

NM noted the wide variety of nominations that he always receives and the great work underway during extremely challenging times. NM and

the Board congratulated the members of staff who had received a SOX award.

TB1 10/3/1.2 **Staff Story**

Antonio Pinna (AP), Health Care Support Worker in Theatres, joined the meeting to provide the Board with a summary of his development and training within Salisbury Hospital. AP described how he had initially found it difficult to gain an understanding of how he could develop and progress within the Trust. However, once he had been pointed in the right direction, he had found the Education Department extremely helpful and has now successfully completed level 2 math's and English and an NVQ. He is now looking forward to starting his Operating Department Practitioner) ODP training in May this year. He thanked several people he worked with and in the Education team for enabling to undertake training and supporting him during his learning journey.

Discussion:
EJ thanked AP for attending the Board and acknowledged the motivation and inspirational spirit he had expressed telling his story.

JD acknowledged that it can be difficult for staff to know the levels of development and training available to them in the Trust. JD explained that the team are working on access to education and steps are being taken to ensure all services are accessible for staff.

AH noted that AP seemed very dedicated to advancing his career and asked how he had managed to keep the passion for this throughout the pandemic and whilst also working in a very busy job. AP explained that you need to love the job you are doing and if every day just felt like work it would be a lot easier to fail. AP explained that he always tries to plan his days, so he has more balance and less chaos.

SH thanked AP for coming to share his story to Board and noted that outside of the Board meeting AP had shared that his wife left the organisation because she found she could not access the training she required. SH asked AP for one thing the Board could do in Theatres to enable people to do their best at work, every day. AP noted that he had already seen great improvements in Theatres in terms of learning and collaboration. However, AP pointed out that further work is required to share the learning from Never Events so issues can be easily anticipated and prevented.

PM reference the long list of people who had helped him on his learning journey and asked AP if he had to find this help or were people readily available. AP explained that it was a combination of both and explained that it is the staff member's responsibility to actively find help and advice if they require it as people can only solve a problem if they are aware. AP noted that once he knew the right people to speak to for advice, he was helped greatly and knew exactly the right path to start his learning in the Trust.

NM thanked AP for coming to speak to the Board.

TB1 **Welcome and Apologies**

10/3/1.3

NM welcomed everyone to the meeting and noted that there were no apologies received.

TB1 10/3/.4 **Declarations of Conflicts of Interest**

There were no declarations of conflict of interest pertaining to the agenda.

TB1 10/3/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 13th January 2022.**

NM presented the minutes from 13th January 2022, and the following amendments were suggested:

- EJ noted that on p. 3 under Chairman's business the first line should read 'his', not 'her'.
- It was noted that on p. 11 under the Q2 learning from deaths report it should read "quarterly focus on deaths" rather than "effectiveness".
- EJ noted that part of the item on the Annual Equality and Diversity report discussion was missing. *(post meeting note: the correct version of the minutes with this section has been uploaded on the public website).*
- JD noted that under the Q2 patient experience report there had been 352 complaints reported, not 52.

It was agreed that subject to these amendments the minutes were approved as a correct record of the meeting.

TB1 10/3/1.6 **Matters Arising and Action Log**

NM presented the action log and noted that both actions were to be picked up on a future agenda or closed.

There were no further matters arising.

TB1 10/3/1.7 **Chairman's Business**

NM highlighted the following key points as part of his verbal report to the Board.

The Trust is focusing on is trying to respond to pressure in a variety of areas and it is the responsibility of the Board to acknowledge and support the executive in doing this whilst also taking into consideration the staffing pressures in the Trust and across the system.

The Trust is fast approaching the end of the financial year and the Board are planning to have a detailed update on planning for 2022/23 in the private meeting.

A common theme underpinning several concerns in the detail coming to Board is staffing and there should be a focus on what can be done to minimise these pressures.

NM's report was noted.

TB1 10/3/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- The report is set out to align to the Trust's Strategy in relation to Population, Partnerships and People.
- Operationally, the Trust remains under significant pressure with consistently high levels of escalation, with the system declaring OPEL level 4 for 10 days during February.
- Despite the dedicated and hard work of the Trust's staff there are currently over 100 people in the Trust who are ready for discharge but are unable to leave due to the appropriate care outside of the hospital being unavailable. The constraints in domiciliary care are increasingly impactful and a strategic response is needed. There are ongoing conversations with the chief executive at Wiltshire Council to establish how to best improve this position and several options will come back to the Board in the near future on how this might be mitigated
- Due to the current pressures on flow and the requirement to maintain and urgent and emergency service, extremis capacity has been opened in the Spinal Gym. This is having and adverse impact on the delivery of the spinal injury service.
- February saw the launch of the Improving Together programme which will support us to continue to deliver outstanding care by improving the systems and processes that we use and the way we work together. This is a long-term programme that will be reaching every member of staff over the next few years.
- SH was pleased to report that the catering team have retained their 5-star food hygiene award and she congratulated the team on this achievement.
- The paper and accompanying appendices detail the good progress on work with secondary care partners in the BSW Acute Hospital Alliance
- The BSW Partnership Board received a report from the public engagement work on Shaping a Healthier Future which is the Integrated Care System's (ICS) strategy for a redesigned care model to support local communities. Future Board development session about the Trust's role in the new ICS landscape are planned and the Board will receive an update as part of this session on the emerging BSW Care Model which this engagement report relates too.
- Women's and New-born division continue to progress their work to respond to both Ockenden and the most recent CQC inspections. The detail from this is reported to Clinical Governance Committee (CGC) and a letter is included in the papers regarding Ockenden one year on and a full report is due out in next few months.
- The Board and wider Trust's thoughts are with people in Ukraine who are suffering losses and incredible humanitarian hardship.

There are various ways that staff and the wider population can help the people of Ukraine and SH noted that if people have useful items to donate, they can take them to City Hall in Salisbury.
- SH noted that reflecting on the current situation in Russia and Ukraine, the private Trust Board would be receiving an update on cyber preparations.

Discussion:
DB referred to the Trust remaining in OPEL 4 for long periods of time and noted that remaining in this situation requires a huge amount of internal effort, energy and time. DB asked if the executive could provide any assurance that the Trust will not be in OPEL 4 going forward and asked if there is anything the Trust could do differently to mitigate this. SH explained that there is no clear path out of the situation over the next few months due to the increased demand at the front door and the extreme flow issues in the Trust and wider system. The partnership work with Wiltshire Council has got a lot of potential as there could be further action taken to help improve domiciliary care which is a key constraint with no criteria to reside patients. There is a further need to digitalise and transform services and therefore no short-term fix.

PC noted that the Trust is actively engaged in what can be changed and improved, e.g., the current response to COVID-19 and Infection, prevention and Control measures which do still add constraints. There is an active debate about whether this will change soon and if this will be a national, regional or local process.

TB referred to the hope that provision of domiciliary care can be improved and asked where the workforce to support this would come from as previously concerns have related to lack of staffing. SH explained that some NHS Trusts have set up their own agencies and early figures suggest they are not struggling to recruit. SH explained that these employees are additional to the system and have mainly be sourced from the leisure industry as it is recognised the market for these staff is already constrained.

PK asked for further assurance around the long-term strategic risks of providing the spinal rehab service. AH explained the impact on the spinal service of opening the spinal gym to increasing medical patients and the effect on the rehab programme. A Quality Impact Assessment (QIA) has been undertaken and equipment has been relocated and maintained but the facilities are not as good. The Board discussed the risks and mitigations in detail, and it was noted that patients are safe but in terms of the long-term impact the Trust is not currently providing the expected rehab service it would normally deliver.

PM reflected that by adding more beds into an already full hospital the Trust is buying time and not offering a solution to the issue. Alternatives were discussed but SH explained that longer ambulance waits are part of what is causing the pressure to open more beds and if the Trust were not doing this ambulance waits would be even longer. AH noted that these are not decisions that are taken lightly and are reviewed constantly.

EJ asked that as this is a specialised commissioning service, has the Trust contacted regional units to see how they are managing with this. SH explained that if there is capacity in other units there are opportunities for access.

EJ referred to the Ockenden letter and noted that there are clear expectations relating to the 7 Immediate and Essential Actions (IEAs) that they should be reported at Trust Board before the end of March. JD explained that these details would be going to CGC as it was felt this was the most appropriate forum. EJ agreed and asked her NED colleagues if they were content with this proposal. The NEDs supported this.

PK referred to the risk impacting spinal service provision and noted that the appended paper does not close the issue. PK suggested that the Board need to set timetable of when this service will be delivering what is expected. It was agreed that performance information was not necessary but a longer-term inability to recover the service to what is expected should initiate a Board level strategic discussion. LT explained that there are ongoing discussions about elective ring fencing of beds and there should be a minimum we will protect to ensure service delivery. It was agreed that if this is a sustained position, there needs to be a conscious decision about the service going forward.

SH explained that there is work underway at system level, which is due to come back through BSW partnership board in the next two weeks, which will quantify what out of hospital provision is required. SH reminded the Board that the Trust have always ringfenced spinal beds, but the Trust is now working within a new context. AH clarified that there are no medical outliers in commissioned spinal beds but nationally the demand for spinal beds has increased since the start of the pandemic. PC noted that Board had spent their time discussing spinal patients but noted the time dependency of care is the same in several specialities with high numbers of patients waiting for treatment. PM noted that it is about getting the optimal balance of risks and SH advised that the Trust is applying the national framework to ensure correct protocol is followed.

NM noted that this had been a lengthy but necessary discussion as it was his priority to focus on the issues that are important.

TB1 10/03/1.9 **Register of Attendance**

The register of attendance was noted.

TB1 10/3/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 10/3/2.1 **Clinical Governance Committee (CGC) 22nd February 2022**

EJ presented the report, providing a summary of escalation points from the meeting held on 22nd February. EJ asked for the report to be taken as read and highlighted the key points:

- The two deep dive presentations were useful and demonstrated that learning is being applied. The presentations clearly showed how executives and clinical teams are aligning work to the Improving Together, particularly in relation to falls where there is a strong focus.
- The Committee are waiting for the spinal team to present to CGC and EJ will pick this up with PC and to ensure the team have time allocated to come to committee.
- The Committee received a positive presentation from the senior digital team about how they are providing support to clinical teams.
- Assurance was provided that the Trust continued to be licensed under the Human Tissue Authority (HTA) to undertake stem cell work and post-mortem examinations. Areas for improvement were discussed and a detailed timeline was requested from PC for the clinical SOP work.
- A key theme from the meeting is the impact that delayed discharges are having on the hospital, particularly in relation to potential or actual harm.

The report was noted.

TB1 10/3/2.2 **Finance and Performance Committee (F&P) 22nd February 2022**

PM provided a summary of escalation points from the Finance and Performance Committee held on 22nd February. PM asked for the report to be taken as read as the key points from his escalation report were picked up in the public and private meeting.

The report was noted.

TB1 10/3/2.3 **People and Culture Committee (P&C) – 24th February 2022**

MvB provided a summary of escalation points from the People and Culture Committee held on 24th February. MvB noted the following key points:

- The Committee reflected on its purpose and terms of reference. The drafting of the People Plan will take some time, and this will influence how the Board Committee is structured to support delivery of the plan and provide the necessary assurance.
- The Committee discussed appraisals and the decrease in compliance with annual appraisals and different methodologies that could potentially support meaningful conversations.

Discussion
PK endorsed the idea that appraisal compliance is an early warning sign and asked what action the Trust is taking to mitigate the falling numbers. MW explained that a number of staff were currently not at work due to illness, maternity leave and annual leave as we approach the end of the financial year. This paired with operational pressures means that numbers have decreased. The process has been reviewed formally and it has been suggested that line managers undertake more regular but less formal health and wellbeing discussions that are recorded as there needs to be documented evidence. The team need to

devise a template, and this will be piloted in Theatres and Medicine. The line managers from these departments will feedback and record on ESR. It is acknowledged that this is not a replacement for the appraisal but a supportive conversation between staff and managers. MvB supported this idea but noted that performance and development needs should be part of these conversations.

PK supported this approach but noted the difference between non-medical and medical appraisal compliance and asked what could be learnt from this. MW explained that regular and frequent conversations are needed, and whilst OD&P need to support in terms of the structure and template, the culture needs to shift and operationally managers must create the time which is a challenging task. SH noted that there are different drivers for medical and non-medical appraisals. Medical staff have nationally mandated specific planned time each week which is not afforded to other staff. PK noted that more could be done to ensure all staff were provided with time to undertake appraisals.

AH explained that leaders and line managers were having 1:1s with their staff on a very regular basis to check in, listen and reiterate realistic expectations, particularly during extreme operational pressures.

LT explained that there are other reasons that appraisals might not be recorded in the numbers, for example as appraisals have moved to ESR there are members of staff working from home who do not have a smart card and therefore cannot login. There are practical solutions to some of the issues rather than assuming the appraisals are not being done. JD explained that senior nurses have been advised to undertake 'light touch' appraisals where full appraisals are challenging to organise.

RA did not believe that appraisals were not taking place but that the systems and processes in place do sometimes get in the way of documentation. If the organisation is still running and people are providing safe care, RA believed these conversations with staff are happening. PK acknowledged RA's point but noted that turnover is the highest it has been for a long time and whilst the main cause was not appraisals this was signalling a retention issue.

SH noted that the Board were right to be concerned as appraisals are an important mechanism to support staff and the Trust need to get back on track and demonstrate that these important conversations are happening.

NM noted that this would be picked up further via the People and Culture Committee.

TB1 10/3/2.4 **Integrated Performance Report (IPR) (M9)**

AH presented the Integrated Performance Report and noted it provided a summary of January's performance. AH noted that a lot of the current operational challenges facing the Trust had already been discussed but highlighted that the Trust is not just in OPEL level 4 but also a major incident level 4 whilst also trying to recover its elective position.

Discussion:

PK highlighted that the number of incidents in January were higher than in previous months and asked if this was related to operational pressures. JD explained that in January there were increased issues because of staffing and operational pressures. The Trust has thematically reviewed and falls and pressure ulcers were the key contributors during the reporting period.

TB referred to the maternity dashboard and noted that she was struggling to make sense of some of the maternity data. JD noted that there was a piece of work at system level to try and align the maternity dashboard, but it was agreed it would be helpful for JD and TB to discuss outside of the meeting. **ACTION: JD** SH agreed and noted that the definitions need to be attached as an appendix to the report. PK further suggested that the commentary section needed to consider that non-clinical people need to understand the detail. **JD**

EJ referred to cancer performance deterioration and asked if this staff related. AH explained that staff do have had a knock-on effect to these KPIs but noted that whilst the Trust slipped on the two week wait it currently sits at around 16 days for those who breach the two weeks.

PM referred to the turnover rate at 12% and related this to the potential plan of recruiting over 400 people in 2022/23. PM noted that when the Trust is calculating recruitment figures it needs to consider those people who are leaving. SH noted that she had be part of a national discussion relating to this and currently the most common reason for people leaving is retirement as in the context of COVID more people stayed on for longer to help. Additionally, other staff have chosen to leave due to the pensions issue.

TB1 10/3/2.5 **Trust Management Committee (TMC) 23rd February**

SH noted that the Trust Management Committee (TMC) scheduled to take place on 23rd February had been cancelled.

TB1 10/3/3 **PEOPLE AND CULTURE**

TB1 10/3/3.1 **Health and Safety Annual Report**

MW presented the Health and Safety Annual Report for 2020/21. It was noted that the report was delayed in coming to the Board as there was a period the Trust did not have a Health and Safety Manager. However, in the 6 months that Gordon Perry was in this role, a structure was implemented back into the service with the help of FMc. The service now has an interim Health and Safety Manager, and it is hoped that a more robust governance structure will be put in place in line with the financial year. Therefore, a further annual report will be received later in 2022.

Discussion
EJ noted the helpful context MW had provided as she noted the report had not provided assurance in relation to Health and Safety compliance and regulations. It was noted that the Trust's risk register reflects that the Board is unsighted on some aspects of health and safety compliance and this remains on there.

SH noted that the comments were entirely fair and this reflects the discussion that was had at CGC. It is not what it should be as an annual Health and Safety report and the next one will provide the assurance required.

TB1 10/3/3.2 **Nursing Skill Mix**

JD presented the Nursing Skill Mix report which asked the Board to note the analysis which will be further updated in the next full skill mix review expected to be completed in September 2022. JD noted the following key points:

- Ward staffing numbers have been challenged over the past six months driven by the COVID-19 pandemic. This is reflected in the consistent red flag escalation of staffing to NHS regional teams and the corporate risk of 7039 with a current score of 20.
- Whilst staffing is challenged this is focused piece of work on ward establishment and no increases have been made as a result of this review, as primarily, the wards have been unable to achieve the current funded establishment levels. There is a process of commissioning work to look at staffing across the three acutes.
- Certain wards are on the limit of their available establishments as they are caring for other patient groups with different levels of acuity which has resulted in staffing requests to their funded templates.

Discussion:
MvB acknowledged the extremely challenging position but noted that the impact on providing flexible working to staff has not been mentioned in the report. MvB asked if any modelling had been done to see how this will impact staff. It was explained that NHS England has been doing a lot of work about retention and flexible working but what is clear is that there is a balance. JD noted that nursing as a career already provides flexible opportunities, but it is acknowledged that this needs to be a more formal process. SH reflected that more and more people are looking at a different work balance to traditional full-time employment and this is common for new entrants as well as existing staff. There is acknowledgement that robust workforce planning requires quantifying, however, this is part of a wider political debate.

PM thanked the team for the report and highlighted that in reference to table 4.2 it is clear when looking at patient care hours the Trust is having to spread the workforce thin with 12% less care hours per patient per day than the national average. PM noted that there needs to be a sustainable balance with staff the Trust is able to recruit and the extended bed base. JD explained that the Trust is out for additional shifts on a constant basis to provide sufficient staffing to those areas.

RA highlighted the importance of the Trust looking at alternative, new and emerging roles and how this could improve attractiveness of particular jobs and retention of staff. RA noted that this needs to be taken forward and an understanding of this progressed as part of workforce analysis.

EJ noted that the Trust's inability to recruit should not be a factor in decisions relating to an increase in establishment.

JD explained that the Trust will need to recruit about 80 nurses but there are a number of different methods being utilised to attract these staff and also Healthcare Support Assistants too.

LT pointed out that when it comes to resourcing nurses there is a developed process of analysis and investment. However, the same process for other roles is not used across the Trust and this can sometimes lead to under investment in other important roles non-nurse roles. The Trust need to be careful as there are lots of other professions that do not have the same voice in the same structured way.

TB1 10/3/4 **GOVERNANCE**

TB1 10/3/4.1 **Trust Constitution**

FMc presented the report and noted that the Constitution came to January's Board for approval as part of the annual review process. Further to this meeting the Council of Governors have reviewed, and the amendments detailed in the executive summary were proposed and approved at their meeting on 28thn February 2022. The Trust Board is asked to note and ratify the approved changes detailed in the executive summary.

Decision:
The Board approved the changes to the Constitution.

TB1 10/3/5 **CLOSING BUSINESS**

TB1 10/3/5.1 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted they key points from the meeting as follows.

- There is continued pressure on the organisation and there is no straightforward answer to those issues we face with fewer people able to meet the demand and this will be a constant theme going forward.
- In relation to the spinal service if the Spinal Gym remains as escalation a medium to long term perspective is required on the service going forward.
- In parallel to operational pressures a new financial year is upon us and requires the operational and financial planning that has not been needed to such an extent for the past few years.

TB1 10/3/5.2 **Any Other Business**

There was no other business.

TB1 10/3/5.3 **Public Questions**

There were no public questions.

TB1 **Date of Next Public Meeting**

10/3/5.4	
	Thursday 7th April 2022, Board Room, Salisbury NHS Foundation Trust
TB1 10/3/6	**RESOLUTION**
TB1 10/3/6.1	Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log
Open Actions

Contact Kirsty McAllister, kirsty.mcallister@nhs.net, 4439, for any issues or feedback

1	Deadline passed
2	Progress made, please detail
3	Completed
4	No progress made

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB Public 13/01/2.5 - Charitable Funds Strategy	07/07/2022	Nick Marsden, NM	PK asked if the Trustees could have a session just to remind everyone of the principles being applied so the Trustees could endorse the position. NM agreed and noted that he will bring this back to the Board in three months' time when the financial strategy for the charity was fully developed	**Deferred from April as Financial Strategy not yet confirmed.**	N	4
Trust Board Public	Sasha Grandfield	TB1 13/1/4.3 - DIPC report/ Ventilation	07/07/2022	Judy Dyos, JD	PM noted that the ventilation issue is an important one and whilst he is assured that it is on the executive's radar he asked that the DIPC report include a small section explaining the Trust's position.	**Jul-22**	N	4
Trust Board Public	Sasha Grandfield	TB1 10/3/2.4 - IPR / Maternity Dashboard	07/07/2022	Judy Dyos, JD	Further work required to maternity dashboard in the IPR as it is difficult to understand . JD to speak with TB.	**Apr-22**	N	2
Trust Board Public	Sasha Grandfield	TB1 13/1/5.4 - Equality, Diversity and Inclusion Annual Report/ Staff Networks	10/02/2022	Melanie Whitfield, MW	SH asked when the Board will see what the Trust's intentions are in relation to staff networks which are vital in moving the EDI agenda forward. MW reported that there is an encouraging proposal to bring to back to the executive meeting first and then to Board.	**The draft proposals to reinvigorate the network were discussed by the Executive Team in late January and supported by the wider Board when discussed further at the Board Development Seminar on the 10th February.An inlusion network to commence on 4th April to provide strategic leadership. Item closed**	Y	3

CLASSIFICATION: UNRESTRICTED

Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of Meeting:	07 April 2022		

Report Title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	X			
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Stacey Hunter, Chief Executive Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to receive and note this paper as progress against the local, regional and national agenda and as an update against the leadership responsibilities within the CEO portfolio.

Executive Summary:

The purpose of the Chief Executive's report is to highlight developments that are of strategic relevance to the Trust and which the Trust Board needs to be aware of. This report covers the period since the last public board meeting on the 10th March 2022.
Key points to note:

- The hospital and BSW system continues to be under our highest levels of pressure measured at OPEL 4. At the time of writing this report the number of hospital admissions with and or for COVID has more than doubled during March putting significant pressure on bed occupancy levels. The numbers of staff unavailable for work for COVID related issues is worse creating significant challenges in maintaining staffing levels in our ward based clinical teams. Whilst this is being managed within our escalation and oversight framework, it is a concern in respect of providing the level of care and experience to all individual patients and the impact this is having for some of our staff.
- The work to decrease the number of people in acute beds who have no criteria to reside has not delivered the required reductions. This continues to place risk to the elective recovery plans for 22/23.
- There has been some improvement in the position of the Spinal Injury Service which is detailed in the report.

- The BSW elective care board prioritised bids for capital monies available to support elective recovery. The criteria set out from the regional team stipulated that bids that served more than 1 organisation and where feasible more than 1 ICS would be favoured. SFT developed a bid for additional ward beds to service 3 additional theatres for BSW which has been prioritised by the regional team and will now progress to business case stage. We have been asked to accommodate work from the Dorset system as part of the case. The Finance Director and Chief Operating Officer are taking this forward with the BSW elective care board on our behalf and they will share further details of this work with the Board in due course.
- The Board will receive an update on the operational plan for 22/23 during our session in April. This will include building upon the work that was shared with the Board in March 2022 around the financial plan. It is key for the Board to agree and quantify the ambition to address the underlying deficit during this next 12 months.
- The Trust and Salisbury Cathedral hosted a *We Reflect* event for NHS and care staff in March marking 2 years since the start of the pandemic. My thanks to our communications team who led this on our behalf and delivered a poignant and moving service that many of our colleagues from across Wiltshire's health and care services were able to take part in.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

1. Our Population

1.1 Operational Context

The hospital still continues to be under pressure with staff absence and high levels of inpatients. The number of hospital admissions for COVID positive patients has doubled in the last 2 weeks of March 2022 which is putting significant strain on bed occupancy with the requirement to have all of the escalation beds open still. The numbers of staff not available for work on a day to day basis due to COVID related issues has also significantly increased, which is placing a significant strain on staffing levels in our ward teams. I know the Board will want to join me in thanking all of our colleagues in those front line teams who are most impacted by this for everything they are doing. It is recognised that the ongoing context is putting significant strain on some of our teams who continue to do a fantastic job in difficult circumstances.

The Executive team agreed and helped facilitate a week of *Food for Fuel* treats for colleagues in the last week of March as a thank you to everyone.

There hasn't been any significant progress made in reducing the number of people in hospital with no criteria to reside across the BSW system which is a concern. The Chief Operating Officer and his team are engaged in ongoing work with system colleagues

including having commissioned external support to quantify the demand and requisite capacity needed across the out of hospital provision. The current position presents a significant level risk to our ability to increase the elective activity levels and we have signalled clearly that we need to see a step change (a minimum of a 30 percent reduction) to secure the elective plan.

1.2. Elective Recovery

We continue to deliver the plan we agreed for elective recovery for 21/22 with progress against the key milestones (104 week waits, 78 week waits and 52 week waits) all on or ahead of the performance required by the end of March.

The work to detail delivery against the asks in the 22/23 operational plan is ongoing both at an organisation and system level, which will require a material increase in activity to deliver the new requirements in this next year's plan.

1.3. Spinal Service

The Board will recall the paper I shared via my CEO report in March 2022 re ongoing concerns in the spinal service. This centre around the use of a spinal gym as in extremis additional inpatient beds and an increase in the number of spinal patients with no criteria to reside leading to longer waiting times for people waiting to come into this specialist service. I can report that there have been improvements as follows:

a) We have closed the inpatient beds in the spinal gym and returned the gym to its core purpose.
b) There has been a 50% reduction in the numbers of spinal patients with a delayed discharge.
c) The numbers of people waiting to come into the service has reduced from 22 to 15 (average over the last 2 years had been 7).
d) The Chief Operating Officer has agreed a clear trajectory with the spinal team for ensuring all 39 beds commissioned for the service are available for spinal patients by the end of the first week in April 2022.

The team have met to discuss this with the specialist commissioners who have agreed to continue to monitor and provide support as needed. Whilst there is more to do the progress over the last 4 weeks is positive.

1.4 Financial sustainability

As we near the end of the financial year we continue on our trajectory to reporting a break-even position. It is important that we remember that this success has in part been underpinned by additional funding streams that have been made available to us as part of the response to COVID-19. With these additional funds we have been able to cover the costs of an escalated number of beds and the costs associated with staff unavailable to work, whether through illness or isolation requirements.

As we move into 2022/23 many of these challenges will remain, we will also be required to manage the impact of significant inflationary pressures all while seeking to maximise planned activity levels in order to drive down waiting lists. It is factors such as these which are driving a significant financial challenge for 2022/23, a picture reflected by our neighbouring Trusts. Work is ongoing to increase the productivity of the Trust as well as

identify and drive down excess costs as we move to a stance of living with COVID. This will be discussed with the Board in more detail today and over the coming weeks and months.

1.5 Ockenden report

The final report from Ockenden into Shrewsbury and Telford Hospital Trust has been published on the 30th March 2022. The review detailed 1,600 clinical incidents and identifies repeated care and governance failures, which makes for a very sobering read and sets out clear recommendations for all Trusts providing maternity services. The Board have had oversight of our progress against the interim Ockenden recommendations and we will work with the Maternity and Newborn Division and triumvirate leadership team to build on this to respond to the full report. Whilst the focus on the report is on Maternity services the Board will appreciate that there are broader lessons in respect of leadership and governance that we will want to reflect on.

2.0 Our People

2.1 COVID-19 vaccination

The statutory consultation period has ended with the outcome that there is no legal foundation for insisting our staff are vaccinated. We continue to advise our employees to be vaccinated, this is in both their own best interests and in the interests of patient safety. Further, we continue to risk assess staff COVID vulnerability and to ensure we are compliant with health and safety legislation, so risks to highly vulnerable employees are mitigated.

2.2 Workforce

Staff availability remains a significant challenge. We continue to experience operational pressures, and staff sickness related to COVID saw a brief decline and then a sudden and significant increase. Staff absence has remained high which is impacting on staff training and the completion of appraisals.

Actions taken during the period to support colleagues include:

- We are currently targeting growth in bank and volunteers and for the future biding funds to set up a system wide NHS Reservist management infrastructure.
- We have clarified the rules on holiday carry over and proposed the option for colleagues to sell back some of their accrued 21/22 leave.
- We are also producing more frequent detailed absence reports and working on an absence forecast with our OD&P team working with line managers to improve annual leave planning for example, with the emphasis on improving management of ‘peak holiday periods’ (e.g., bank holidays) and supporting managers in the pro-active management of long-term sickness absence cases.

2.3 Development

- We have been able to host two cohorts of our Best Place to Work Leadership Development Course consisting of 38 Trust leaders. The course is currently being reviewed and evaluated to align with our Trust Strategy, Improving Together and Just and Learning culture. Two new cohorts with 24 delegates will start in mid-April.
- Our focus on supporting the Improving Together roll out has started in earnest with the appointment of x2 OD Leads who will be working very closely with the Coach House Team

and Front-Line Leadership. Work is being completed to work up a coaching package of OD & Learning in direct support to teams who have completed their front-line training

- Continuing our focus on Health and Wellbeing conversations the wider team, with OD&P support, we have launched a trial of the conversation framework, training and direct support with AMU and Transformation, to inform a wider roll out later in the spring.

2.4 Re-introducing staff car park charges

From 1st April staff car park charges will be re-introduced. As a result of feedback and mitigate the impact for some staff the charges have been amended to place bands 3&4 in the lowest monthly charge bracket and once the number plate recognition system is installed in July charges will reflect all 12 pay points. Unsurprisingly the change has caused some negative comment in the local media given the broader economic climate which is having an impact on our colleagues.

2.6 “We Reflect” Cathedral service

On 22nd March the Trust and Salisbury Cathedral held a special service to reflect on the past 2 years. All NHS staff, carers and the community attended. The evening combined specially commissioned readings, poems from the My Name is Mercy collection with prayers and music. All readers and participants were health and care staff, family members, cared for or volunteers. The service was livestreamed and broadcast by Radio Odstock. Feedback has been exceptional and I would like to thank Dave Roberts and the communications team for leading this work on behalf the Trust.

2.7 Podcast Series

I am pleased to report that our new podcasts “**Cake with Joe and Jayne**” has been launched internally and at the time of writing has had a high number of listens (750 plus) and incredible feedback on some challenging topics – Race, Sexuality and Religion. The podcasts can found on Apple, Spotify or wherever you get your podcasts, or you can listen to them on Acast’s website: Cake with Joe and Jayne - Hosted by NHS Salisbury & Listen (acast.com) . I am grateful to Joe and Jayne for their ideas and to everyone who participated in the podcasts. We will commission a further 12 over the coming year.
In addition, a new staff Inclusion Network will be launched on Monday 4th April in our efforts to continue to build a positive culture of inclusion for all of our staff and patients.

2.8 Staff survey results

As the board will know the results of the staff survey were published on the 30th March 2022 and have been shared with colleagues across the Trust. We have seen some positive results in some areas which we want to acknowledge and learn from, however there are other areas where the results are not as positive as we would like. It is important for us to understand more about that and continue to work collectively to colleagues who are feeling overwhelmed where staffing levels have been and continue to be a real challenge.

To help we have increased our headcount by circa 400 additional staff over the last 2 years and are committed to continue to focus on managing our staffing levels.

We have asked teams to discuss their results together given that there is variation across the divisions and different staff groups and will be facilitating some listening events to inform our response to some of the areas we know we need to improve.

I know the Board will want to endorse our absolute commitment to continuing to strive to make our trust the best place to work and endeavouring to ensure our colleagues can thrive in the workplace.

3.0 Our Partnerships

3.1 BSW Acute Hospital Alliance (AHA)

There is no material change in the work programme to share with colleagues since the last Board update. All of the work continues to progress as per the detail shared in March 2022. Going forward we have asked the AHA programme director to develop a standard board report for all 3 trusts to use.

We have agreed the sequencing of both the CEO Senior Responsible Officer (SRO) leadership and the Chair of the committee in common (CIC) of the AHA between the 3 trusts.

The CEO SRO will rotate to SFT in Jan 2023 and the Chair of the CIC in 2024.

3.2 BSW ICS partnership

The focus for the partnership over the last four weeks has been:

- Submission of a high level 22/23 plan
- Recruitment of the ICB executive team. This is ongoing at the time of writing this report. I will share any available updates at the Board meeting
- Work to complete the technical transition from CCG to the ICB which needs to be in place by July 2022

The executive team and senior leaders from SFT continue to make an active contribution to this work

Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

Meeting of Board of Directors

Report Summary Sheet

Report Title	**Acute Hospital Alliance Briefing, March 2022.**		**Agenda item**	
Date of meeting	April 2022			
Purpose	Note X	Agree	Inform	Assure
Author, contact for enquiries	Ben Irvine, Programme Director (ben.irvine@nhs.net)			
Appendices	Appendix 1. AHA Briefing			
This report was reviewed by	• Cara Charles-Barks, CEO RUH, Senior Responsible Owner • Kevin McNamara, CEO GWH • Stacey Hunter, CEO SFT			
Executive summary	This short briefing provides an update on the activities of the Acute Hospital Alliance (AHA) from January to March 2022, as well as description of priorities for the forthcoming period. Work of the AHA Committees in Common of the three Trusts, and the AHA Programme Executive is described. The following areas are covered in the briefing: 1. Committees in Common: priorities 2. Programme Executive Activities (PMO; Clinical & Corporate Workstreams) 3. Decisions taken 4. AHA in BSW Integrated Care System 5. Resources update 6. Risks & Issues 7. Communications 8. AHA Forward Meeting Cycle Further information on the AHA Programme please contact Programme Director Ben Irvine (ben.irvine@nhs.net).			
Equality Impact Assessment	An AHA Programme Equality Impact Assessment is planned for Q1 2022-23, as part of the process to create a refreshed three-year AHA Programme 2022-25. This will be coordinated by the AHA Core Team and reviewed by AHA Programme Committees in Common at its May 2022 meeting.			
Public and patient engagement	The current AHA clinical programme incorporates public and patient involvement where possible. For example, expert patients were involved in a BSW Ophthalmology Strategy workshop, which was part of the BSW Clinical Teams programme. Our AHA Clinical Strategy work is closely linked with the BSW Care Model – which has recently been through a significant public engagement exercise.			

<table>
<tr><td></td><td colspan="8"></td></tr>
<tr><td>Recommendation(s)</td><td colspan="8">To note the AHA briefing.</td></tr>
<tr><td>Risk (associated with the proposal / recommendation)</td><td>High</td><td></td><td>Medium</td><td></td><td>Low
X</td><td></td><td>N/A</td><td></td></tr>
<tr><td>Key risks</td><td colspan="8">The development of the BSW Acute Hospital Alliance is in line with national policy and strategic direction on provider collaboration. The AHA Programme Executive, SRO and Programme Director identify and manage risks associated with programme delivery.</td></tr>
<tr><td>Impact on quality</td><td colspan="8">The AHA maintains a strong focus on quality and patient safety and assumes continuous focus on quality improvement – the Improving Together programme is one of the AHA core activities. The AHA clinical workstream is designed to improve clinical service effectiveness, patient experience and quality. The corporate workstream aims to deliver value for money, quality and resilience of corporate services.</td></tr>
<tr><td>Resource implications</td><td colspan="8">During the period covered by this report, the Trusts have committed to recruit 1 x WTE Programme Manager (AfC 8B), to support programme delivery.

In February 2022, the Programme Executive agreed to invest in nursing/AHP Clinical Transformation lead/s – funding requirement to be confirmed by CNOs.</td></tr>
<tr><td>Conflicts of interest</td><td colspan="8">None known.</td></tr>
<tr><td>This report supports the delivery of the following BSW System Priorities:</td><td colspan="8">☒ Improving the Health and Wellbeing of Our Population
☒ Developing Sustainable Communities
☒ Sustainable Secondary Care Services
☒ Transforming Care Across BSW
☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan</td></tr>
</table>

Appendix One. Acute Hospital Alliance, March 2022 Briefing

Introduction

This short briefing provides an update on the activities of the Acute Hospital Alliance (AHA) from January to March 2022, as well as description of priorities for the forthcoming period. The following contents are included:

1. Committees in Common: Priorities
2. Programme Executive Activities (PMO; Clinical & Corporate Workstreams)
3. Decisions taken
4. AHA in BSW Integrated Care System
5. Resources update
6. Risks & Issues
7. Communications
8. AHA Forward Meeting Cycle

1. Committees in Common: Priorities

The AHA Committees in Common (CIC) is designed to set strategic direction and provide oversight of the AHA programme. Meeting on six occasions per year, its membership comprises the three Chairs and three CEOs, with the chair rotating every 12 months (see Figure 1). Liam Coleman, Chair GWH, agreed to chair the CIC for the first rotation.

At the meetings in December 2021 and February 2022 the CIC members considered AHA ambition, potential priorities, Board development, risk context and approach, and the AHAs role in the emerging BSW environment. CIC confirmed that the Trusts would continue to work together on areas that support: *Equity* – for our local population; *Sustainability* and *Improvement*. It was agreed that further work would be important to define our approach to these areas.

In relation to priorities, members proposed the following five core areas would be most enabling, that is, where CIC and AHA might have most strategic and collective impact:

1. *Transparent financial baseline* across AHA parties. Aim to make demonstrable improvement in our individual and collective Model Hospital and other benchmarking scores leading to improved efficiency/productivity and sustainability.
2. *Transparent staff modelling* across AHA parties. A systemic approach to staffing will lead to us addressing risk.
3. *Secondary care clinical strategy* for BSW.
4. *Single capital strategy.* Shared view of priorities – multi-year.
5. *Single EPR role out* and effective integration with partners.

It was agreed that this list would not be to the exclusion of other work, but rather would be the focus of CIC interest for the next period. It was anticipated that efficiency and productivity information from *Model Hospital* and other benchmarking intelligence sources would inform the AHA's work.

CIC agreed that an away day development session should be arranged to enable detailed discussion of approach and the five proposed priorities. The Programme Executive would be asked to prepare materials to inform away day discussions. A CIC Away Day preparation session is planned for 8th April.

Figure 1. CIC and Programme Executive Membership

Committees in Common	Programme Executive *(monthly)*
• Liam Coleman (*Chair*), Chair, GWH • Alison Ryan, Chair, RUH • Nick Marsden, Chair, SFT • Cara Charles Barks, CEO, RUH • Kevin McNamara, CEO, GWH • Stacey Hunter, CEO, SFT • *Ben Irvine, Programme Director*	• Cara Charles Barks (*Chair*), CEO RUH • Stacey Hunter, CEO, SFT • Kevin McNamara, CEO, GWH • Bernie Marden, MD RUH • Jon Westbrook, MD, GWH • Peter Collins, MD SFT • Claire Thompson, Director of Partnerships & Improvement, GWH • Libby Walters, DoF, RUH • Lisa Thomas, DoF SFT • Simon Wade, DoF, GWH • Melanie Whitfield, HRD, SFT • Antonia Lynch, Chief Nurse, RUH • *Ben Irvine, Programme Director*

2. Programme Executive Activities (PMO; Clinical & Corporate Workstreams)

The Programme Executive drives programme delivery, meeting monthly and chaired by Programme SRO, Cara Charles-Barks. Membership spans a range of executive portfolios (see Figure 1). In Q1 2022-23, the Programme Executive will lead the creation of a detailed three-year programme and will put in place necessary arrangements to ensure the strategy set by the CIC can be achieved. The current programme is shown in figure 2 below.

Figure 2. Current AHA Programme 2021-2023

AHA Draft Programme 2021-2022- 2023

Major programmes 2021 - 2022

Corporate Stream	Clinical Stream
Common AHA Quality Improvement Programme • Roll-out of framework across 3 Trusts from June 2021.	AHA Acute Clinical Services Approach. • Acute Clinical Strategy in context of BSW Model of Care
EPR Alignment Programme – OBC, • Procurement and FBC.	BSW Virtual teams work; Phase 2. • Specialties tbc following May 2022 summit
DGHs as effective system partners across health and care • Contribution as anchor organisations to local populations • Enabling system financial sustainability.	BSW Elective Strategy to support achievement of the enhanced access, quality and financial sustainability triple aim. • Single waiting list. • Network Lead Provider
Corporate Back-Office Programme [Refer Model Hospital] • Finance programme defined. Now focussed on back office collaboration opportunities in Recruitment; Occupational Health; Temporary Staffing; Training/Organisational Development; Sustainability; Soft FM services; IM&T functions, Legal.	Clinical Services Networks [Details TBC] • Ophthalmology • Dermatology • Orthopaedics

AHA Corporate Stream:

- **Improving Together**– rollout is continuing across the three Trusts of Improving Together - common improvement methodology.
- **EPR Alignment Programme –** EPR OBC has been approved by the SW Region and is currently being reviewed by the NHSE National Team. The FBC is on track to start in May 2022. The Clinical Design Authority, co-chaired by the Medical Directors of GWH (Jon Westbrook) and SFT (Peter Collins), has started work on the development of Clinical Design Principles for the EPR Programme. The Operational (non-clinical) Design Authority Chair has been appointed (E Provins, SFT) and the Change Management Group chair has

been appointed (A Thompson, RUH). An expert core team is in place and site teams are being established.

- **Corporate Back-Office Programme – Finance team:** good progress continues to be made in **procurement,** now working as a single team. Successful delivery of 21/22 procurement programme of £2.7m. Focus now on building programme for 2022-23 [£5m]. Lead has established three core workstreams (Management of Expiring Products and Waste, Catalogue and Contract Management and Management of substitutions, alternative products and new item requests).
- Other joint work on **ledger, income, contracting, costing** is being pursued, led by Directors of Finance and their teams.
- **Robotic Process Automation (RPA) -** GWH team is coordinating **RPA scoping** – steering group has met; Terms of Reference created and circulated. Each Trust is currently formulating business case to identify funding options for RPA teams.
- **Legal services**. Collaboration scoping in legal services is underway; range of areas being examined - employment law, contracting and commercial, healthcare law, mental health law); service optimisation, resilience and opportunities identified.
- Programme Executive has asked **Estates and people** services to scope potential collaboration.

AHA Clinical Stream:

- **Secondary Clinical Services Strategy Development.** A review of secondary clinical services, closely linked to BSW care model has begun. A core team is being established comprising, Nursing & AHP leads, the three new Associate Medical Directors for Clinical Transformation (see section 5 below) and Trust strategy leads. Expert external advisory support has been secured. Six Clinical Summit dates are being confirmed for 22/23/24.
- **Robotic Surgery Options paper.** Duncan Murray is coordinating an options paper exploring how BSW population might benefit from robotic surgery in BSW. The paper is linked to the Elective Care Strategy and Elective Care Board, with delivery due in April 2022.
- **Virtual Clinical Teams –Dermatology** work is ongoing with good progress now being made. Telederm advice & guidance in place. RUH mutual aid to SFT has continued.
- **Ophthalmology** team has defined vision, strategy and priorities for change – including standardised pathways. Approval secured to continue CUES (Covid Urgent Eyecare Service) for 24 months. Development of eyecare hubs plan underway. Clinical lead time confirmed in job plan.

3. Decisions Taken – Q4 2022-23

Resources

- It has been agreed that *AHA Standing Financial Instructions (SFIs)* should be created by the Directors of Finance – led by Simon Wade, GWH. These SFIs will create a framework to manage a range of internal and external funding streams and variety of hosting arrangements.
- During the period covered by this report, the Trusts have committed to recruit 1 x WTE Programme Manager (AfC 8B).
- In February 2022, the Programme Executive agreed to invest in nursing/AHP Clinical Transformation lead/s – funding requirement to be confirmed by CNOs.

EPR Outline Business Case

- In February we received confirmation that the EPR Outline Business Case has been approved the SW Regional Team.

Meetings

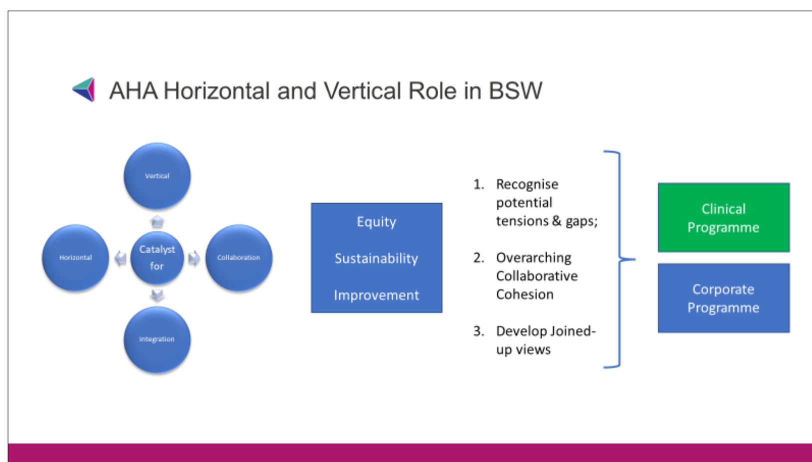
- Programme Executive agreed to meet face-to-face quarterly.

4. AHA in BSW Integrated Care System

Published in Q3 2021-22, W*orking together at scale: guidance on provider collaboratives* – sets out expectations and principles for establishing provider collaborative arrangements. Providers are now expected to work together to plan, deliver and transform services. As such, all trusts providing acute and mental health services expected to be part of one or more provider collaboratives. ICS leaders, trusts and system partners are expected to work to identify shared goals, appropriate membership and governance, and ensure activities are well aligned with ICS priorities.

Having built strong relationships between leadership teams over the past years, the AHA is well-placed to meet the expectations of this changing national context, recognising both the importance of working with partners in place, as well as the opportunities to work together at scale (see figure 3). By working together the Trusts can enhance overarching collaborative cohesion, recognising potential gaps, developing joined-up views, and focusing on delivery of small number of impactful changes.

Figure 2. AHA Horizontal and Vertical Role in BSW



5. Resources Update

The Acute Alliance has a small core team in-post. During the period covered by this report, the Trusts committed to recruit 1 x WTE Programme Manager (AfC 8B); the post being required to ensure successful delivery of agreed programme. Interviews for the post are planned in late April.

The Trust Medical Directors have recently recruited 3 x 0.4 WTE Associate Medical Directors to lead AHA Clinical Transformation work – one based in each Trust, but each working in support of system-wide activities.

- *AHA Programme Clinical Transformation leads:* Anushka Chaudry (GWH), Marc Atkin (RUH) and Duncan Murray (SFT).

Following discussion at its February 2022 meeting, the Programme Executive agreed to invest in nursing/AHP Clinical Transformation lead/s – funding requirement to be confirmed by Chief Nursing Officers. In the short-term, AHA Nursing and AHP leads are being identified to work with the medical leads to support our AHA Clinical strategy development.

The AHA Programme is funded by equal contributions from the three Trusts. Posts are hosted by all three Trusts. The Clinical programme also receives programme and project management support from the CCG Strategy & Transformation Directorate.

Work is underway to define the priorities and associated resource requirements of the programme for 2022-2025; updates will be reported in Q1 2022-23.

6. Risks & Issues

A range of risks and issues are being managed by the programme team. A risk register is held centrally, with significant items being reported to Programme Executive. In February, the following risks & issues were reported.

1. ***Capacity constraint:*** Response: Balance between short-medium & long-term priorities
2. ***Uncertainty regarding priorities***. Response: CIC & Executive to confirm and communicate priorities generating common understanding. CEOs reviewing workstream sponsorship arrangements.
3. ***Leadership Transition in BSW. Transition of CCG*** and establishment of new ICS leadership team creates destabilising effect. Response: Maintain focus on effective delivery by AHA.
4. **Access to EPR Funding.** Response: CIC support will be required over next 12 months.

7. Communications

An AHA Communications strategy is in place, created by Communications lead, Tim Edmonds (GWH), with internal and external strands including:

- Monthly Board Briefings. This briefing paper will be issued to Boards monthly, following Programme Executive meetings.
- Monthly Newsletter for wider dissemination through Trusts and BSW.
- ICS Highlight Report – for CIC, Programme Executive and BSW Integrated Care Board.
- National profile raising. The AHA's successes as a Provider Collaborative are building and provide sharing and learning opportunities for colleagues across the NHS. The Programme SRO and Programme Director will work with Trust executive colleagues to continue to build the national and regional profile of our work.

8. AHA Forward Meeting Cycle

The table below sets out the dates of our CIC, Programme Executive and Clinical Summits for 2022-23. A detailed meeting planner, providing a clear view of key decision points and milestones is being prepared by the programme team and will be shared once the three-year programme refresh is complete.

AHA Committee In Common Dates 2022				
8th April	May (TBC) Away Day	10th June	21st October	9th December

AHA Programme Executive Dates 2022								
29th April	27th May	24th June	29th July	26th August	30th September	28th October	25th November	16th December

AHA Clinical Summit Dates 2022/23					
20th May	September tbc	December tbc	March 2023 tbc	May 2023 tbc	September 2023 tbc

Close

Drafted by Programme Director, Ben Irvine
1st April 2022

NHS

Official
Publication approval reference: B1523

To:
- NHS Trust and Foundation Trust:
    - Chief Executives
    - Chairs
    - Chief Nurses
    - Chief Midwives
    - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:
- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard	**Ruth May**	**Professor Stephen Powis**
NHS Chief Executive	Chief Nursing Officer	National Medical Director

Public Trust Board
Annual Business Cycle 2022/23

					No Public meeting		No Public meeting		No Public meeting		No Public meeting		No Public meeting	
Item	**Sponsor**	**Author**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
Board Administration														
Opening Business														
Apologies for absence	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Declarations of interest	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Presentation of SOX certificates	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Patient story	Director of Nursing	Various	✓					✓				✓		
Staff story	Director of OD & People	Various		✓		✓				✓				✓
Minutes from the last meeting	Chair	Head of Corporate Governance	✓	✓		✓		✓		✓		✓		✓
Matters arising and action log	Chair	Head of Corporate Governance	✓	✓		✓		✓		✓		✓		✓
Approve next years cycle of business	Chair	Head of Corporate Governance	✓											
Register of attendance	Chair	Head of Corporate Governance				✓		✓		✓				✓
Chairman's business	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Chief Executive report inc STP update	Chief Executive	Head of Communications	✓	✓		✓		✓		✓		✓		✓
Assurance and reports of Committees														
Committee escalation reports	Executive Director	NED Chair of Committee	✓	✓		✓		✓		✓		✓		✓
Integrated Performance Report (inc, operational perf, workforce, finance, quality, safer staffing and Wiltshire Health & Care)	Chief Executive	Executive Directors	✓	✓		✓		✓		✓		✓		✓
Quality and Risk														
Board Assurance Framework and Corporate Risk Register (aligned with corporate priorities)	Chief Nursing Officer	Director of Integrated Governance		✓			Going to Private Board			✓			Going to Private Board	
Patient Experience Report	Chief Nursing Officer	Head of Complaints	Q3			Q4/Annual Report				Q1		Q2		
Learning from Deaths Report	Chief Medical Officer	Head of Clinical Effectiveness	Q3			Q4/Annual Report				Q1		Q2		
DIPC Report	Chief Nursing Officer	Lead Nurse Infection Control				Annual Report						✓		
Clinical Governance Annual Report	Chief Nursing Officer	Head of Clinical Effectiveness						Annual Report						
Risk Management Strategy (3 yrly, due 2020, 2023, 2026)	Chief Nursing Officer	Head of Risk								✓				
Quality Improvement Progress update	Director of Improvement & Partnerships	Director of Improvement & Partnreships				✓						✓		
Research Annual Report	Chief Medical Officer	Head of R&D						Annual Report						
Strategy and Development														
Annual Sustainability Strategy Report	Director of OD & People	Campus Project Programme Lead				Annual Report								
Digital Strategy Update	Chief Finance Officer	Chief Information Officer												✓
Improving Together Quarterly Update Report (tbc)	Director of Improvement & Partnerships	Director of Improvement & Partnreships	✓			✓		✓				✓		
Financial and Operational Performance														
Corporate Priorities 2021/22 (aligned with BAF)	Chief Finance Officer	Associate Director of Strategy		✓			Going to Private Board			✓			Going to Private Board	
Quarterly review of Trust Strategy Progress Report	Chief Finance Officer	Associate Director of Strategy		✓			Going to Private Board			✓			Going to Private Board	
Data Security & Protection Toolkit Self-Assessment	Chief Finance Officer	Chief Information Officer				✓								
Data Protection Officer Annual Report and Compliance with GDPR	Chief Finance Officer	Chief Information Officer				✓								
Standing Financial Instructions	Chief Finance Officer	Chief Finance Officer	✓											
People and Culture														
Nursing Skill Mix Review - agreed with FH January	Chief Nursing Officer	Deputy Director of Nursing						✓						✓
Guardian of Safe Working Annual Report	Chief People Officer	Guardian of Safe Working						Annual Report						
Equality & Diversity Annual Report	Chief People Officer	Head of Diversity and Inclusion										Annual Report		
National Staff Survey Results	Chief People Officer	Deputy Directof of OD & People	✓											
Medical Revalidation and Appraisal Annual Report Including Statement of Compliance	Chief Medical Officer	Chief Medical Director				Annual Report/ Statement of compliance								

Freedom to Speak Up Guardian Annual Report (quarterly to Workforce Cttee)	Chief People Officer	FTSUG Lead				✓								
Health & Safety Annual Report	Chief People Officer	Health and Safety Manager				Annual Report								
Education & Development Annual Report	Chief People Officer	Associate Director Education, Inclusion, Comms & Engagement								Annual Report				
Medical Education Performance Report	Chief Medical Officer	Director of Medical Education										Annual Report		
Governance														
Annual Report and Accounts (to be approved prior to submission to parliament)	Director of Corporate Governance	Director of Integrated Governance/ Head of Corporate Governance				✓								
Annual review of Board effectiveness	Director of Corporate Governance	DDirector of Integrated Governance						Annual Report						
Annual review of Committee effectiveness	Director of Corporate Governance	Director of Integrated Governance						Annual Report						
Annual review of Directors Interests/ Annual Review Fit and Proper Persons Test	Director of Corporate Governance	Director of Integrated Governance/ Head of Corporate Governance	✓											
Review of Board Committee Terms of Reference	Director of Corporate Governance	Director of Integrated Governance/ Head of Corporate Governance	✓											
Integrated Governance Framework	Chief Executive	Director of Integrated Governance/ Head of Corporate Governance	✓											
Accountability Framework	Chief Operating Officer	Chief Operating Officer		✓										
Emergency Preparedness Annual Report	Chief Operating Officer	EPRR Manager										Annual Report		
EPRR Compliance Statement	Chief Operating Officer	EPRR Manager										✓		
Register of Seals	Director of Corporate Governance	Director of Integrated Governance	Q4			Q1				Q2		Q3		
NHSI Self-Certification (FT4, G6, CoS7)	Chief Finance Officer	Director of Integrated Governance		✓										
Annual Review of the Constitution	Chief Executive	Director of Integrated Governance										✓		
Approve Board and Committee dates for next year	Director of Corporate Governance	Director of Integrated Governance						✓						
Closing Business														
Agreement of principal actions	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Any Other Business	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Public Questions	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Date of Next Meeting	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓
Resolution	Chair	Verbal	✓	✓		✓		✓		✓		✓		✓

Private Trust Board
Annual Business Cycle 2022/23

	Sponsor	Author	April	May	June	July	August	September	October	November	December	January	February	March
					Private only		Private only		private only		private only		private only	
Board Administration														
Opening Business														
Resolution	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Apologies for absence	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes from the last meeting	Chair	Head of Corporate Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters arising and action log	Chair	Head of Corporate Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Approve next years cycle of business	Chair	Head of Corporate Governance	✓											
Register of attendance	Chair	Head of Corporate Governance				✓		✓		✓				✓
Chairman's business	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive report inc BSW update	Chief Executive	Head of Communications	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Assurance and reports of Committees														
Committee escalation reports (published on the wesbite each month)	Executive Director	NED Chair of Committee		✓	✓		✓		✓		✓		✓	
Subsidiary Governance Escalation Report to Private Board	Executive Director	NED Chair of Committee	✓			✓			✓			✓		
Integrated Performance Report inc operational, workforce, finance, quality, safer staffing and Wiltshire Health & Care)	Chief Executive	Executive Directors		✓	✓		✓		✓		✓		✓	
Quality and Risk														
Board Assurance Framework and Corporate Risk Register (Public May and Nov)	Chief Nursing Officer	Director of Integrated Governance					✓						✓	
Clinical Review/SII Report	Chief Nursing Officier	Head of Risk Management	✓		✓		✓		✓		✓		✓	
Legal and Litigation Report	Chief Nursing Officer	Head of Legal Services						✓						✓
Annual Quality Report and External Auditors Assurance (Quality Accounts)	Chief Nursing Officer	Head of Clinical Effectiveness		✓										
Strategy and Development														
Campus Development	Chief Finance Officer	Campus Project Programme Lead	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estates Technical Services Quarterly Update	Director of Estates	Director of Estates			✓			✓			✓			✓
Strategy Session (90 mins)	Chief Finance Officer	Associate Director of Strategy	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial and Operational Performance														
Corporate Prioities (aligned with BAF Public May and N	Chief Finance Officer	Associate Director of Strategy					✓						✓	
Quarterly review of Trust Strategy (aligned with BAF Public May and Nov)	Chief Finance Officer	Associate Director of Strategy					✓						✓	
Annual Report and Accounts (including AGS)	Chief Finance Officer	Deputy Director of Finance			✓									
Operating Plan 2022/23	Chief Finance Officer	Associate Director of Strategy											✓	
Approval of the 2021/22 budget	Chief Finance Officer	Deputy Director of Finance		✓	June in 2021									
System Working	Chief Finance Officer	Chief Finance Officer		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Concluding Business														
Agreement of principal actions	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Any Other Business	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Next Meeting	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospital tasting menu	Chair	Eating							✓					

NHS
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NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of Meeting:	7th April 2022		

Report from: (Committee Name)	Clinical Governance Committee		Committee Meeting Date:	29th March 2022
Status:	Information	Discussion	Assurance	Approval
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation
Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 29th March 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - Several items were deferred this month due to the pressure on services from the increasing Covid impact on workforce availability. For assurance, discussion between the Chair and the Clinical Executives has taken place to ensure any risks or gaps will be addressed in a timely manner. Assurance was provided that the weekly Executive led patient safety meeting dealt with any urgent safety issues.
  - A presentation was provided to the committee by the spinal service. It was positive to have the service triumvirate present including the new clinical lead who is an occupational therapist. It was good to note that the new clinical lead is also supporting some regional work. During the presentation assurance was provided to the committee that all 'must do' actions from the CQC inspection had been completed. Audit evidence was available. Further monitoring of progress will be addressed through the Divisional performance processes. The discussion also focussed on the culture of the service and recognised that there was work to do on fresh motivation and purpose for the service. It was noted that there was a demand / capacity mismatch across the region and the new clinical lead is working with specialised commissioning on understanding the pathway of care. The team were keen to return in the future to update the committee on further progress.
  - The Terms of Reference document was reviewed with minimal changes made. These were approved as part of the annual requirements.
  - An update was provided that the clinical elements of the new Trust strategy were in line with both local and national plans.

- The discussion on the quality elements of the IPR noted the impact of staffing on care. It was noted that care hours per patient day (CHPPD) were the lowest they had been. The mitigations in place include supporting staff to focus on maintaining safety.
- The Quarter 3 Learning from Deaths report was presented and the impact of Covid on HSMR was noted. This has been discussed and challenged in detail in the Trust mortality meeting. Both the CMO and the Head of Clinical Effectiveness are preparing further assurance on this.
- The 6-month report on maternity and neonatal staffing was presented. Good assurance was provided in relation to progress on staffing in relation to the Maternity Incentive Scheme (MIS) requirements though the gap to deliver Continuity of Carer (CoC) and the ongoing staffing gap (15 WTE vacancies) was noted. Midwife to Births ratio was mostly achieved as was 1:1 care in labour. Supernumerary labour ward lead was achieved in 94% of the 4-hour slots measured. Further work to understand the gap is being undertaken. One gap in the report was the lack of information relating to neonatal staffing. This will be included in future reports as neonatal staffing nationally is under pressure. Further more general information and assurance will be provided in the next quarterly maternity report due in May. This will also cover the latest Ockenden report just published.
- The upward report from the CMB was noted. An area to highlight was the annual report for Hospital at Night (H@N) which demonstrated excellent H@N activity despite the challenges of the pandemic. It was also noted that the new strengthened governance through Safety, Experience and Effectiveness subgroups was beginning to become embedded.

- There was a discussion about the Trusts HSMR which sat above the statistically expected range in Q3. The committee received assurance from CMO that this had been extensively discussed at the last mortality surveillance group. Telstra (who provide the data analysis of mortality statistics for the Trust) have altered their calculation methods and feel that the change is due to the impact of COVID deaths on the modelling. HSMR when COVID death are excluded falls within the statistically expected range. HSMR will continue to be subject to scrutiny and would be expected to normalise in Q1 of 2022/23 (when the peak of COVID death falls out of the 12 month calculation period).

In summary, a key theme in today’s meeting was the quality impact of staffing absence due to Covid.

The Board is asked to note and discuss the content of this report.

CLASSIFICATION:

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Report to:	Trust Board	**Agenda item:**	2.2
Date of Meeting:	7th April 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	29th March 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non-Executive Director			
Board Sponsor (presenting):	Paul Miller, Non-Executive Director			

Recommendation
To note key aspects of the Finance and Performance (F&P) Committee meeting held on the 29th March 2022

Items for Escalation to Board

(1) Cardiac suite and plaster room – This procurement recommendation report was received and discussed at length. It was agreed that, whilst the procurement outcome could be recommended to the Trust Board, given the cost of the capital scheme, a business case would need to go to the Private Trust Board on the 7th April 2022, alongside this procurement recommendation report for formal approval.

(2) Genetics business case – The Committee agreed to recommend this business case to Private Trust Board on the 7th April 2022, with one addition that the possible risk of service continuity, following any transfer to the University Hospital Southampton Foundation Trust (UHS) be included.

(3) Design Costs for the Elective Care Centre – The Trust Board and Finance and Performance Committee have been previously briefed on this development, including approving the Campus Strategic Outline Case (SOC) at the Trust Board meeting on the 3rd February 2022. The proposal made to today's Committee was to approve the allocation of a further £200,000 to progress design work, funded out of the 2021/22 year-end capital programme.

(4) Finance and Performance Terms of Reference (ToR) – the updated ToR were approved with minor changes.

(5) Draft Operational Plan 2022/23 – The Committee received a comprehensive update on the current progress on next year's Operational Plan. A further comprehensive update of this plan will be going to the Trust Board meeting on the 7th April 2022, therefore I will not attempt to summaries the key issues, as these will be reported directly to the Trust Board at that time.

However, one issue to highlight is the proposal to ask the Trust Board on the 7th April 2022 to delegate the final approval of the Operational Plan 2022/23 to the Finance and Performance Committee, on the 26th April 2022. This will be prior to the submission of the final Bath & North Somerset, Wiltshire and Salisbury ICS Operational Plan to NHSE/I on the 28th April 2022. This process of delegation was supported by the Committee.

(6) Day Case and Elective Inpatient activity bridges 2019/20 to 2022/23 – The Committee received a very detailed and comprehensive analysis of the issues and constraints impacting on the Trusts ability to fully recover clinical services, post COVID. The reason for including this in the escalation report is not to summarise this work, but to commend the work of Lynne Abbott (Associate Director of Finance – Contracting and Income) and Phil Browne (Interim Director of Recovery) and all operational and clinical staff involved for this excellent work.

(7) Funding to build an additional ward – The Committee were informed that the Trust has been successful in securing new funding to build an additional inpatient ward, to allow the Trust to move from using the current 13 theaters to a full complement of 16 theatres. The Committee noted this good news and look forward to receiving the associated business case as soon as possible, to ensure work can be completed within the required timescales.

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Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	7th April 2022		

Report from: (Committee Name)	People and Culture Committee		**Committee Meeting Date:**	31st March 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele, Non-Executive Director			
Sponsor (presenting):				

Recommendation
The Public Trust Board are asked to note the items escalated from the People and Culture Committee meeting held on 31st March 2022.

Items for Escalation
The committee spent the bulk of its time discussing the direction of travel for the OD&P function. The Chief People Officer presented an excellent and detailed analysis of the reality of how it is working, after 6 months in role. The Chief People Officer has identified a number of critical gaps in our ability to conduct strategic and operational planning, and in our ability to provide the level of transactional and Business Partner support that the Trust requires. Having identified the gaps in function and structure the CPO is now preparing a plan that will prioritise areas for action and investment, based on what is urgently required, necessary, and achievable. This will deliver incremental and sustained improvement across the whole People and Culture domain, but the committee recognised that it will take time, and sustained interest and commitment at Board level, and we therefore offer our full support to the way ahead that has been proposed.

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Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	7th April 2022		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	24th March 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Summary

The Trust Board is asked to note the matters below.

The Committee received the draft opinion from the Head of Internal Audit. The formal summary is that the Trust's management of its control environment has been "GENERALLY SATISFACTORY WITH SOME IMPROVEMENTS REQUIRED".

Four internal audit reports were received from PWC.

- Safeguarding Review
- Workforce Planning
- IT Disaster Recovery
- Key Financial Controls

Three of these reports included high risk audit findings, which were the focus of the discussion at the committee that is detailed in the body of this report.

The Committee reviewed a paper from the Executive, recommending that the Annual Accounts for 2021/22 are prepared on a Going Concern basis. This paper is on the current Board agenda and is recommended for approval.

The committee reviewed a paper from the Executive proposing changes to the Standing Financial Instructions (SFI). The Committee discussed with the Finance lead and recommended a minor adjustment to the proposal, which was accepted. This paper is on the current Board agenda and is recommended for approval.

Key Items for Escalation
Draft Opinion of Head of Internal Audit. The Committee received the draft opinion from the Head of Internal Audit. The formal summary is that the Trust's management of its control environment has been "GENERALLY SATISFACTORY WITH SOME IMPROVEMENTS REQUIRED". This is consistent with the opinion given for the previous two years. In discussion, it was established that, whilst the opinion given was fully justified, the severity and number of medium and high risk audit findings in the year were higher than the previous year and reflect a slight downwards trend in the management of the control environment. However, there was some mitigation to this from the evident improvement in the management and clearing of audit points raised. **First Draft Internal Audit Plan for 2022/23** A first draft of the Internal Audit Plan for 2022/23 was presented and discussed. A number of questions were asked by the committee and general feedback was provided to the Executive. The plan will continue to be refined and a final version provided for formal sign off at the Audit Committee in May. **Going Concern Basis** All Boards are required to consider and decide whether their organisation's annual financial accounts should be prepared on what is known as a "Going Concern" basis. For commercial organisations, this reflects that the organisation has sufficient resources in hand to continue normal operation for the foreseeable future – generally regarded as eighteen months. For NHS Foundation Trusts, the government has decided that the only requirement to meet the Going Concern test is that the organisation has not been formally notified that it is to be wound up or replaced. As no such notice has been received, it is recommended that the Board approve the preparation of the 2021/22 annual accounts on a Going Concern basis. **Changes to Standing Financial Instructions** The committee reviewed a paper from the Executive proposing changes to the Standing Financial Instructions (SFI). The Committee discussed with the Finance lead and recommended a minor adjustment to the proposal, which was accepted. This paper is on the current Board agenda and is recommended for approval. **Internal Audit Report – Safeguarding Review** This report was rated overall as Medium Risk, with three medium and one low risk findings reported. The medium risk findings related to failures in timing and documentation of SWARM and section 42 referrals, lack of safeguarding strategy and lack of formal adult safeguarding supervision. The committee was satisfied that appropriate plans for resolution were in place and that the detailed follow up of these matters would take place in the Clinical Governance Committee. The report was noted. **Internal Audit Report – Workforce Planning** This report was rated overall as High Risk, with one high, four medium and one low risk findings reported. The findings focussed on the lack of a clear strategic plan to resolve the matching of workforce to patient demand/requirements, lack of a defined establishment control process, information/reporting shortfalls in workforce reporting and lack of executive ownership of the e-roster implementation.

It was noted that there were some gaps in the management responses to this report and there was discussion at the committee regarding the fact that the report was identifying both short term management risks and longer term strategic ones. The auditors were asked to work with the executive team to more clearly separate and define these matters and so allow the Executive to develop full management responses and plans to address them. These revised management responses will be reviewed and noted at the May Audit Committee. Primary responsibility for follow up of this report will sit with the People and Culture Committee.

Internal Audit Report – IT Disaster Recovery

This report was rated overall as High Risk, with one high and two medium risk findings reported. The high risk finding related to the lack of ITDR action plans. The CIO accepted the finding and explained that a new ICS role had been recently recruited that will look at coordination of policy in this area across the ICS as a priority, with a commitment that the action will be closed out by the end of June 2022. The Committee were satisfied with the discussion and conclusion of this report

Internal Audit Report – Key Financial Systems

This report was rated overall as Medium Risk for accounts payable and Low Risk for fixed assets. In total, there was one high risk finding and seven low risk findings reported. The high risk finding related to failures in control of expenditure approvals. This occurred as a result of temporary changes applied to the SFI's applied to mitigate processing problems during the transition to the new Oracle 12 ledger. These temporary changes were not properly notified to the Audit Committee and were not promptly reversed when conditions returned to normal. A number of transactions were improperly approved, although subsequent review showed that these were technical breaches, rather than improper transactions. The actions to close the high risk finding have already been completed and the Committee were satisfied that plans for the remaining items were appropriate.

CLASSIFICATION: UNRESTRICTED

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.7
Date of Meeting:	07 April 2022		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Sections approved by responsible committee: Operational Performance & Resources – Finance & Performance Committee Quality and Care – Clinical Governance Committee Workforce – People and Culture Committee			
Prepared by:	Louise Drayton, Performance & Capacity Manager			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officer			
Appendices (list if applicable):				

Recommendation:
The Board is requested to note the report and highlight any areas of performance where further information or assurance is required.

Executive Summary:
Performance against the 4 hour standard continues to be operationally challenging, with 76.3% of patients being discharged or admitted within 4 hours (82.5% in M10). Flow out of the department remains the biggest factor with an average occupancy level of 96.3% across the month, the highest occupancy level since Feb 20 (96.1%). The proportion of patients reaching the Stroke Unit within 4 hours was 27% due to the flow pressures; however this was improved from 20% in M10. There was deterioration in the number of Stroke patients receiving a CT within 1 hour (40% compared to 54% in M10), the number receiving a CT within 12 hours (80% compared to 84.6%) and the number of patients spending at least 90% of their admission on the Stroke Unit (60% compared to 85% in M10). The number of patients not meeting the criteria to reside increased to almost 70, and there continues to be an increasing number of patients (54 at the peak) that are Covid positive in the hospital, the need to isolate both positive and contact covid patients there were on average 10 unoccupied beds closed throughout the month in contact areas. There were 3 hospital onset cases of C.difficile in February. There were also 3 hospital cases of each of E.Coli and MSSA bacteraemia. There was one category 3 pressure ulcer and one category 4 pressure ulcer identified in February. There were no never events reported in

February - 3 SIIs were commissioned in total. There were 10 falls in February of which 4 were graded as 'major.' The number of hospital acquired VTE's continues to remain significantly below the national average (0.11% of total admissions verses 0.5%-1.6% nationally). Over 99% of patients are reporting their experience as either good or very good via the friends and family test - 2.3% of eligible patients and half of wards submitted feedback in February.

There were no still births or maternal deaths in February. Midwifery vacancy rate is 14.65 – over recruitment of support workers and some flexible working solutions are helping to mitigate the risks.

Escalation in to DSU continued, with both areas of DSU being escalated into for a period which led to some cancellations of elective surgery. Elective activity remains under plan in due to unavailability of theatre workforce, and bed capacity constraints. The number of theatre sessions increased to 472; however utilization of Day Surgery lists was affected by escalation into Day Surgery, patient cancellations and ongoing issues with the Day Surgery Estate.

Pressure on staffing levels remains high, with absence on 4.58% (improved from M10), and a high turnover rate of 12.64%. Wellbeing calls to staff are having an impact in terms of identifying options for support for staff.

The number of patients waiting over 52 weeks for surgery improved to 634 which is ahead of the trajectory. The total waiting list size reduced to 18039 from 18844 in M11.

Positively, the Trust achieved the 6 week diagnostic standard in M11, with just 38 (56 in M10) patients waiting over 6 weeks. There are significant workforce challenges in several services from M12, with Cardiology and Radiology being identified as areas of concern and at this stage it looks like the overall position will deteriorate to below the 99% standard in M12.

There has been a deterioration against the cancer standards, with Two Week Wait at 77% (target 93%), 62 Day at 72.8% (target 85%), and 62 Day Screening at 0%. The 28 Day Faster Standard was achieved at 78% (target 75%) and the 31 Day standard at 97%. Capacity issues in relation to the Breast 2 week wait pathway remain a big factor in the performance of the 2 week wait standard, with patient choice also still having a big effect. There were multiple issues across the 62 day performance, with complex clinical pathways and diagnostic delays particularly in relation to PET scans which are not provided at SFT.

The Trust is confident of meeting its final plan for H2 2021/22, agreed in mid-November. All additional revenue streams assumed have been confirmed, this revenue is made up of a combination of ERF, ERF+, and discretionary system allocation. The Trust recorded a deficit of £7k in month 11, bringing the YTD position to a small surplus of £27k against the H2 plan. There are pay overspends across most staff groups, and there are significant overspends on non-pay around the increased cost of clinical supplies and in the category of other non-pay expenses.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒

Other (please describe) -	☐

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

April 2022

(data for February 2022)

An outstanding experience for every patient

Summary

NHS
Salisbury
NHS Foundation Trust

Performance against the 4 hour standard continues to be operationally challenging, with 76.3% of patients being discharged or admitted within 4 hours (82.5% in M10). Flow out of the department remains the biggest factor with an average occupancy level of 96.3% across the month, the highest occupancy level since Feb 20 (96.1%).

The proportion of patients reaching the Stroke Unit within 4 hours was 27% due to the flow pressures; however this was improved from 20% in M10. There was deterioration in the number of Stroke patients receiving a CT within 1 hour (40% compared to 54% in M10), the number receiving a CT within 12 hours (80% compared to 84.6%) and the number of patients spending at least 90% of their admission on the Stroke Unit (60% compared to 85% in M10).

The number of patients not meeting the criteria to reside increased to almost 70, and there continues to be an increasing number of patients (54 at the peak) that are Covid positive in the hospital, the need to isolate both positive and contact covid patients there were on average 10 unoccupied beds closed throughout the month in contact areas.

There were 3 hospital onset cases of C.difficile in February. There were also 3 hospital cases of each of E.Coli and MSSA bacteraemia. There was one category 3 pressure ulcer and one category 4 pressure ulcer identified in February. There were no never events reported in February - 3 SIIs were commissioned in total. There were 10 falls in February of which 4 were graded as 'major.' The number of hospital acquired VTE's continues to remain significantly below the national average (0.11% of total admissions verses 0.5%-1.6% nationally). Over 99% of patients are reporting their experience as either good or very good via the friends and family test - 2.3% of eligible patients and half of wards submitted feedback in February.

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Summary Performance February 2022

NHS
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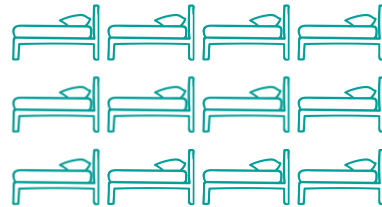
NHS Foundation Trust

There were **2,447** Non-Elective Admissions to the Trust

We delivered **32,467** outpatient attendances, **18.6%** through video or telephone appointments

We met **4 out of 8** Cancer treatment standards

We carried out **265** elective procedures & **1,737** day cases



We provided care for a population of approximately **270,000**

RTT 18 Week Performance: **66.0%** ↓

Total Waiting List: **18,039**↓

99.0% ↑ of patients received a diagnostic test within **6 weeks**

Our income was **£ 27,203k** (£2,096k above plan)

18.2% ↑ of discharges were completed before 12:00

Emergency (4hr) Performance **76.3%** ↓ (Target trajectory: 95%)

86 patients stayed in hospital for longer than 21 days

Our overall vacancy rate was **3.44%** ↓

NHS Salisbury NHS Foundation Trust

Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of “normal”

There should always be a minimum of 24 months worth of data

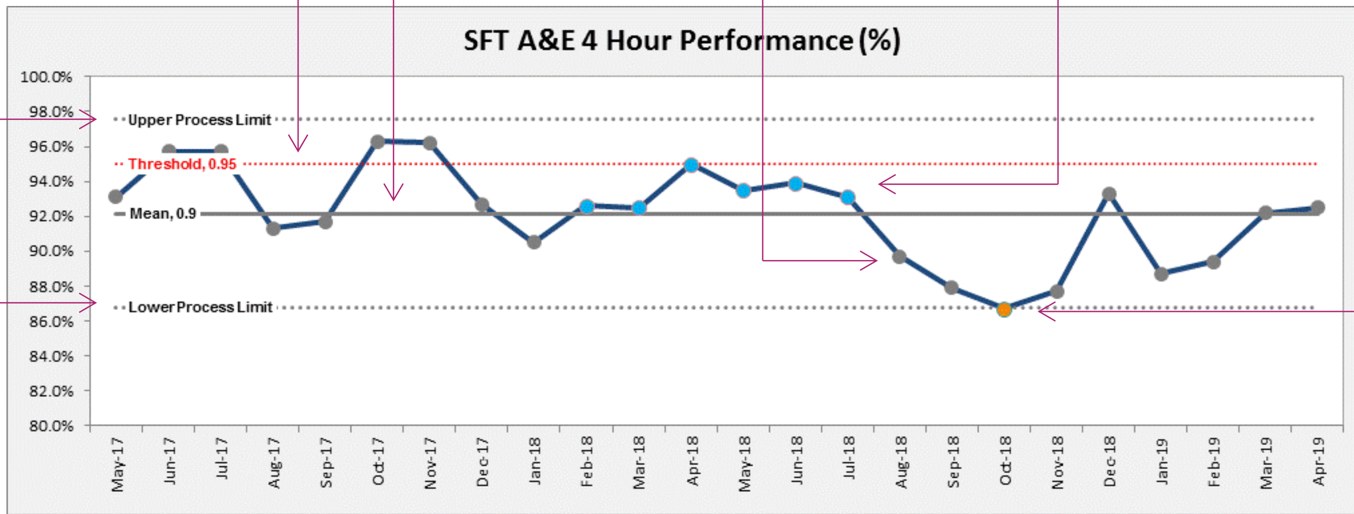
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points continuously improving or any point above the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points continuously deteriorating or any point below the lower limit



Statistical Process Control Chart Key:		
	Target	Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
	Mean	Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
	Upper / Lower Process Control Limits (UPL/LPL)	Common Cause Variation

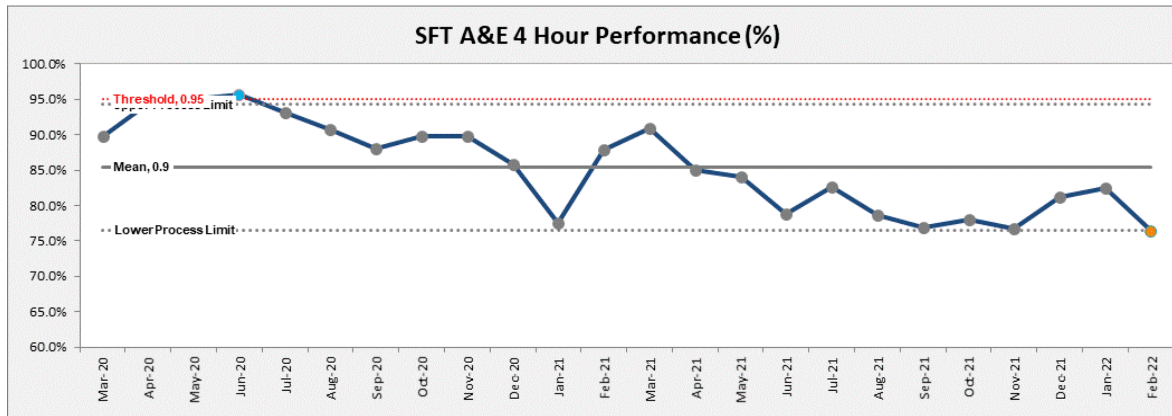
Part 1: Operational Performance

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Emergency Access (4hr) Standard Target 95% / Trajectory 95%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	76.3%
Attendances:	5276
12 Hour Breaches:	0
ED Conversion Rate:	31.9%

Background, what the data is telling us, and underlying issues

M11 saw a decrease in attendances of 5276 compared to 5545 in M10 which is to be expected with a short month. There has been a significant decrease in the 4 hour performance target from 82.5% in M10 compared to 76.3% in M11.

SFT ED conversion rate has remained fairly similar from 33.5% in M10 compared to 31.9% in M11. This may be reflective of the high acuity of patients presenting at the Front Door and across the Trust and the need for specialty expected patients to access SFT via ED and not admission units.

Capacity across the Trust and flow out of ED and AMU remains the biggest contributors to the low performance against the 4 hour standard.

The ED department continues to have many unfilled nursing gaps on nearly every shift and this continues to impact on existing staff, with minors triage being impacted on a regular basis.

Improvement actions planned, timescales, and when improvements will be seen

Phase 2 of the minors build is ongoing and is scheduled to be finished in M12.

The ED Clinical Lead is currently working with Surgical Specialties with regards to SDEC and is analysing the amount of time specialty patients await review within the ED Department and the adherence to IPS (Internal Performance standards).

Initial talks have taken place with SWAST regarding reintroducing Navigator role at the Front Door.

The ED team are currently in discussion with Estates with regards to layout of department and how best we can utilise current floor space. The ED team are also reviewing the Nunton Space in order to provide space to deliver SDEC

ED continue to promote Free phone Pilot to the Walk In Centre.

Review of triage process at the Front Door is ongoing.

The ED has a cohort of new Reception starters and they are all settling in well to the department

Risks to delivery and mitigations

Flow out of the department continues to remain one of the biggest challenges for ED/AMU with many discharges taking place late evening.

AMU SDEC space (Same Day Emergency Care) continues to be escalated into overnight. This results in poor flow out of the ED department the following day and severely limits AMU's capacity to deliver SDEC the following day, often resulting in the medical take being diverted to ED. This continues to be monitored and audited by the UEC Service Manager.

Delays from specialty teams coming to review their referred/expected patients according to IPS (Internal Performance Standards). This results in bays being occupied for long periods waiting review with impact on capacity within the ED Department.

Staffing Gaps especially nursing and middle Grade continue to impact on existing staff and the department as a whole.

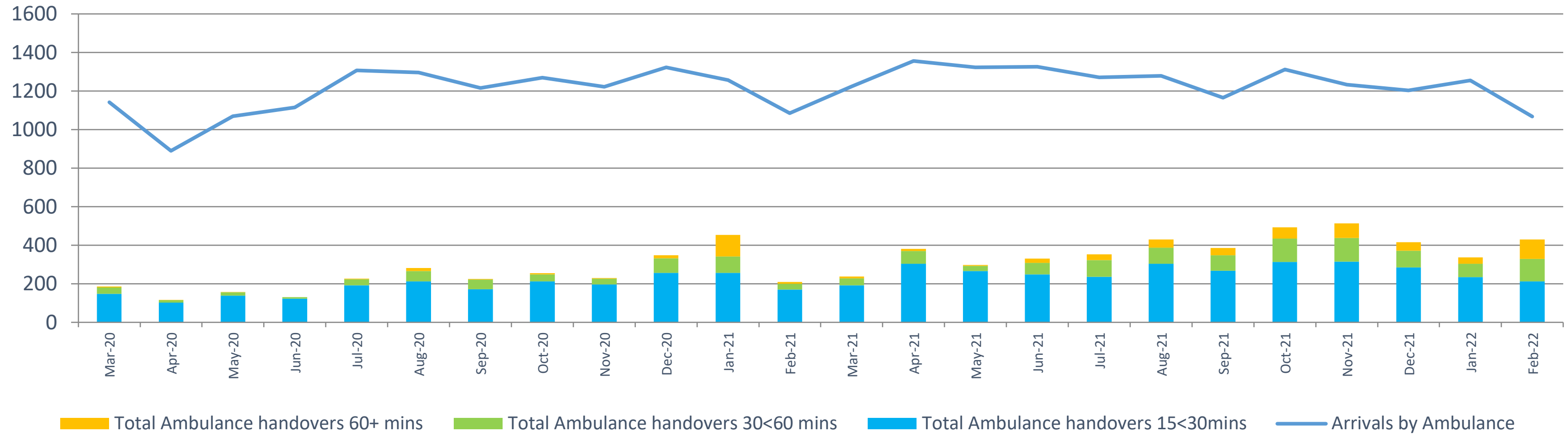
The reporting and investigation of 4 hour performance target breaches and ambulance breaches are having a significant impact on existing administration time within the department.

Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

Ambulance Handover Delays

National Key Performance Indicators



Background, what the data is telling us, and underlying issues

M11 saw a decrease in numbers of ambulances presenting to SFT of 1068 compared to 1256 in M10, which is to be expected with the 28 day month. There has been a significant decrease in performance for timely ambulance handover 79.68% in M11 compared to 91.88% in M10.

Breaches >60 minutes have seen a significant increase in M11 to 100 compared to 32 in M10. Breaches >30 minutes have also seen an increase to 117 in M11 compared to 102 in M10. There is a slight decrease in breaches >15 minutes of 213 in M11 compared to 235 in M10.

With AMU ambulatory area having to be escalated into overnight regularly, subsequently the medical take is diverted to ED adding to pressures in off loading ambulances.

Improvement actions planned, timescales, and when improvements will be seen

There will be an initial Pilot in M12 with a ACP from Wiltshire Health & Care based at the front door to provide Rapid Frailty Response. The Pilot will have an ACP and a HCA along with a Car in the aim to provide admission avoidance where possible.

ED are continually looking into pathways for streaming of ambulances into dedicated specialty areas. SAU and Urology with Surgical DMT contacted to develop surgical access for SWAST

ED staff remain aware of the need to off load ambulances as quickly and safely as possible. Staff are continually reminded of the need to escalate as per policy of any ambulances unable to be off loaded immediately.

SFT continue to work collaboratively with SWAST and BSW partners in accepting peripheral diverts when required in order to provide the best quality of care to our patients.

Risks to delivery and mitigations

Hospital flow constraints and the resulting impact of the department reaching capacity, remains the biggest challenge in being able to off load ambulances in a timely manner. The Service Manager continues to monitor ambulance conveyance in hours.

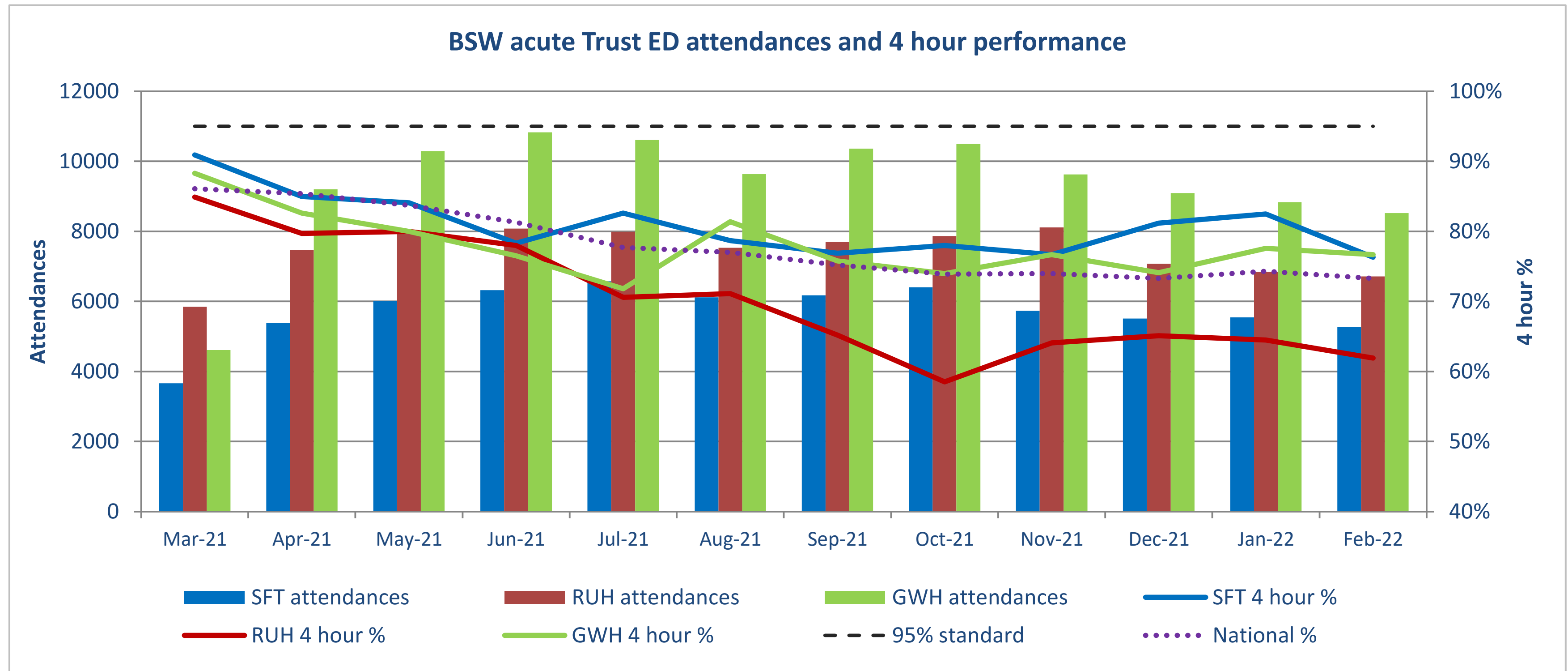
Staffing gaps, especially nursing, have a large impact on ambulance conveyance times within the department, gaps in workforce continue to remain a challenge at times.

AMU diverting the medical take will continue to impact on number of ambulances presenting to ED and our conveyance performance.

Impact on Paediatric space in ED from utilization as extra adult capacity impacts on statutory requirements in the management of this group of patients.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

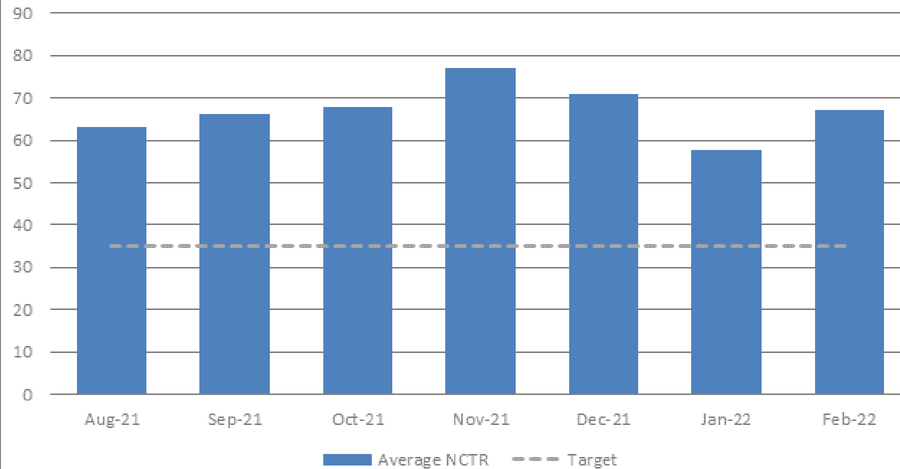


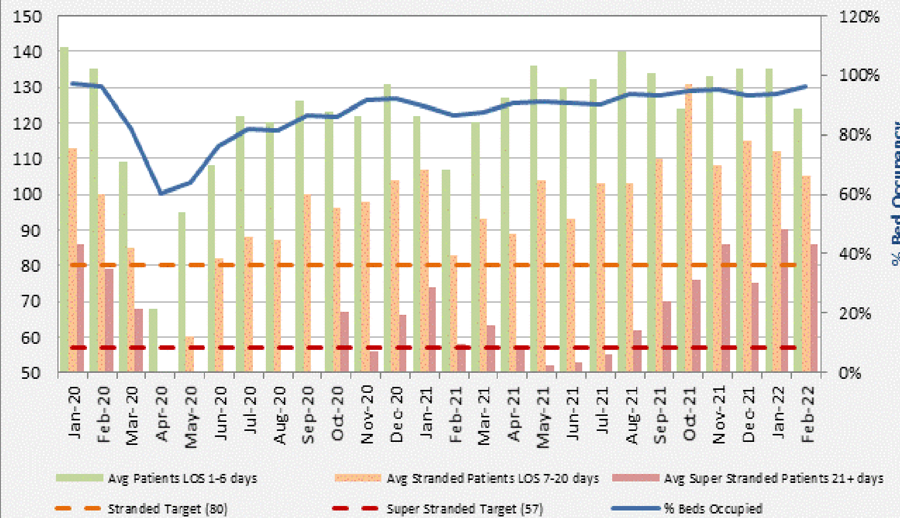
Performance against the 4 hour Emergency Access standard continues to be operationally challenging across all three BSW acute Trusts, all sites reported lower performance in M11 compared to M10. This was also seen at a National level. There were 77 twelve hour trolley waits at GWH, 1 at RUH and none at SFT.

Attendances were higher than in M11 of the previous year, although this was during a covid wave, however attendances were lower than in M11 of 2019/20 prior to the start of the pandemic.

Patient Flow and Discharge

Are We Effective?





Background, what the data is telling us, and underlying issues

February continued to be a challenging month in patient flow with escalated numbers of patients remaining in hospital despite no longer meeting the criteria to reside. Bed occupancy was sustained at just under 100% and the data would indicate that there was an increase in the <1day LOS group. However flow did not facilitate a reduction in the numbers of people remaining in hospital.

Improvement actions planned, timescales, and when improvements will be seen

Wiltshire ICS have implemented several surge schemes with the aim of facilitating discharge from hospital. These include a discharge grant scheme that will provide some financial support to otherwise informal carers, one off cleans and decluttering that would prevent discharge quickly if not undertaken.

Additionally Ward 4 at St. Martins Hospital in Bath has been identified as an additional bed resource for people waiting for care at home, alongside a care hotel also in Bath which can provide care needs for people waiting for care to be available in their area. There are 7 bed at South Newton in use for people with low level rehabilitation needs. Escalation calls are in place, as is the use of SHREWD for acute hospital and ambulance data which is a source of information informing decisions at ICS.

Risks to delivery and mitigations

Covid surge – there is currently no community discharge support in a bed base for people with COVID. Isolation requirements mean people can remain in an acute setting for 10 days without need for acute care.

Bath is over an hours travel for visitors and carers and will require some skilled conversations and additional information to support decision making so as to avoid patients and families declining provision that can accommodate physical needs.

Staffing remains a challenge in both acute and community health and social care settings. Further challenges will impede the success of additional schemes.

Additional resource is commissioned to accommodate the least complex needs – patients requiring higher level support will remain the acute setting awaiting appropriate provision.

Theatre Performance

Theatre KPI's

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 21	Feb 21	Mar 21
19/20	497	532	501	531	453	522	524	555	476	548	481	364
20/21	239	294	327	317	346	362	379	401	328	248	263	383
21/22 Actual	301	378	379	442	455	473	507	520	465	469	472	
21/22 Plan	252	411	452	456	441	463	451	463	451	435	423	482
21/22 Plan+	252	411	551	560	540	563	554	568	547	541	517	588

Measure - Theatre Performance & Efficiency	Area	Target	Feb 22
% Utilisation	Day Surgery Theatres	90%	69%
	Main Theatres	85%	86%
Turnaround	Day Surgery Theatres	8 mins	17 mins
	Main Theatres	12 mins	26 mins
% short notice Hospital Cancellations (0-3 days)	Total	2%	1.85%
% Short notice Patient Cancellations (0-3 days)	Total	2%	8.51%

Background, what the data is telling us, and underlying issues

An average of 118 theatre sessions a week were run in M11, an increase of 12 per week on M10, achieving more than baseline plan and 19/20 levels. However list utilisation lower in DSU in month due to impact of escalation. 12th in week theatre opened on 7th February slightly behind target of 10.8 baseline weekday theatres open in February (plus 2 for insourced teams) but high staff sickness and elective cancellations in the first week of the month, and the additional impact of bed pressures and DSU estate problems in second half of the month, meant that 10.6 theatres open on average in the week, and some lists at lower list numbers due to late PCR results, bed pressures and patient cancellations. However, weekend HVLC activity increased on M10 by 13 patients

Underperformance of elective activity accounts for overall theatre activity still being lower than plan in M11 as elective activity remained short of pre-Covid levels, at 61%, and below plan, at 78%, however this maintained the significant increase achieved in M10 from 51% in M9. This has been further exacerbated by issues around late starts, high levels of emergency and trauma and high numbers of cancellations

Daycase performance remains fairly steady with a slight decrease on M10 to 92% of pre-COVID levels and 103% of plan

Increased cancellations were also seen throughout M11, due to the continuing impact of COVID prevalence, which is reflected in the further increase in percentage of patient driven cancellations

Improvement actions planned, timescales, and when improvements will be seen

Improvements continue to be maintained in both TXM compliance with contract and quality. TXM workforce now stable and skilled but scrubs still covering HCA shifts at full cost. Plan for another Theatre to open using substantive staff in March 22. Transition now taking place from TXM (insourced staff) to a more stable substantive workforce

Theatre Staff Incentive Payment Scheme uptake remained low in February (£7k). Theatre Education continues with increased numbers of Scrub Nurses, ODP's and SFA's in full time training. Theatre Service Manager appointed and start date expedited to M12. Clinical Lead for Theatres now appointed.

SFT IPC guidelines continue to reflect most national processes for low risk pathways, improving the ability to book patients into cancelled slots with less notice required, in turn improving utilisation. Move to pre-Surgery LFT testing rather than PCR now signed off by the Testing Cell for GA procedures. Go-live of this change scheduled for M1

Continuation of High Volume Low Complexity (HVLC) lists running both in week and at weekends for a number of specialties as targeted Waiting List Initiatives focusing on Plastic Surgery as the specialty with the highest volume of elective surgery backlog

Productivity and efficiency work continues focused on the Day Surgery Unit. This is being underpinned by weekly specialty Scheduling Meetings where there is representation from multidisciplinary teams

Risks to delivery and mitigations

Theatre workforce for local lists continues to be a blocker despite slow improvement. High levels of sickness continued to impact lists in M11 leading to the cancellation of elective work and although the number of theatres opened is almost on plan (-0.8 in M11) this has been supported by TXM staff. The mitigation for this is the focus on delivery of the actions of the Theatre Workforce Review led by OD&P, the Theatre Service Manager and the DMT. The resilience of the local workforce is a particular focus as transition from reliance on TXM (insourced staff) to a more stable substantive workforce

An ongoing risk to elective activity remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand. This is being mitigated by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately.

Bed pressures continue to impact the elective programme and have led to cancellations throughout M11, especially elective cases; however the simultaneous use of both upstairs and downstairs of DSU for inpatients has also impacted daycase performance. Daily review by the Matrons and DMT undertaken as required, avoiding cancellations whenever practical. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimise cancellations

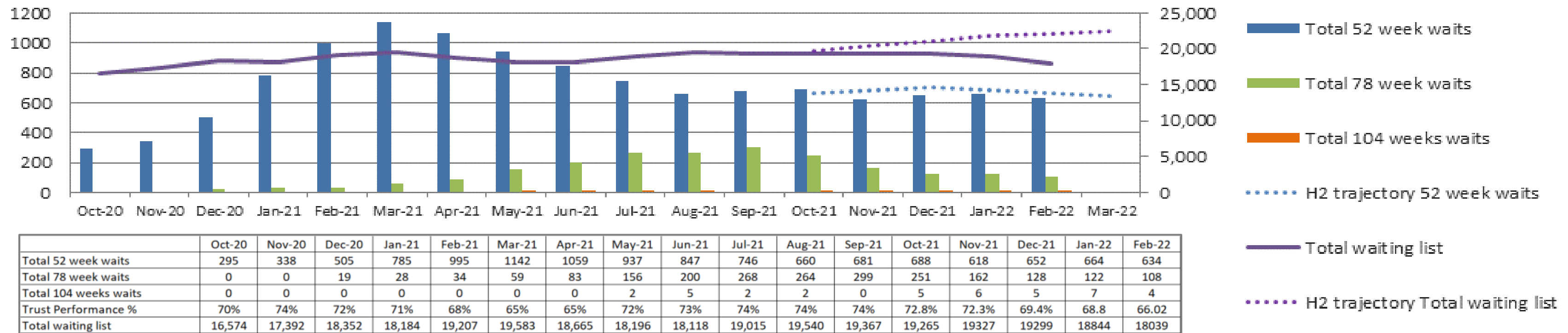
Issues with the estate in DSU also led to cancellations in M11

Risk of activity being impacted by cancellations due to continuing prevalence of COVID resulting in rise in sickness and isolation of clinicians. Ongoing risk due to patient cancellations which has increased to 8.5% in M11

Theatre access continues to be allocated by clinical priority and need resulting in theatre access varying by specialty month to month and the impact of this can be especially seen on specialities with a high proportion of clinically routine, low priority patients

Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Total 52 week waits	295	338	505	785	995	1142	1059	937	847	746	660	681	688	618	652	664	634
Total 78 week waits	0	0	19	28	34	59	83	156	200	268	264	299	251	162	128	122	108
Total 104 weeks waits	0	0	0	0	0	0	0	2	5	2	2	0	5	6	5	7	4
Trust Performance %	70%	74%	72%	71%	68%	65%	65%	72%	73%	74%	74%	74%	72.8%	72.3%	69.4%	68.8	66.02
Total waiting list	16,574	17,392	18,352	18,184	19,207	19,583	18,665	18,196	18,118	19,015	19,540	19,367	19,265	19327	19299	18844	18039

Longest Waiting patient (Weeks)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
	101	106	110	108	112	103	106	110	110	107	111

Top 5 with highest 52 week wait submitted breaches (Incomplete PTL)

Treatment function	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	% change from
Plastic Surgery	140	133	130	129	129	111	121	132	130	-2%
Urology	88	78	52	54	59	60	63	57	60	5%
Trauma and Orthopaedic	99	85	74	59	56	48	39	45	41	-9%
Oral Surgery	87	76	63	63	44	38	38	38	37	-3%
Ophthalmology	120	92	92	90	71	55	44	25	24	-4%

Background, what the data is telling us, and underlying issues

The number of patients waiting longer than 52 weeks decreased by 30 to a total of 634 in M11. This is ahead of the H2 trajectory of 660. The number of patients waiting longer than 78 weeks continues to decrease reducing by 14 to a total of 108. Among this cohort who have waited longer than 78 weeks approximately 3% are patients who have chosen to delay their pathway. Overall PTL size in M11, 18,039, which is 1328 below of the H2 target of 19,367

The number of reportable patients waiting 104 weeks in M11 was 4, with the longest waiting patient waiting 111 weeks. These patients are all been dated for surgery in M12 apart from 1 delay due to kit required for a clinically complex pathway. A solution has been identified and awaiting delivery of required kit

Of the patients waiting on non-admitted pathways the highest volumes are within Respiratory, Plastic Surgery and ENT. Of the patients on admitted pathways awaiting surgery the split is broader with Plastic Surgery, Gynaecology and Urology being the most challenged specialties

Improvement actions planned, timescales, and when improvements will be seen

HVLC lists for Plastics LA lists have continued to run throughout the month of February for this long waiting cohort although this was reduced due to consultant cover reducing TXM lists

To further address these long waiters weekend outpatient clinics planned in Ophthalmology in M12 for patients that are not clinically appropriate for transfer to the IS and an all day weekend theatre list also scheduled for Breast Surgery in M11

H2 trajectories were set to reflect the national guidance to eliminate 104 week breaches by 31st March 22 (unless P6 patient choice to wait), hold or reduce the number of patients waiting longer than 52 weeks, and hold total waiting list size around September 21 levels. SFT currently on track to achieve these targets by the end of M12 however the national target for 104 week elimination has now been revised to the end of July 22

Ongoing use of IS with the transfer of clinically appropriate Orthopaedic patients to Newhall and Ophthalmic Cataract patients to Newhall continuing although transfers to IHG are on hold awaiting an updated from them on capacity

Risks to delivery and mitigations

As with theatre activity continued risks remain in relation to theatre workforce for local lists including the risk of high levels of sickness. The mitigation for this issue is linked to the Theatre Workforce Review being led by OD&P with support from the Theatre Service Manager, Theatre Clinical Lead and DMT

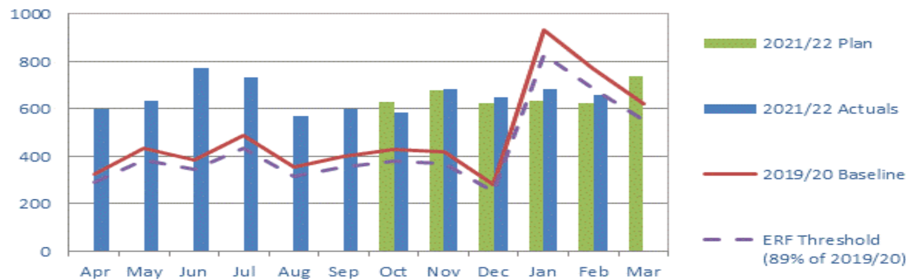
Risks associated with staffing levels as a direct result of COVID-19 also remain prevalent with the risk of both theatre and outpatient activity being lost due to the impact of sickness and isolation

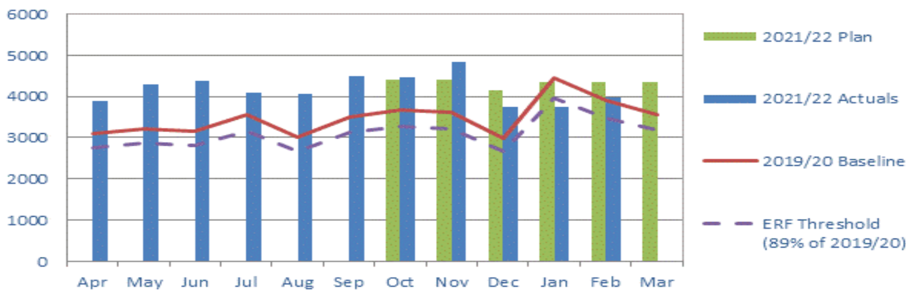
Another ongoing risk remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand as this may continue to result in cancellations especially of long waiting, clinically routine patients. This is being mitigated where possible by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately minimising elective cancellations wherever possible

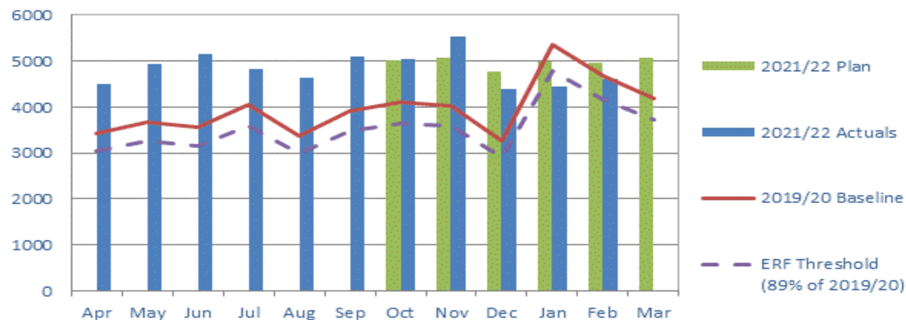
Capacity pressures continue to impact the elective programme, especially affecting the casemix, and led to elective cancellations in M11. Daily review by the Matrons and DMT undertaken as required avoiding cancellations whenever practical. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimalise cancellations. Trustwide SAFER week also running to support timely discharges. Continued high levels of patient led cancellations are also a risk to delivery especially in light of COVID prevalence, rate of almost 9% in February

Elective Recovery Fund - RTT Stops

National Key Performance Indicators







Background, what the data is telling us, and underlying issues

ERF total RTT stops performance continued to be behind plan in M11. Again the admitted RTT stops performance remained above plan though but the non-admitted was below impacting overall performance

Outpatient attendances in M11 exceeded current month plan, 109%, falling slightly below pre-COVID levels, 97%. A wide range of specialties now achieving over 100% of pre-COVID levels

Go live of new rota and increased clinic templates in Ophthalmology in M11 facilitated the optimisation of the use of the outpatient department creating increased capacity for non-admitted patients to address the current backlog and resulted in an increase to 167% of pre-COVID levels

Virtual appointments continue to work well in a number of specialties with Gastroenterology and Cardiology seeing high numbers of their outpatients virtually

Specialties showing the most significant challenges with outpatient activity levels are Gynaecology, Geriatric Medicine, Paediatrics and Rheumatology

Improvement actions planned, timescales, and when improvements will be seen

Improvement actions and timescales for improvements in elective and daycase activity discussed on previous slides

Wait to First Appointment has been selected as a Breakthrough objective as part of the Trusts Improving Together program. Analysis has been undertaken to identify challenges and greatest opportunities for improvement and work is ongoing as part of the Divisional Improving Together coaching sessions to confirm the Driver and Watch metrics that will support this objective

Non-admitted performance impacted by continued high levels of outpatient cancellations due to COVID-19 where both patient cancellations and hospital cancellations were high due to the impact of the continued prevalence on sickness and isolation. Emergency, trauma and urgent theatre activity continued to take clinical priority over routine outpatient activity

Risks to delivery and mitigations

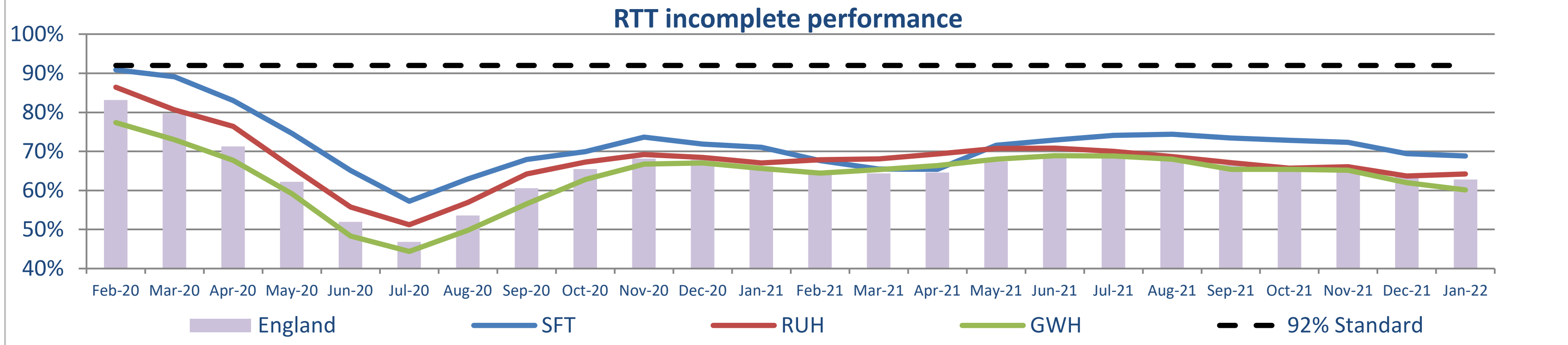
Continued risk of increased cancellations due to COVID-19

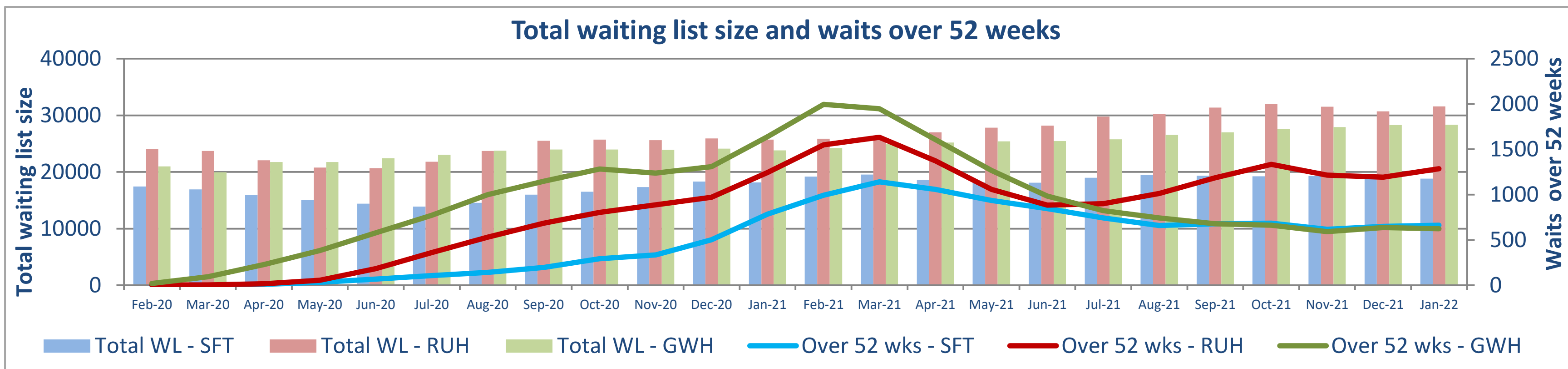
Space constraints across outpatient departments continue to be a significant risk as social distancing and IPC requirements have been reduced but not removed

Creep in some specialties back to onsite preferences. Focussed work is being undertaken with DMT's, Clinical Leads and Transformation team to continue to increase this in line with national targets and to improve medium-long virtual models in line with national and ICS targets and priorities

BSW Context – Referral To Treatment (RTT)

Are We Effective?





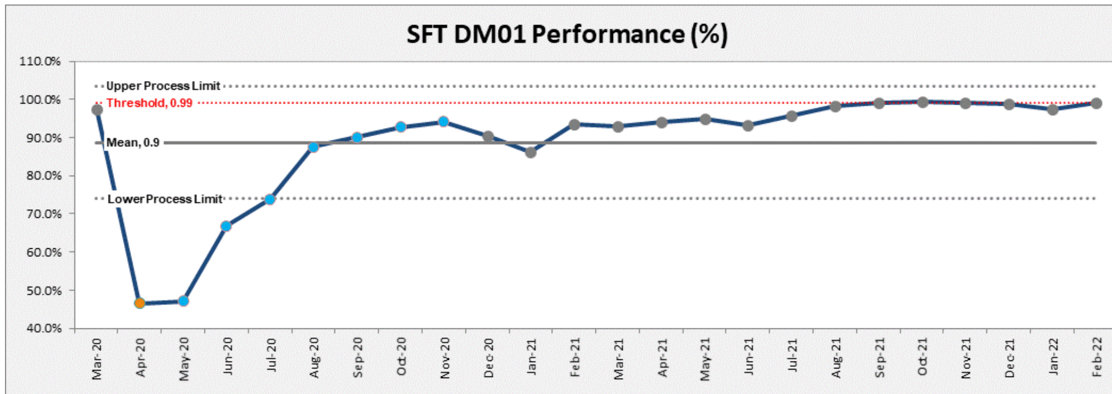
*Due to the time it takes to for NHSE to publish the data, RTT benchmark data on this slide is a month behind the reporting month.

Total waiting list size across the three acute Trusts remained broadly static, with slight growth at RUH, and small reductions at SFT and GWH. There were 7 patients at SFT waiting over 104 weeks, 4 at RUH and none at GWH. The number of patients waiting over 78 weeks increased slightly at RUH and GWH, and growth in the number of patients waiting over 52 weeks increased at SFT and RUH.

The proportion of the waiting list waiting over 52 weeks was 3.5% at SFT, 4.1% at RUH and 2.2% at GWH. Nationally 5.5% of the waiting list has waited over 52 weeks. Total waiting lists in England now stand at 6.1 million.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: 99.0%

Waiting List Volume: 3783

6 Week Breaches: 38

Diagnostics Performed: 6494

Modality performance

MRI	98.9%	US	100.0%	Audio	90.9%	Neuro	100.0%	Flexi sig	97.1%
CT	99.8%	DEXA	100.0%	Cardio	99.7%	Colon	96.7%	Gastro	97.5%

Background, what the data is telling us, and underlying issues

Diagnostic wait time performance has improved from 97.55% in M10 to 99.04% in M11 representing a return to compliance for the performance standard. 38 patients have breached the standard in M11 (this is a reduction from the 84 patients impacted in M10).

19 of the 38 breaches were within Audiology although the service's performance has improved significantly from M10 (reported 56 breaches in M10).

The remaining 19 breaches of the total 38 were across endoscopy and radiology due to either complex GA cases or workforce issues in MRI impacting some last capacity requirements in month to resolve all waiters.

Improvement actions planned, timescales, and when improvements will be seen

Trajectory for future performance required from Cardiology. Whilst performance was compliant in M10, this is unlikely to be the case for M11 and M12.

Endoscopy continue to maximise capacity as much as possible and manage their complex workload. Weekly validation of waiting list and breaches continuing.

Radiology to confirm diaries for booking further in advance to allow bookings team to be as efficient as possible with advance notice for patients.

Risks to delivery and mitigations

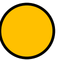
Two highest risks to M12 compliance are workforce related issues within MRI and Cardiology Echo. The latter will likely be a longer term risk (currently 2.4WTE in post vs a required 5.4WTE). The service will illustrate trajectory for performance and this will be discussed at March and April Delivery Group meetings. MRI workforce is dependent on agency currently, two members of staff identified but with later March start dates.

There are some possible vulnerabilities within neurophysiology due to increasing referrals but the Head of Clinical Sciences is reviewing this and trying to mitigate the risk. DDO CSFS will monitor.

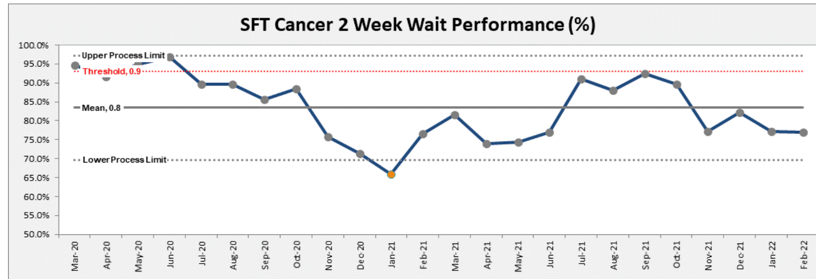
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

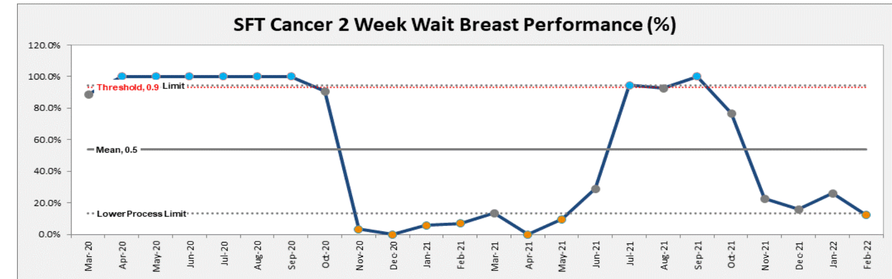
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Data Quality Rating: 

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	77.01%	737/957	220 (44 patient choice)
Two Week Wait Breast Symptomatic Standard:	12.20%	5/41	36





Background, what the data is telling us, and underlying issues

Two week wait standard not achieved for Month 11 with month end validated performance of 77.01% (957 patients seen; 737 in target; 220 breaches). Breach reasons associated with:

- Clinic capacity: 148 breaches (predominantly lack of radiology cover to facilitate additional breast one stop clinics)
- Patient choice: 44 breaches
- Incomplete GP referrals: 9 breaches
- Administration delays: 5 breaches
- Clinical delays (including COVID-19): 5 breaches
- Radiology capacity: 2 breaches
- Endoscopy capacity: 1 breach

Breast symptomatic two week wait standard not achieved for Month 11 (41 patients seen; 5 in target; 36 breaches). Breaches associated with patient choice and lack of breast one stop capacity due to insufficient radiology capacity to facilitate additional clinics. Current average waiting time for first appointment within breast is 16 days.

28 Day Faster Diagnosis Standard achieved for Month 11, with month end performance of 78.2% (834 patients diagnosed; 652 in target; 182 breaches).

Improvement actions planned, timescales, and when improvements will be seen

Breast two week wait performance: Radiology and the breast service have agreed to establish ad hoc monthly clinics as required, though demand and capacity modelling to be completed to provide assurance in relation to required additional capacity.

Patient choice: Ongoing challenges associated with patient choice delays and cancellations. There are however limited opportunities to offer a second appointment within the two week timeframe due to capacity constraints across services.

Bowel cancer screening pathway review: Review of existing pathway and reporting underway across BSW ICS. As the BCSP hub, Salisbury reporting 28 day FDS performance will be adversely affected. National team are currently reviewing the BCSP KPIs to ensure these are in line with delivery of 28 day FDS and demand and capacity planning to be undertaken, though future internal reporting will be split by SFT and BCSP. BCSP coordinator recruited to, with the aim of commencing in post from April 2022.

Risks to delivery and mitigations

Consultant radiology capacity to support additional clinics within breast service: Deterioration in two week wait performance seen from October 2021 due to increase in referrals and lack of radiology capacity to support additional one stop clinics.

Statistical Process Control Chart Key:
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- Mean
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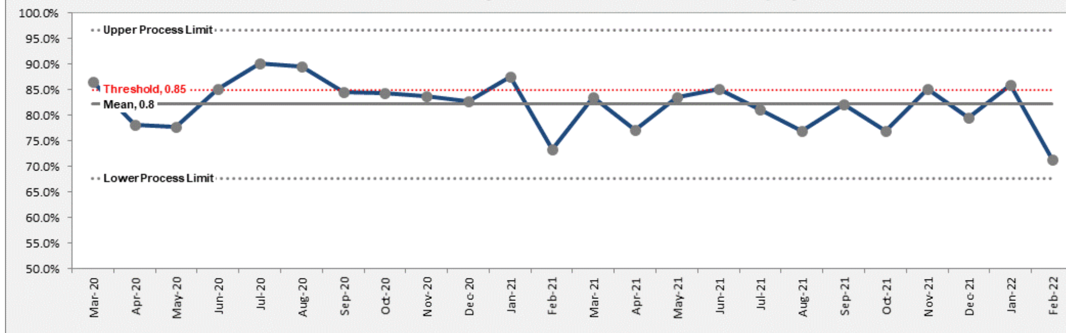
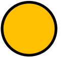
- Common Cause Variation

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating: 

February 22	Performance	Num/Den
62 Day Standard:	72.8%*	57/81
62 Day Screening:	0.00%	0/2.5

*62 day performance is subject to change prior to final submission

Background, what the data is telling us, and underlying issues

Month 11 62 day performance standard not achieved, with validated month end performance of 72.8% (81 patients treated; 59 in target; 22 breaches).

- Breast: 3 breaches (complex diagnostic pathway, delayed diagnostic reporting and patient testing positive for COVID-19);
- Colorectal: 5 breaches (clinical delays, complex diagnostics. Delays in access to PET CT. Histology delays)
- Gynaecology: 1 breach (patient tested positive for COVID-19)
- Haematology: 2 breaches (complex pathways across multiple tumour sites)
- Head & Neck: 1 breach (patient tested positive for COVID-19 and insufficient radiotherapy capacity at tertiary centre)
- Lung: 2 breaches (clinical delays)
- Upper GI: 1 breach (complex diagnostic pathway)
- Urology: 7 breaches (all prostate; insufficient diagnostic capacity)

62 day screening standard not achieved for Month 11, with validated month end performance of 0% (2.5 patients treated; 0 in target; 2.5 breaches). Breaches associated with delayed transfer, insufficient bowel cancer screening diagnostic capacity and complex pathways.

31 day performance standard achieved, with validated month end performance of 97.3% (111 patients treatedl;108 in target; 3 breaches)

Improvement actions planned, timescales, and when improvements will be seen

Access to PET CT: Issue raised via Clinical Lead and Deputy COO directly with provider, as well as through SWAG/Wessex cancer alliances and BSW ICS. Options currently being scoped with radiology and estates services in terms of whether a mobile PET-CT scanner could be available in the future; timescales not currently clear.

Prostate pathway improvement: Surgery DMT to work closely with Urology and cancer services to develop an improvement plan to reduce the length of cancer pathways for prostate patients. Initial discussions underway with service in terms of options and business case being scoped to recruit an additional Consultant Urologist to support increased template biopsy capacity.

Establishment of vague symptoms/non-specific symptoms pathway: Pathway currently being scoped with BSW ICS to support patients with 'vague symptoms' who may otherwise undergo lengthy diagnostic pathways. A GP lead and navigator post are currently out t advert, who will be responsible for finalizing and implementing the pathway. Anticipated go-live date of May 2022.

Impact of pharmacy capacity on delivery of chemotherapy: Business case currently in progress within Pharmacy to increase staffing capacity. Recovery plan to be developed within oncology alongside demand and capacity planning.

Nursing leadership within cancer services: Matron for Cancer and Lead Cancer Nurse posts successfully recruited to. Recruitment checks currently underway, with likely start dates of June 2022.

MDT coordinator capacity and culture: MDT coordinator team now at full establishment following a significant period of reduced staffing. Improvement work underway across cancer services to re-invigorate use of escalation process and breach avoidance.

Risks to delivery and mitigations

Patient fitness: Increase in number of 62 day braches associated with patient fitness and comorbidities. Increase in number of patients requiring anaesthetic review and pre-habilitation ahead of treatment, as well as instances whereby secondary cancers are being found elsewhere in the body that have altered initial treatment plans. The complexity of these patient's pathways is likely to impact 62 day performance going forward.

Access to PET CT: Service provided by Alliance Medical (national contract). Capacity has the potential to adversely affected pathways across all tumour sites and will hinder SFT's ability to deliver the 62 day standard.

Histopathology reporting turnaround times: Ongoing challenges associated with Consultant Histopathologist capacity, which often results in cancer pathology being outsourced. This in turn increases the timeliness of reporting and has the potential to delay diagnosis and MDT discussion.

Diagnostic capacity within the prostate cancer pathway: Challenges associated with diagnostic pathway for prostate patients, in part due to historical pathway processes but also insufficient template biopsy capacity. This is impacting both 28 day and 62 day performance.

Impact of pharmacy capacity on delivery of chemotherapy: Insufficient staffing capacity within Pharmacy and previous challenges with aspectics have resulted in an ongoing need to insource chemotherapy. This has impacted scheduling significantly in that there is limited opportunity to expedite treatments or be flexible

Statistical Process Control Chart Key:

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- Mean
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- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Stroke & TIA Pathways

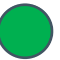
Are We Effective?

SSNAP Case Ascertainment Audit

Highest level = Grade A

Lowest level = Grade E

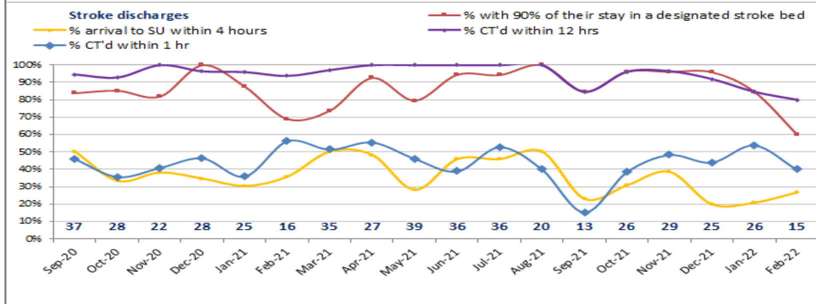
Quarterly	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22	C	C		

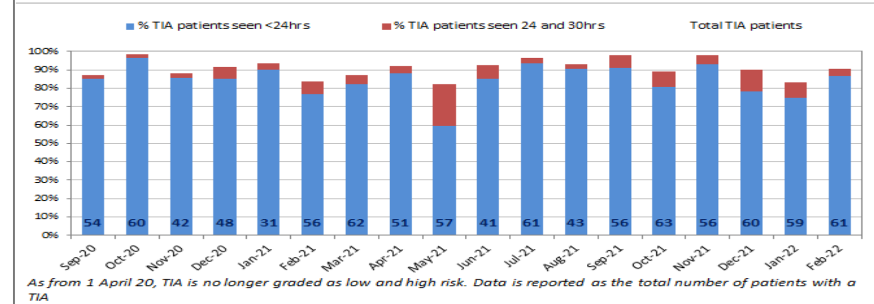
Data Quality Rating: 

% Arrival on SU <4 hours: 26.7%

% CT'd < 12 hours: 80.0%

% TIA Seen < 24 hours: 86.8%





Background, what the data is telling us, and underlying Issue

[Please note: Data is often only partially validated with informatics at the time of publishing. Coding can sometimes result in minor adjustments to the data at a later date].

- There were 15 stroke discharges this month.
- There were 1 stroke deaths within the 7 day period in February.
- 90% stay in the stroke unit was 60% this month; 3 SLOS, 2 to AMU first, 1 in ED>12hrs- late diagnosis
- The number of patient reaching the stroke unit within 4 hours is 27%
- Average Stroke unit length of stay was 7 and an average total length of 8 days
- 40% of patients had a CT within an hour which is a decrease from the last few months. CT within 12 hours was at 80% - a slight decrease mainly due to ongoing ED pressures.
- 1 patient was thrombolysed with an average door to needle time of 70 minutes.
- 8 of the eligible 14 patients were referred to ESD in February.
- 87% of the 53 TIA's had treatment complete within 24hrs; with 3 patients affected by full clinics, 1 having MRI next day, 1 late referral, 1 no AM clinic, 1 declined earlier appt.

Improvement actions planned, timescales, and when improvements will be seen

- Acute Stroke patients continue to be looked after on Farley ward, with the rehab part of Farley still being used to care for respiratory patients. Rehab stroke patients continue to be cared for on Breamore ward.
- COVID operational pressures and staff shortages are still impacting on targets. However, there are plans in place for collaborative efforts with the emergency department, radiology and bed managers to improve these targets.
- The stoke lead has continued to meet with ED leads to agree pathways for improving the handover and transfer of stroke patients from ED to the ward.

NHS Salisbury NHS Foundation Trust

Part 2: Our Care

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Maternity

Are We Safe?

SFT Assurance Dashboard		Target	Improvement Direction	Rolling 6 months						Rolling 6m average
				Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	1	Down	1	0	0	2	0	0	1
	Number of stillbirths (>+ 24 weeks excl TOP)	1	Down	1	0	0	2	0	0	1
	Number of neonatal deaths : 0-28 days	1	Down	1	1	0	2	0	0	1
	Medical termination over 24 +0 registered	NA	Down	NA	NA	NA	NA	1	0	1
Maternal M&M	Number of Maternal Deaths	0	Down	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	0	Down	0	1	1	0	0	0	0
Insight	Number or daytix incidents - moderate or above	1	Down	NA	3	0	1	0	2	1
	Datix incidents moderate harm (not SII)	2	Down	NA	2	5	1	0	2	2
	Datix incidence SII	0	Down	NA	1	0	0	0	0	0
	HSIB referrals	NA	Down	1	0	0	0	0	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	0	Down	1	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	0	Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover	40	NA	40	40	40	40	40	40	40
	Minimum to Birth ratio	1.28	NA	1.4	1.27	1.25	1.25	NA	NA	NA
	Midwifery vacancy rate WTE (black= over establishment; red =under establishment)	0 WTE	Down	NA	NA	NA	NA	10	14.65	NA
	Provision of 1 to 1 care in established labour (%)	100%	Up	100	100	100	100	100	NA	NA
	Datix relating to workforce	0	Down	NA	NA	1	0	1	0	1
	Compliance with supernumery status of the LW coordinator - %	100%	Up	NA	NA	NA	NA	100	NA	NA
	Numbers of times maternity unit on divert	0	Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	NA	Up	24	9	9	2	19	31	16
	Service user feedback : Number of Complaints	1	Down	1	1	1	1	2	4	2
	Number of SOX	NA	Up	NA	12	2	5	5	11	7
Assurance	Progress in achievement of 10 safety actions(CNST)	10	Up	4	4	4	4	4	4	4
	Training compliance - MDT PROMPT %	90%	Up	68	68	56.2	NA	74	74.2	NA

Perinatal Quality Surveillance Tool

The information provided represents the recommendation from the Ockenden report. SFT is further developing this dataset to ensure the Board is informed of safety metrics and indicators.

What does the data tell us ?

Midwifery vacancy has increased – this is because the establishments have now been set correctly hence an appearance that WTE has increased, in reality we have had 2/3 leavers and continue with a recruitment plan. We are interviewing shortly for band 5/6 midwives. Reviewing staffing model and roles that will assist such as RGN, housekeeping. We have over recruited on support workers to mitigate the risk and flex the workforce across the community and acute settings to support women in times of high acuity .

Maternity Incentive Scheme Year 4 (MIS)

Year 3 compliance with ten safety actions was declared as 4

A recent gap analysis highlights concerns regarding 3 safety action

Safety action 2- Maternity Services Data Set

Challenges with IT system being able to deliver against data set – ongoing work with data analyst

Safety Action 6 -Saving Babies Lives

Currently non compliant with 1 of 5 elements with is fetal growth restriction – non compliance around use of Uterine Artery Doppler – action plan required to achieve

Safety action 8- MDT training -PROMPT

Increasing compliance with trajectory to be compliant with >90% by submission date of June 22 across all disciplines therefore overall compliance with safety action

Involvement of PWC to audit self deceleration to provide assurance to board on compliance at time of submission

What actions are being taken to improve?

Recruitment drives for midwives continues

Training drive continues for both PROMPT and CTG interpretation as identified in SII action plans

Work ongoing to increase compliance with the MIS year 4 –predicted compliance presently 7 out of 10

This dashboard remains under development hence some data being unavailable - work is currently underway with our data analyst team to bench mark data to make it more meaningful- two new metrics have been added this month (highlighted in red)

Maternity Clinical Dashboard

Data Quality Rating:

Are We Safe?

South West Region				National										
Measure	**Min**	**Median**	**Max**	**Mar-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Q1 Total**	**Q2 Total**	**Q3 Total**	**Q4 Total**	**Year To Date**
Babies (incl Non Reg)	149	187	217		217	198	187	149	161	**532**	**630**	**534**	**161**	**1857**
Homebirth rate	2.5%	4.6%	5.1%		5.1%	4.6%	4.9%	2.7%	2.5%	**2.5%**	**4.6%**	**4.2%**	**2.5%**	**3.7%**
Inductions %	32.0%	37.4%	41.9%		32.0%	37.4%	39.1%	36.9%	41.9%	**37.1%**	**34.5%**	**37.9%**	**41.9%**	**36.9%**
Total CS rate (planned & unscheduled)	24.4%	26.6%	32.4%	32% National Dash Mar21	32.4%	26.6%	26.6%	29.5%	24.4%	**29.1%**	**30.5%**	**27.4%**	**24.4%**	**28.7%**
Elective caesarean sections %	10.3%	12.1%	16.3%	15% National Dash Mar 21	13.7%	10.3%	16.3%	12.1%	10.6%	**13.1%**	**12.7%**	**12.9%**	**10.6%**	**12.7%**
Emergency caesarean sections %	10.3%	16.3%	18.7%	17% National Dash Mar 21	18.7%	16.3%	10.3%	17.4%	13.8%	**16.0%**	**17.8%**	**14.6%**	**13.8%**	**16.0%**
Instrumental deliveries %	9.2%	12.8%	17.4%	12.5% NMPA	9.2%	10.6%	12.8%	12.8%	17.4%	**11.8%**	**10.6%**	**12.0%**	**17.4%**	**12.0%**
Apgar less than 6 @ 5 min %				Green <1.2%, red >3.5% NMPA	0.9%	0.5%	1.1%	0.0%	0.0%	**0.2%**	**0.3%**	**0.6%**	**0.0%**	**0.3%**
PPH >= 1, 500 %	1.3%	3.8%	4.6%	Green <2.7%, red >5.6% NMPA	4.6%	4.4%	3.8%	1.3%	2.5%	**3.8%**	**3.9%**	**3.4%**	**2.5%**	**3.6%**

Clinical outcomes good and within expected ranges.

Induction of labour rate is increasing this reflects latest national guidance on gestation to induce at 41 weeks and the recommendations of Saving Babies Lives 2. The five elements of this bundle has been implemented nationally with the ambition halving the rate of stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 2030. The ambition was subsequently extended to include reducing preterm birth from 8% to 6% and the timeframe revised to 2025. We are currently compliant with 4 elements with a plan to be compliant with all submission in June 2022.

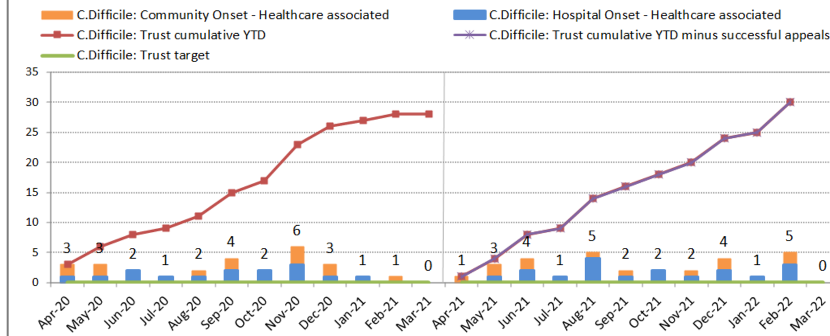
Infection Control

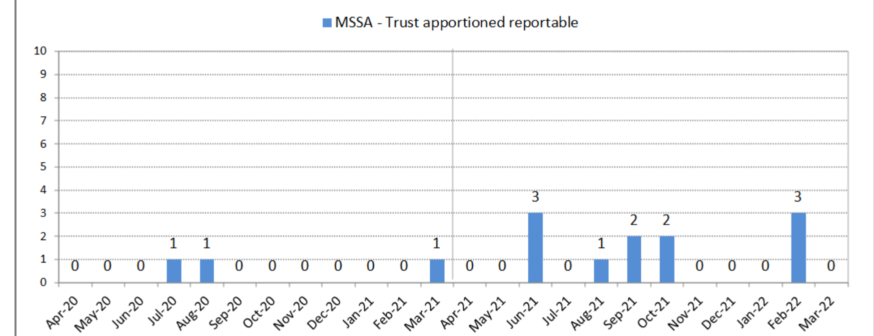
Data Quality Rating:

Are We Safe?

Clostridium Difficile	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
Cases Appealed	0	0	0	0	0	0	0	0	0	0
Successful Appeals	0	0	0	0	0	0	0	0	0	0

MRSA	2020-21	2021-22
Trust Apportioned	3	0





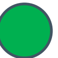
Summary

- MRSA bacteraemia = zero hospital onset cases.
- MSSA bacteraemia = 3 hospital onset cases, with samples sent for patients on Longford Ward, Odstock Ward and Redlynch Ward (unrelated cases)
  - Longford Ward – source assessed as skin/soft tissue related (certain)
  - Odstock Ward – source assessed as line related (probably)
  - Redlynch Ward – source assessed as endocarditis (possibly)
- E.coli bacteraemia = 3 hospital onset cases (unrelated cases)
  - 2 cases were related to lower urinary tract (Longford Ward and Durrington Ward)
  - 1 case related to lower respiratory tract (Spire Ward)
- C.difficile – healthcare associated cases reportable to UKSHA (formerly PHE)
  - Hospital onset; healthcare associated reportable cases = 3 (where samples sent for inpatients on Radnor Ward, AMU and Spire Ward – unrelated cases).
  - Community onset; healthcare associated reportable cases = 2 (1 sample sent for a patient readmitted to Sarum Ward, and 1 was a GP sample – both patients had an inpatient stay at SFT within the previous 4 weeks).

Pressure Ulcers

Are We Safe?

Per 1000 Bed Days	2020-21 Q3	2020-21 Q4	2021-22 Q1	2021-22 Q2	2021-22 Q3
Pressure Ulcers	2.10	2.21	1.47	1.30	1.84

Data Quality Rating: 

Summary and Action

There have been 23 Category 2 PUs in February. This figure is the same as January. Medicine continue to contribute to the majority of this number, with 16 acquired within Medicine, 8 in Surgery and 1 within Women and Newborn Services. None of these PUs were device related. Cat 2 PUs continue to be found most commonly on buttocks/sacrum or heels. Evidence continues to be shown of the use of pressure relieving devices (air mattresses and orthotic boots) however this remains sporadic and there continue to be delays, at times, in the use of pressure relieving devices. This delay is likely due to operational pressures and staffing shortages as well as problems obtaining the devices out of hours (orthotic boots). We continue to push their use as a preventative measure for high risk patients. All ward areas with multiple PUs acquired will present their learning at Share and Learn where any specific themes or actions for these ward areas will be identified. Wards with multiple PUs are also discussed at the weekly Matron and T.V meeting where high PU figures can be discussed and actions identified to reduce further PU occurrence.

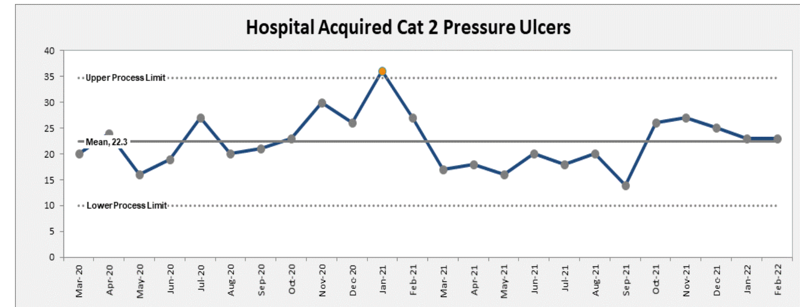
One Category 3 PU was identified in February within the medical division- this was externally reported by community nursing team and not reported during patient's admission. A 72hr report has been completed which identified lapses in care and documentation and will be discussed at the weekly patient safety summit meeting.

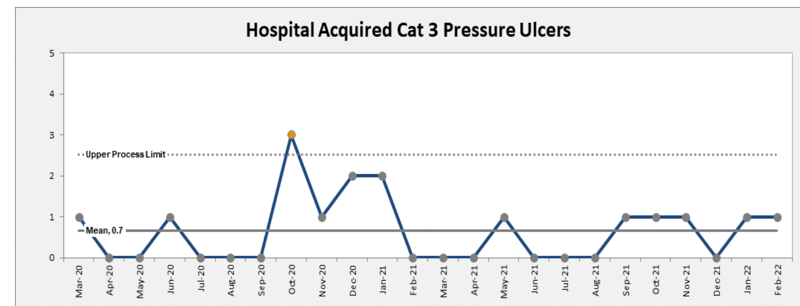
One category 4 PU was identified in February within the medical division. 72 hour report has been completed and this case will be discussed at the weekly patient safety summit meeting. It is likely that this area was present on admission but missed on skin inspections due to atypical placement of PU and patient's complex medical history causing problems with monitoring and adequate pressure relief. Decision around further investigation of the causation of this PU will be made at the weekly meeting.

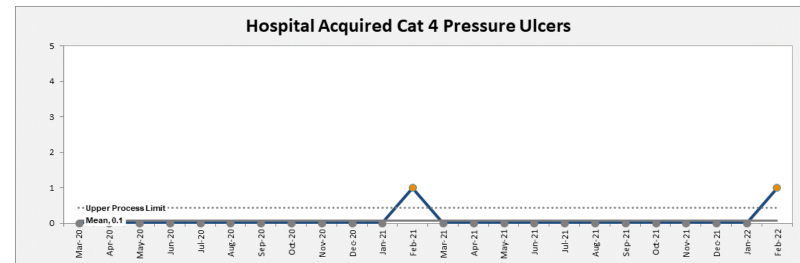
5 Deep Tissue Injuries were identified in February; this is a significant decrease from 11 in January. DTI's continue to be most commonly found on heels and the lack of orthotic boot use is a repeated theme. We continue to remind and encourage the use of pressure relieving boots or strict elevation of the heels, alongside regular monitoring of skin. As in December and January, it is likely that there were missed opportunities for early identification of vulnerable areas due to staff shortages and missed education opportunities.

One unstageable PU was identified in February; this was likely to be superficial skin damage once treated. Patient now deceased therefore we are unable to reassess and downgrade this PU appropriately.

Pressure Ulcer Prevention education continues to have poor uptake. We continue to promote and encourage attendance and offer these education sessions twice a month via MS teams. Pressure Ulcer Prevention education remains a non-mandatory education subject. All categories of PU continue to be discussed at the weekly Matron huddle meeting (as operational pressures allow) and key learning identified at the monthly Share and Learn meeting from ward RCA investigations. Causes for the hospital acquired PUs will be discussed, noting the significant operational pressures and staffing problems across both divisions, as well as the increased acuity of patients admitted into the trust. February Share and Learn meeting did not take place due to hospital operational pressures. Share and Learn meeting has not taken place since October 2021 so there has been no ward or division specific themes or actions identified. March meeting to discuss February figures will take place on 16th March.







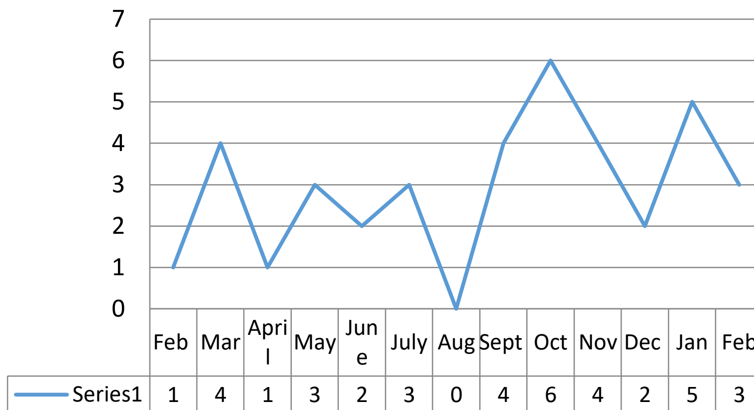
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

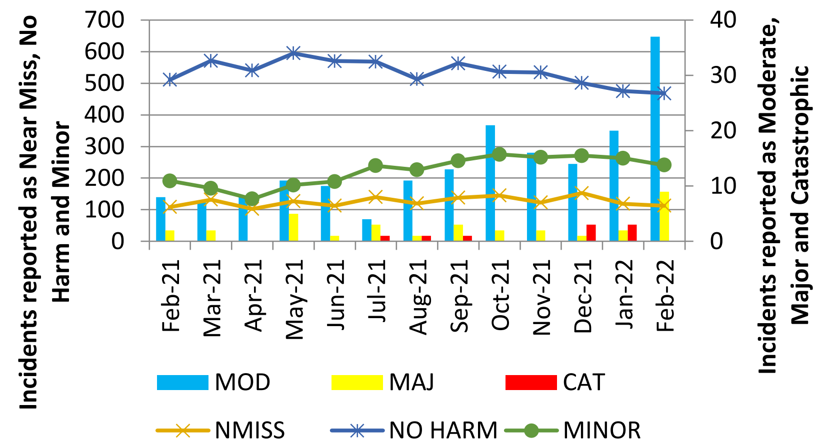
Incidents

Are We Safe?

Year	2020-21	2021-22
Never Events	0	3

Data Quality Rating:





Summary:

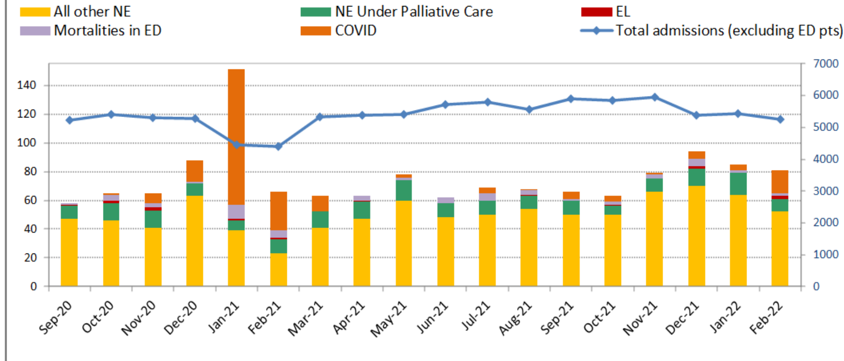
There were 3 SIIs commissioned in February (no never events):

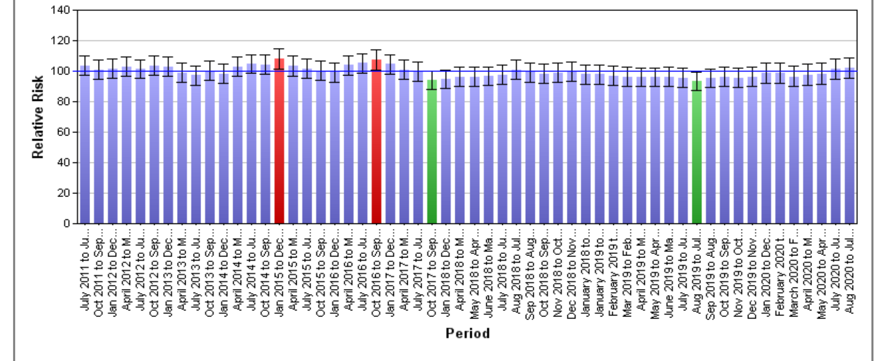
- SII 463 - Inappropriate discharge from ED (RIP)
- SII 464 - Gastro intestinal bleed (RIP)
- SII467 - Incorrect outpatient appointments (ophthalmology)

Mortality Indicators

Data Quality Rating:

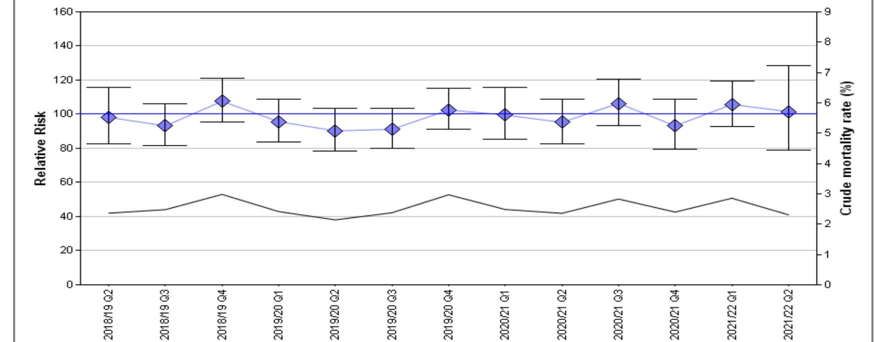
Are We Safe?

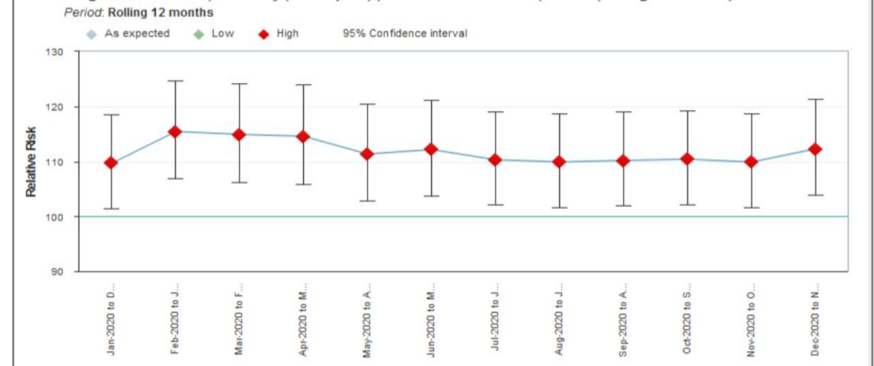




Summary and Action

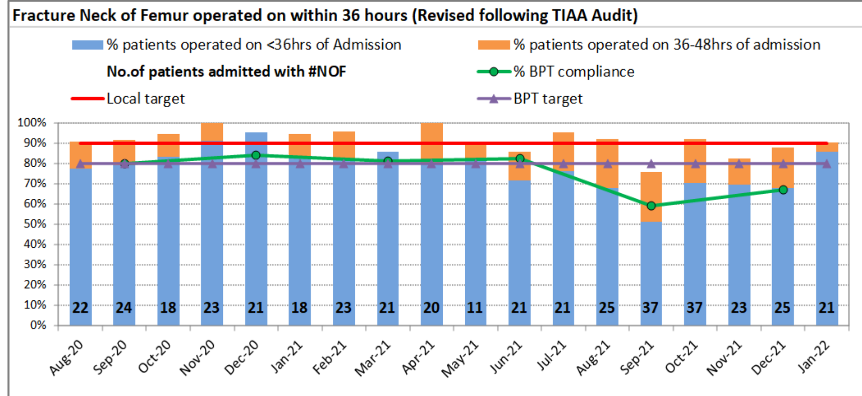
- There were 17 COVID deaths reported in February
- The latest SHMI for Salisbury District Hospital (as published by NHS Digital) for the 12-month rolling period of November 2020 – October 2021 is **1.0269**. This is within the expected range.
- The latest HSMR for the 12-month rolling period of December 2020 – November 2021 is **112.3**. This is statistically higher than expected. The latest data has shown an increase in the relative risk figures, and this follows some changes in how the data is being reported by our mortality partners at Telstra UK. The HSMR remains within the expected range when COVID deaths are excluded.





Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?



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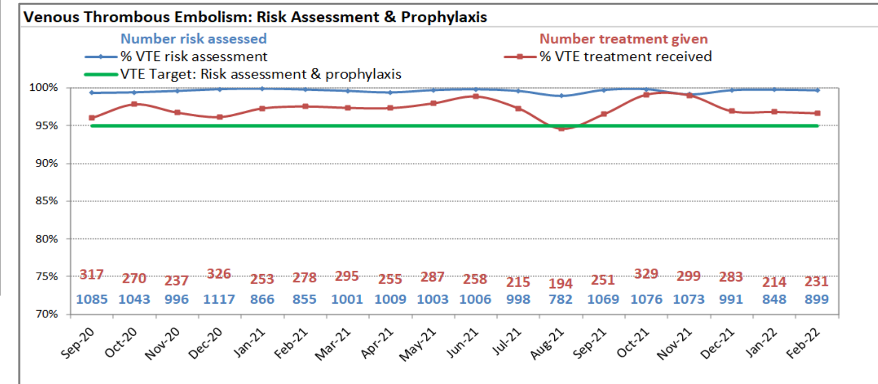


(Please note: due to the time it takes to complete clinical coding, the fracture neck of femur data for the current month may not be displayed on the graph above)

BPT%: February 2022

- Total patients discharged: 35
- Not applicable for BPT: 7 (6 PP# & 1 no operation)
- Number of patients who failed to meet BPT: 6

Reason for failure:

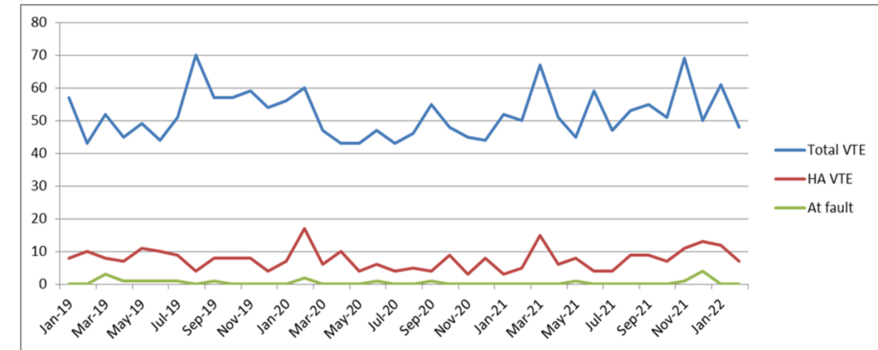
- Awaiting Theatre Space: 5 patients
- Other (Unknown): 1 patient

BPT %: 78.57% **Average LOS**: 21.26 days

Root cause analysis for a recent patient is below:

Patient admitted on a Wednesday at 11:07 with a BPT breach time of Thursday at 23:07. Patient went to theatre on the Friday at 08:45. Time to theatre was 45.63 hours. The theatre activity on the Thursday was the following:

Trauma list – 2 cases (Femoral nail & Revision TKR)
Elective list – 2 cases (Hip arthroscopy & THR)

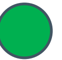


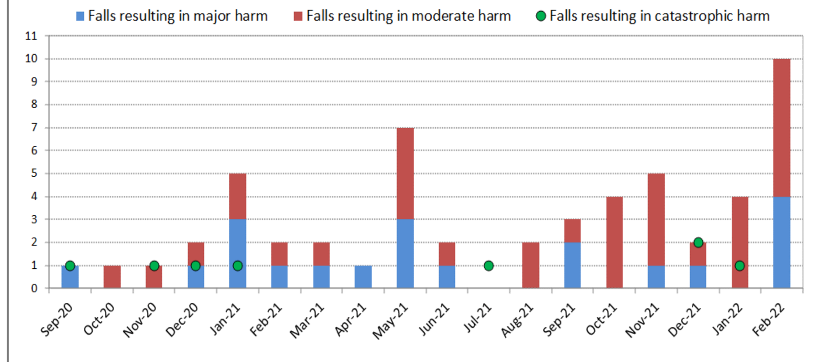
Hospital Associated VTE

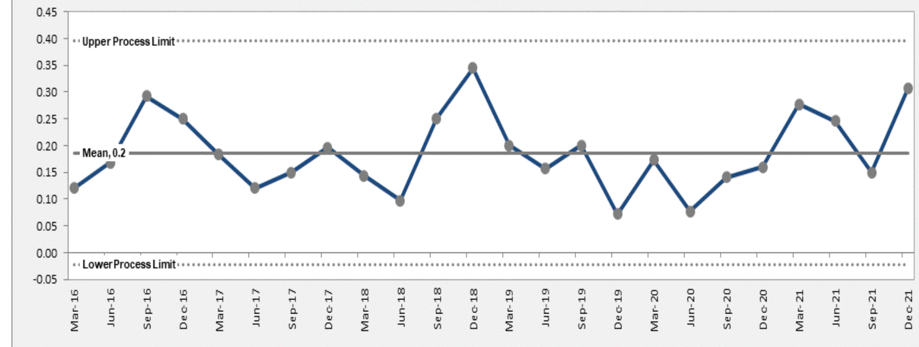
- Total number of VTE in February 2022: 48
- Hospital Acquired (HA) VTE: 7 (14.5% - National average 25%)
- 0.11 % of total admissions (National average 0.5 – 1.6%)
- All patients diagnosed with a VTE are assessed and flagged as HA if associated with a hospital admission / surgery within 90 days of their diagnosis and a root cause analysis is completed.
- All VTE events in February developed a VTE despite having a VTE risk assessment and being provided with appropriate VTE prophylaxis.

Patient Falls

Are We Safe?

Data Quality Rating: 





Summary and Action

There were 6 falls graded as 'moderate' in February – A dislocated shoulder, fractured occipital bone with large laceration, sub arachnoid haemorrhage, fractured distal radius, a rotator cuff tear (causing disability), and an unstable cervical spine fracture.

There were 4 falls graded as 'major' in February – 3 Fractured neck of femurs and 1 fractured neck of femur with a sub arachnoid haemorrhage

BUSINESS AS USUAL:

- Post fall review by specialist nurse for patients who fall
- SWARMs presented weekly to the patient safety summit meeting
- Weekly written reports for all falls shared with divisional matrons for dissemination and learning from themes within the ward teams
- Training programme at ward level

Other Improvement Work:

- Quarterly reporting on progress with actions from the falls reduction action plan incorporating the falls strategy
- Improving Together attendance has commenced with falls reduction being a breakthrough objective.

Statistical Process Control Chart Key:
- Target
- Mean
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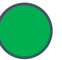
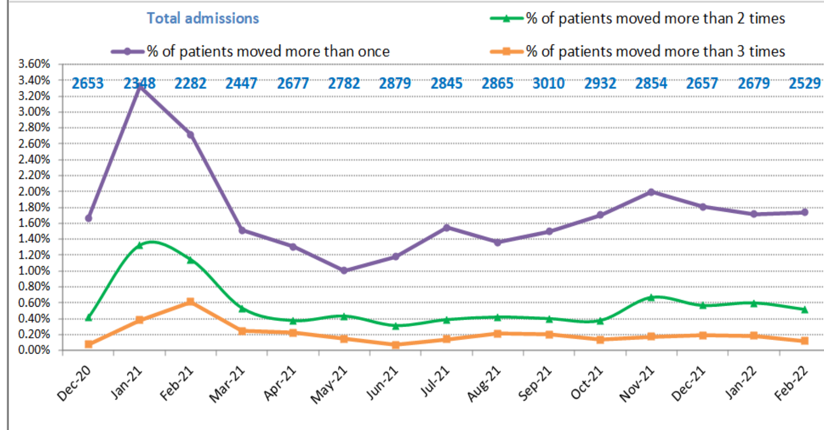
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

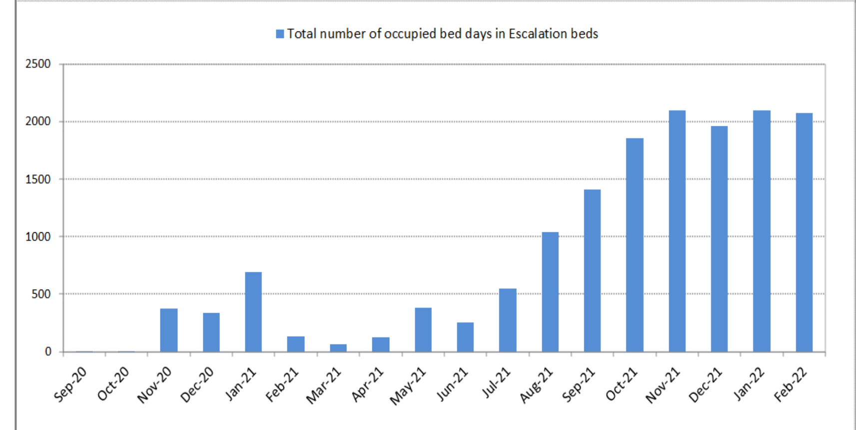
Patient Experience

Are We Safe?

Last 12 months	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
Bed Occupancy %	87.6	90.8	91.2	90.8	90.0	93.9	93.0	94.6	95.0	93.2	93.8	96.3

Data Quality Rating: 





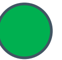
Summary and Action

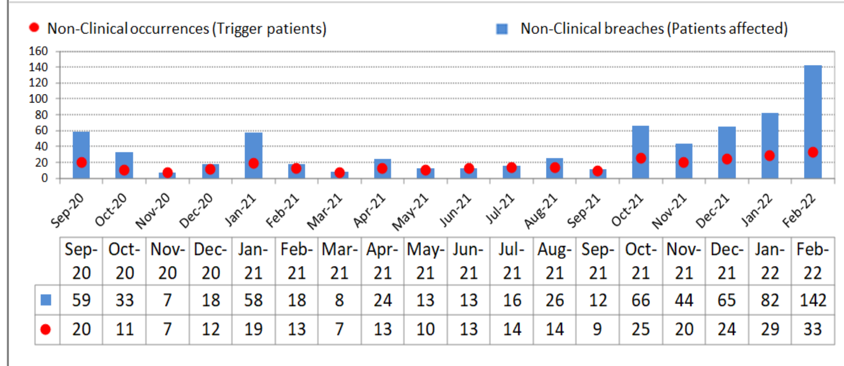
The Trust remains in a sustained position of escalation that has influenced the continuation of both elevated levels of patient moves and occupied days in escalation beds. It remains a priority for all clinical teams for patients to be in the right place for the required care to be delivered in the safest environment possible and this indicates the need for patient moves in a hospital experiencing a significantly high occupation rate.

COVID and COVID contact isolation requirements mean that additional pressure to access the right care at the right time for patients is placed on teams when considering patient placement. Flow into community and social services has been slow, indicating the need to maintain escalation beds for those people not requiring the higher dependency care delivered in base wards.

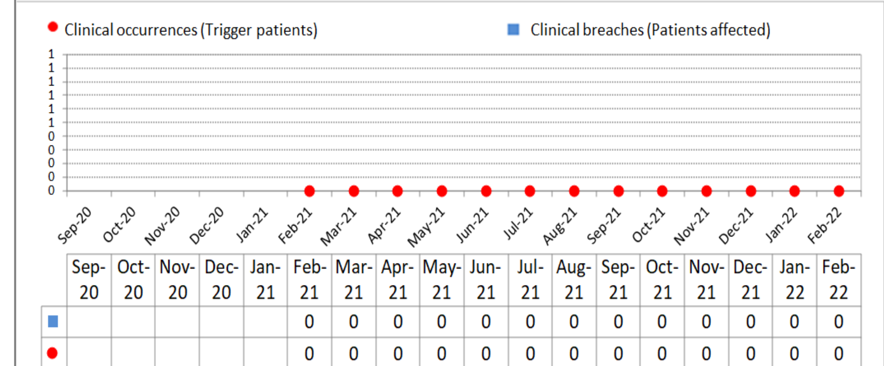
Patient Experience

Are We Safe?

Data Quality Rating: 



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Non-Clinical breaches (Patients affected)	59	33	7	18	58	18	8	24	13	13	16	26	12	66	44	65	82	142
Non-Clinical occurrences (Trigger patients)	20	11	7	12	19	13	7	13	10	13	14	14	9	25	20	24	29	33



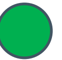
	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Clinical breaches (Patients affected)						0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical occurrences (Trigger patients)						0	0	0	0	0	0	0	0	0	0	0	0	0

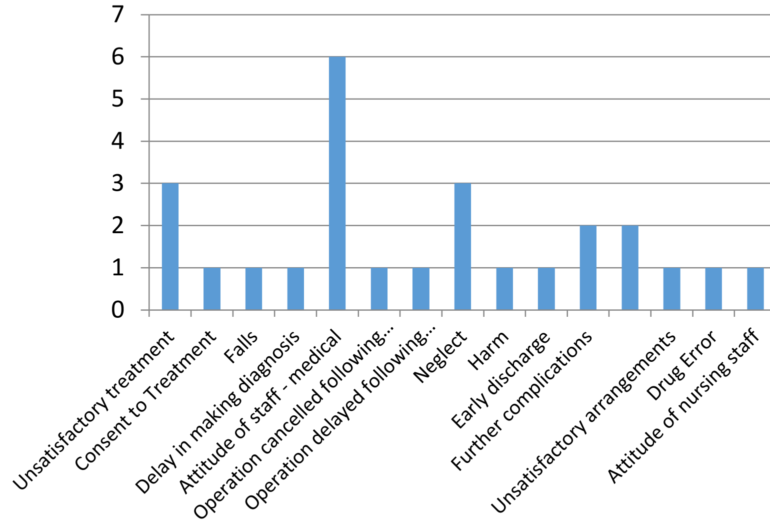
Summary and Action

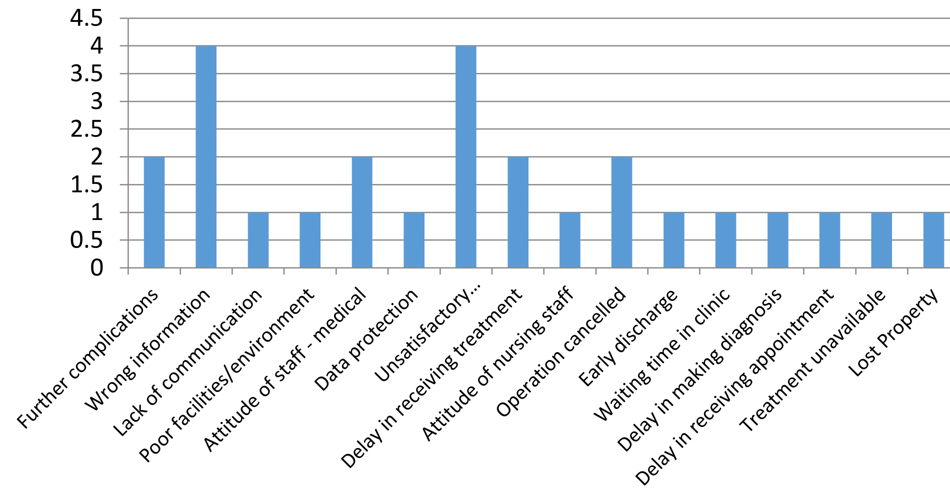
- There were 12 breaches affecting 12 patients which occurred on Radnor. These were all patients who were unable to be moved off the department within 4 hours of being declared fit to move.
  - 5 breaches were resolved within 24 hrs
  - There were 7 patients who had a breach time of over 1 day while awaiting a speciality bed
  - Privacy and dignity was maintained at all times within the patients bed space
- There were 17 breaches affecting 109 patients on AMU assessment bay. All patients had access to single sex bathrooms within the ward and screens were used to maintain privacy and dignity.
  - 13 of the breaches were resolved within 24 hours
  - The remaining 4 were resolved within 48 hours
- There was 1 breach on AMU bay 1 affecting 5 patients. Privacy and dignity was maintained at all times within the patients bed space. The breach lasted for 7 days due to Covid isolation policy.
- There was 1 breach on Pitton ward affecting 7 patients. Privacy and dignity was maintained at all times within the patients bed space. The breach lasted for 7 days due to Covid isolation policy.
- There was 1 breach on Laverstock ward affecting 8 patients. Privacy and dignity was maintained at all times within the patients bed space. The breach lasted for 8 days due to Covid isolation policy.
- There was 1 breach on Chilmark ward affecting 3 patients. Privacy and dignity was maintained at all times within the patients bed space. The breach was resolved within 24hrs.

Patient & Visitor Feedback: Complaints, Concerns & Compliments

Are We Responsive?

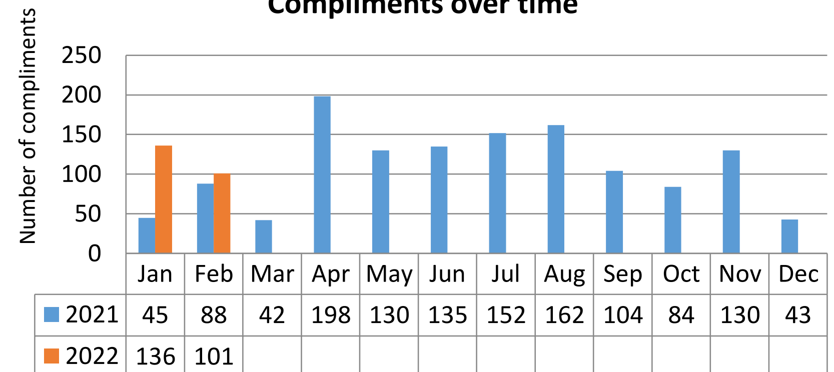
Data Quality Rating: 





Summary and Action

- Compliments in February were higher than for the same month last year and far outweigh the number of complaints for the same month.
- The biggest cause of complaints is attitude of medical staff. This is currently under review by the Chief Medical Officer.
- The main concerns for February are shared equally between wrong information being given and unsatisfactory treatment and outcome.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	45	88	42	198	130	135	152	162	104	84	130	43
2022	136	101										

NHS
Salisbury
NHS Foundation Trust

Part 3: Our People

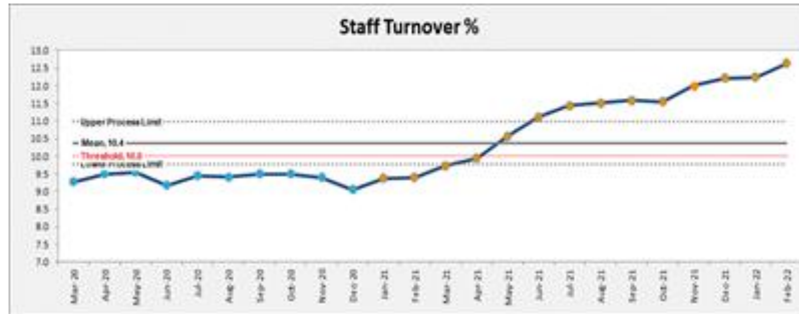
Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Workforce – Turnover

Use of Resources

Total Workforce vs Budgeted Plan - WTEs



Background – What is the data telling us, and underlying issues.

12 month turnover for month 11 is 12.64%. This was an increase from last month's position which was 12.24%. There were 43 leavers and 35 starters by headcount in month. The most common reason, where recorded, for leaving was "Relocation" 21% of all reasons for leaving.

BSW Benchmarking Nov 2021 - RUH Bath : 9.61%, GWH Swindon 14.32%

Corporate had the highest turnover (14.15%), the only Division whose turnover was under 10% was Women and Newborn (9.36%).

Improvement actions planned, timescales and when improvements will be seen.

In the last month 25% of staff leaving (11 people) completed the exit questionnaire they received from ESR. Thematic analysis and insights to inform proactive stay interventions.

Focus on improving retention to include scheduling early/mid/late career conversations - in complement to " stay". Priority staff groups and schedules to be agreed with each Division.

Since our update last month work is underway to relaunch this processes with communications to managers and staff around both exit interviews and stay/ career conversations.

Risks to delivery and mitigation

Operational pressures / care to patients will always take priority

HR BP availability .

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

Feb 22	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	443.4	467.1	(23.7)
Nursing	1,030.8	1,104.9	(74.1)
HCAs	540.7	544.4	(3.6)
Other Clinical Staff	632.1	680.5	(48.3)
Infrastructure staff	1,266.4	1,368.5	(102.1)
TOTAL	**3,913.4**	**4,165.3**	**(251.9)**

Background – What is the data telling us, and underlying issues.

Vacancy rate in month 11 (February) was 3.44%, compared to 3.65% in January. The Division with the highest vacancy rate was Medicine at 6.09%.

A brief overview of the statistics tells us: of the 124 staff who have left medicine in the last year: 26 (21%) chose to relocate elsewhere, 23 (19%) left with no reason given, 22 (18%) left due to work life balance, 16 (13%) took retirement due to age and 8 (6%) left due to health reasons.

BSW benchmarking Nov 2021 – RUH Bath : 4.75%, GWH Swindon 6.55% (Dec 21)

Improvement actions planned, timescales and when improvements will be seen.

Business case presented to Trust Investment Group (TIG) to recruit 40 international nurses during 2022/23. Pending authorisation by Trust Management Committee (TMC) in month 12, 2022.

Student virtual recruitment event held on 17.02 (supported by CE, CPO and RM's). A total of 21 attended via teams. Positions have been advertised and interviews are scheduled to be held mid March. A full review is being undertaken of the event including follow up with students. 2nd event booked for 1 December. Preparation for event to commence mid-Sept.

IR Midwives – during month 11, 4 interviews held, with 1 offer made for GWH allocation. Further interviews planned for month 12 – 8 to date provisionally planned.

BSW RN International Recruitment Collaborative – agencies have been appointed to support recruitment across BSW.

3rd recruitment event confirmed for Facilities and Estates to be held in the Guildhall on 08.04.

A hard to recruit post of a Consultant Geriatrician care appointed to in month.

2nd recruitment campaign for Heath Care Assistants (HCS) completed - 10 offers made. 3rd round of recruitment to commence with changes being made to how applicants can apply further to applicant feedback.

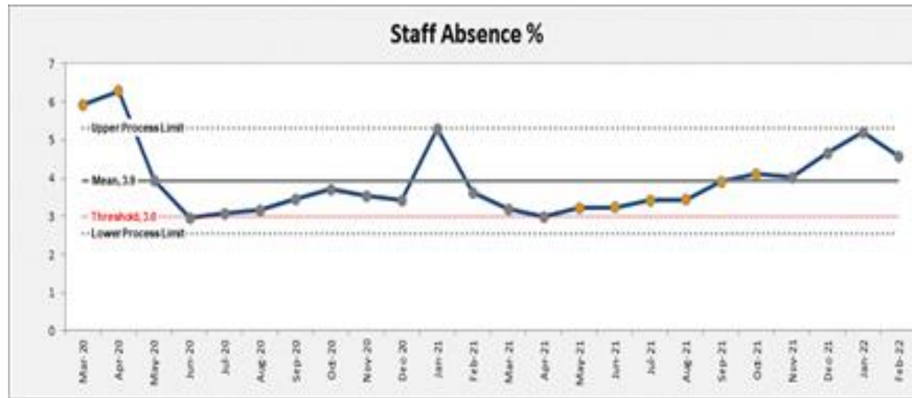
Contractor identified to work with the Trust to overhaul recruitment and promotional practices to ensure greater efficiency, equity and fairness in the process. Kick off meeting scheduled to be held in month 12.

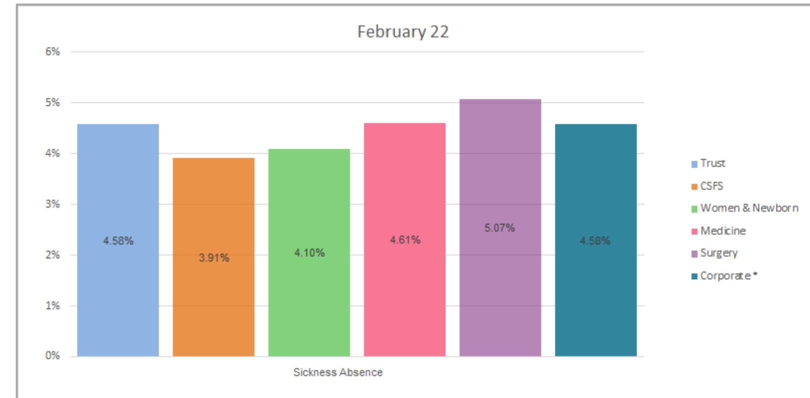
Risks to delivery and mitigation.

National professional shortages

Workforce - Sickness

Use of Resources





Background – What is the data telling us, and underlying issues.

Sickness in month 11 saw a decrease to 4.58%, sickness for the rolling year was at 3.92%. All Divisions are above the Trust target of 3%. For the month of February, "Infectious Diseases" was the top cause of sickness across all Divisions.

BSW Benchmarking data for Nov 2021: RUH Bath 5.63%, GWH Swindon : 5.29%

Improvement actions planned, timescales and when improvements will be seen.

In month 32 staff were contacted as wellbeing phone calls, of these:

- Return to work agreed (will be back within next month) – 1
- Return to work arrangements being made – 8
- Already returned to work – 2
- Pending OH referral – 1
- Ill health retirement in progress – 3
- Waiting for treatment – 1
- Undergoing/recovering from treatment – 12.

Wellbeing calls are set to continue in March

In month 78 staff were in a formal short term sickness process and 62 a long term sickness process.

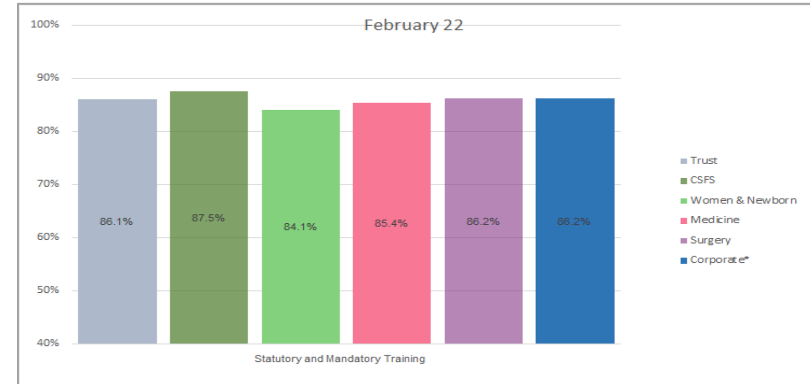
These supportive calls have prompted and enabled staff to revisit their actions/ decisions about their future health care and employment. With 3 staff deciding to take ill health retirement and a number of staff reaching stage 4 review meetings.

From April we will re-introduce sickness absence training for line managers to ensure they are aware of how to effectively support staff in the process.

Risks to delivery and mitigation.

Workforce – Staff Training

Use of Resources



Background – what is the data telling us, and underlying issues.

The Trust's mandatory training compliance rate was 86.06% for month 11. This is slightly below the previous month and below the same time last year. All 5 Divisions are below target.

BSW Benchmarking Dec 2021 - RUH Bath : 83.60%, GWH Swindon 88.85%

The poorest performing subjects are Life Support and Hand Hygiene and the staff groups with the poorest compliance are Nursing and Medical staff.

Limited take up with Hand hygiene focus fortnight- limited staff were available to carry out departmental assessments, but it also fell at a time where staffing was significantly worse than it had been.

Improvement actions planned, timescales and when improvements will be seen.

Data regarding staff group compliance and non-attendance at Life Support training to be taken to Exec Performance Reviews.

Changes have been recommended to content and frequency of training to ensure we are aligned with Corse Skills Training Framework- the planned implementation of these changes, if approved, will commence in April 2022 and will be completed by Jan 2023.

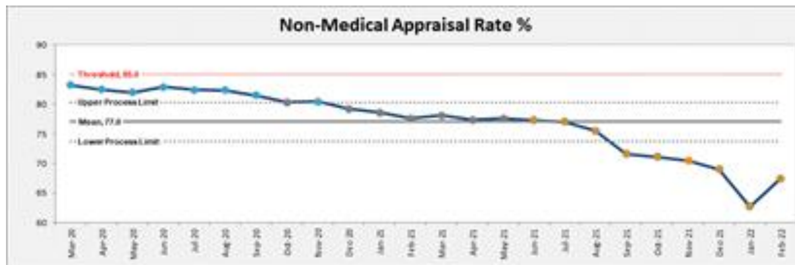
Administration support will review data accuracy and a full review of end to end process including allocation and maintaining cores skills training to be completed in month 12.

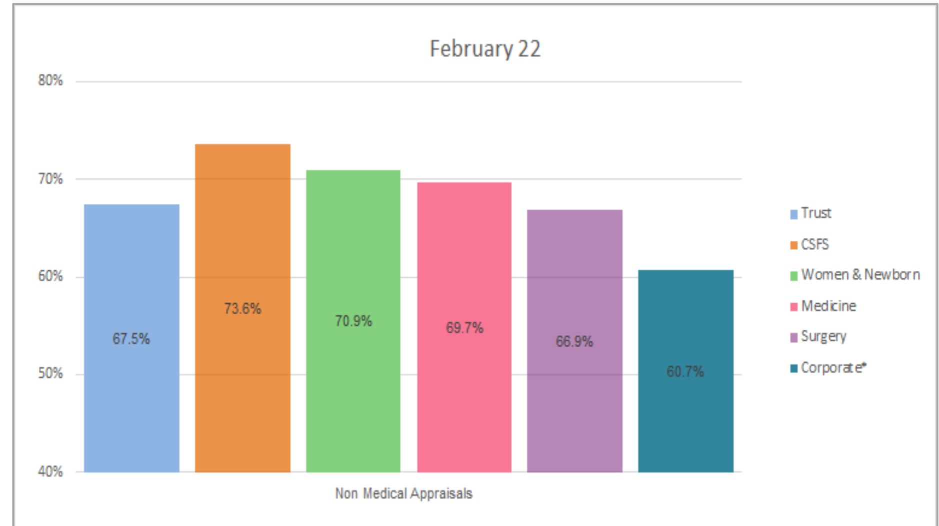
Risks to delivery and mitigation.

Changes required to ensure alignment with CSTF will result in an decrease in compliance due to changes to reporting. Suggested mitigation is to provide separate reports on key subjects to provide transparency of progress alongside current reporting scheme.

Workforce – Appraisals

Use of Resources





Background – What is the data telling us, and underlying issues.

Non Medical Appraisals for month 11 remain under target at 67.5%, this is an increase on the previous month position (62.7%). Hotspot areas are Corporate (60.7%) and CSFS (73.6%)

BSW Benchmarking - RUH Bath : 61.9% (Nov 21), GWH Swindon 74.17% (Dec 21)

Improvement actions planned, timescales and when improvements will be seen.

All DMTs are putting in place recovery action plans for appraisals to schedule all overdue.

DMTs have been provided with the number of outstanding appraisals by individual line managers to help identify how they may be best supported and have time and capacity to complete these within a reasonable timescale.

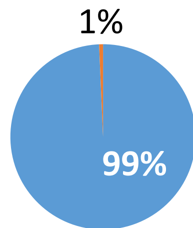
Risks to delivery and mitigation.

Management time from operational pressures to undertake the appraisals. To mitigate the DMTs will support managers with this.

Feedback from Friends and Family test - January 2022

Are We Responsive?

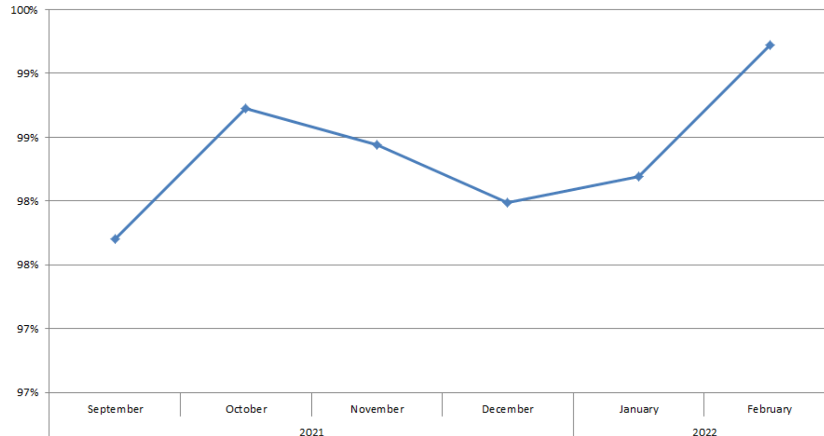
What was good about your experience?



“I have been extremely well looked after. Thank you so much, including the catering staff. To receive this level of care when all branches of the hospital are suffering from staff shortages is much appreciated” *Tisbury*

“I was very scared due to pain but the nurse was very gentle and answered all my questions. Also explained what was about to happen which made it better for me to cope with” *Vascular and Diabetes*

“Improve communications with consultants, More time to listen to patient's concerns”



“Appointment was 10am, didn't get taken through until gone 11 and no explanation given. Tell the patient reason for delay! I wasn't told or apologised to”

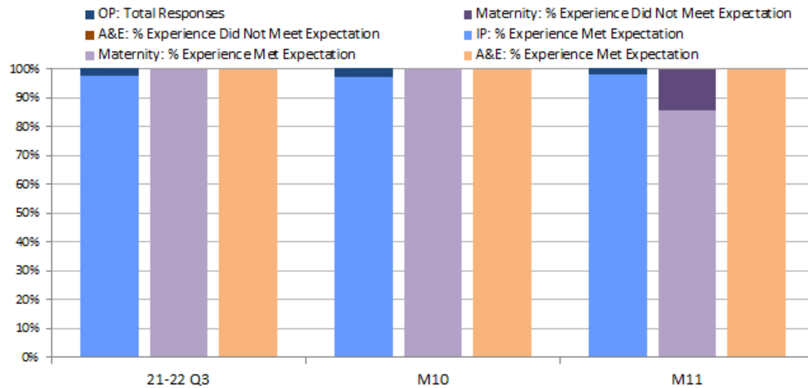
“Fantastic professional care from ultra-sonographer, Immediately put me at ease and explained clearly and in a caring manner, what was going on. Very impressed” *Gynaecology*

“Not having much sleep due to another patient. Ear defenders would of helped me get some sleep”

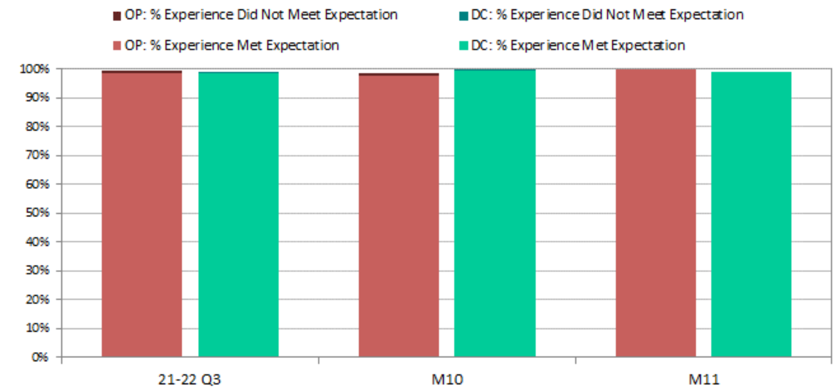
Friends and Family Test – Patients and Staff

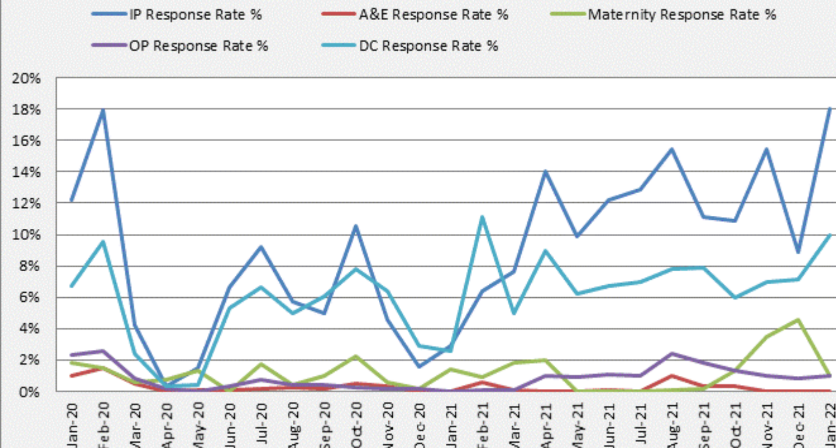
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





Summary:

- Britford ward received feedback from over 50% of patients in February
- Pembroke ward received feedback from almost 40% of patients
- Over 99% of patients reported their experience as very good or good
- Only 2.3% of eligible patients are currently giving feedback
- Only half of wards had feedback submitted in February

NHS Salisbury NHS Foundation Trust

Part 4: Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

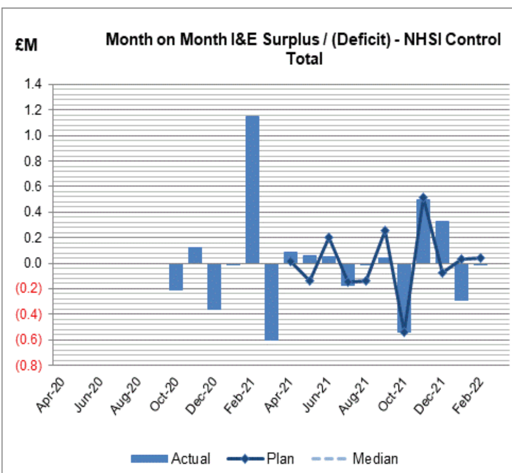
Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	Feb '22 In Mth				Feb '22 YTD				2021/22
	Plan £000s	Actual £000s	Variance £000s		Plan £000s	Actual £000s	Variance £000s		Plan £000s
Operating Income									
NHS Clinical Income	20,691	22,179	1,488		227,597	237,910	10,313		248,288
Other Clinical Income	1,251	798	(453)		14,581	8,351	(6,230)		15,832
Other Income (excl Donations)	3,165	4,226	1,061		32,500	33,085	585		35,658
Total income	**25,107**	**27,203**	**2,096**		**274,678**	**279,346**	**4,668**		**299,778**
Operating Expenditure									
Pay	(15,858)	(16,655)	(797)		(171,224)	(173,523)	(2,299)		(187,141)
Non Pay	(7,526)	(9,011)	(1,485)		(85,794)	(88,734)	(2,940)		(93,280)
Total Expenditure	**(23,384)**	**(25,666)**	**(2,282)**		**(257,018)**	**(262,258)**	**(5,240)**		**(280,421)**
EBITDA	**1,723**	**1,537**	**(186)**		**17,660**	**17,088**	**(572)**		**19,357**
Financing Costs (incl Depreciation)	(1,678)	(1,544)	134		(17,636)	(17,060)	576		(19,313)
NHSI Control Total	**45**	**(7)**	**(52)**		**24**	**27**	**3**		**44**
Add: impact of donated assets	*(50)*	*(7)*	*43*		*(463)*	*(557)*	*(94)*		*(511)*
Surplus/(Deficit)	***(5)***	***(14)***	***(9)***		***(439)***	***(529)***	***(90)***		**(467)**



Variation and Action

The Trust is confident of meeting its final plan for H2 2021/22, agreed in mid-November. All additional revenue streams assumed have been confirmed, this revenue is made up of a combination of ERF, ERF+, and discretionary system allocation.

The Trust recorded a deficit of £7k in month 11, bringing the YTD position to a small surplus of £27k against the H2 plan. There are pay overspends across most staff groups, and there are significant overspends on non-pay around the increased cost of clinical supplies and in the category of other non-pay expenses.

The overall pay position continues to feel the pressure of high staff absence ,and the supernumerary costs of this year's planned intake of overseas nurses who have all arrived later than intended due to the international impact of Covid.

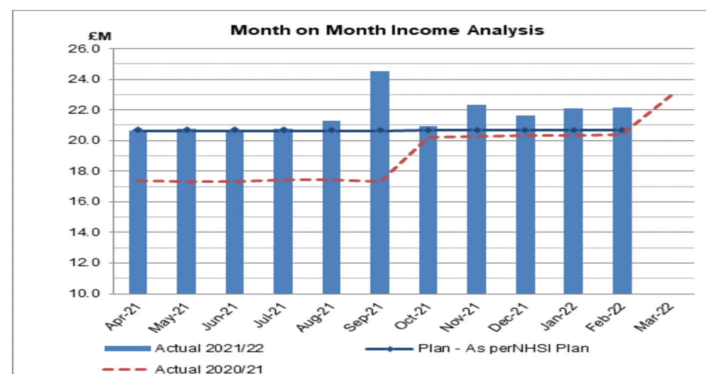
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	8,233	8,792	559
Day Case	13,793	14,851	1,058
Elective inpatients	12,261	9,045	(3,216)
Excluded Drugs & Devices (inc Lucentis)	19,051	19,347	296
Non Elective inpatients	57,519	59,348	1,829
Other	93,529	98,415	4,886
Outpatients	23,211	28,112	4,901
TOTAL	**227,597**	**237,911**	**10,313**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	139,583	147,191	7,608
Dorset CCG	22,887	23,227	340
Hampshire,Southampton & IOW CCG	17,224	17,481	257
Specialist Services	31,152	32,749	1,597
Other	16,751	17,263	511
TOTAL	**227,597**	**237,911**	**10,313**



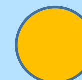
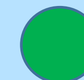
Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	62,723	62,164	(559)	47,130	15,034
Day case	18,144	18,779	635	13,366	5,413
Elective	3,375	2,561	(814)	1,933	628
Non Elective	25,689	25,664	(25)	23,079	2,585
Outpatients	212,539	244,415	31,876	195,659	48,756

Variation and Action

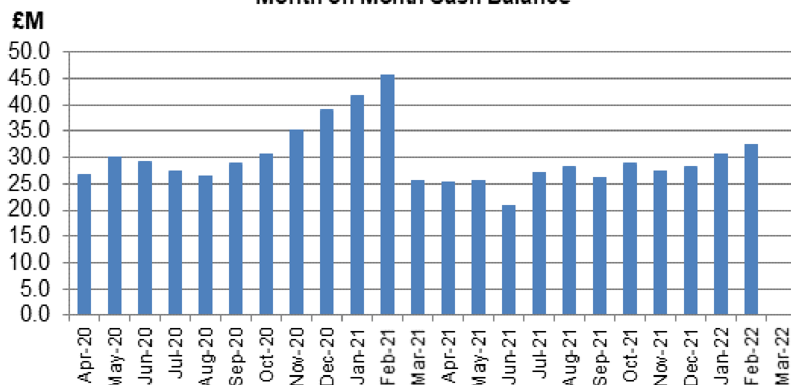
Activity in February in Day cases recorded 11 spells more than in January and exceeded the plan for the month by 48 cases. Day case activity remains above plan year to date and has improved this month in the specialties of Plastic Surgery (33 cases) , Urology (11 cases), and Rheumatology (20 cases) but activity levels have dipped this month in T&O/Spinal (37 cases). Activity in elective inpatients remains below plan and actual activity in February was higher than in January with improved performance in Plastic Surgery (10 cases). Non-Elective spells were higher than in January in the specialties of General Surgery (45 cases) and Cardiology (29 cases) but remain marginally below plan year to date. Activity pressures continue in Obstetrics and less spells were reported in Medicine. Outpatient activity decreased this month in most specialties as there were less working days. Activity levels in A&E remain below the plan year to date.

For the second 6 months of the financial year (H2) the block allocations from commissioners have been uplifted. The plans have not been adjusted and remain at H1 levels The .Elective Recovery Fund (ERF) income for the first 6 months of the financial year (H1) of £2.02m has been included in the financial position against BSW CCG. Additional H2 income from BSW CCG of £3,717k has been included in the position in February: this represents the value agreed as part of the final H2 planning process and included pro rata of an additional £700k.

Cash Position & Capital Programme

Capital Spend:  Cash & Working: 

Use of Resources

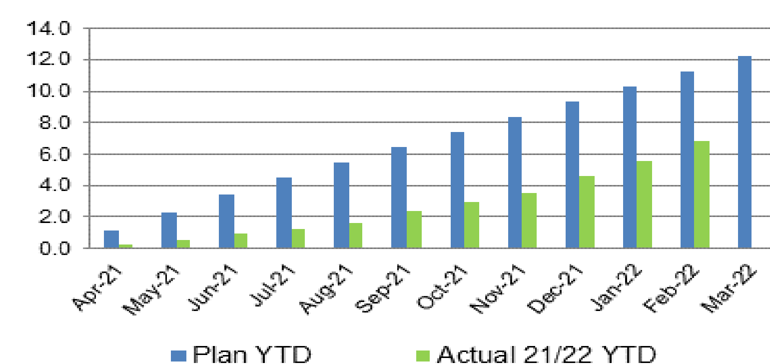


Creditors have risen since the year end partly due to the move to SBS which has resulted in taking longer to clear supplier invoices involving queries.

Purchase order related invoices have been delayed since mid-December where NHS SBS have been undertaking a 'stabilisation' process to clear invoice backlogs. These have now been cleared and invoices are moving into the internal SFT section of the approval process.

90+ days includes £300k on a single invoice submitted in advance which has been held prior to sign off of project completion.

Capital Expenditure Position				
	Annual	Feb '22YTD		
Schemes	Plan £000s	Plan £000s	Actual £000s	Variance £000s
Building schemes	1,175	1,128	1,302	(174)
Building projects	4,979	4,565	1,485	3,080
IM&T	3,872	3,553	2,301	1,252
Medical Equipment	1,728	1,606	1,251	355
Other	450	404	403	1
Additional Funds approved in year	3,668	0	108	(108)
TOTAL	**15,872**	**11,256**	**6,850**	**4,406**



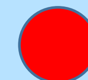
Summary and Action

2021/22 capital allocations have been made at a system level, and although the Trust's baseline allocation of £12.2m exceeds the initial 2019/20 allocation by c£3m, the Trust remains capital constrained based on an initial assessment of over £20m. The internal funding of a £12.2m capital plan is contingent on the Trust delivering a balanced revenue position in 2021/22, and a further £0.5m from the opening cash balance.

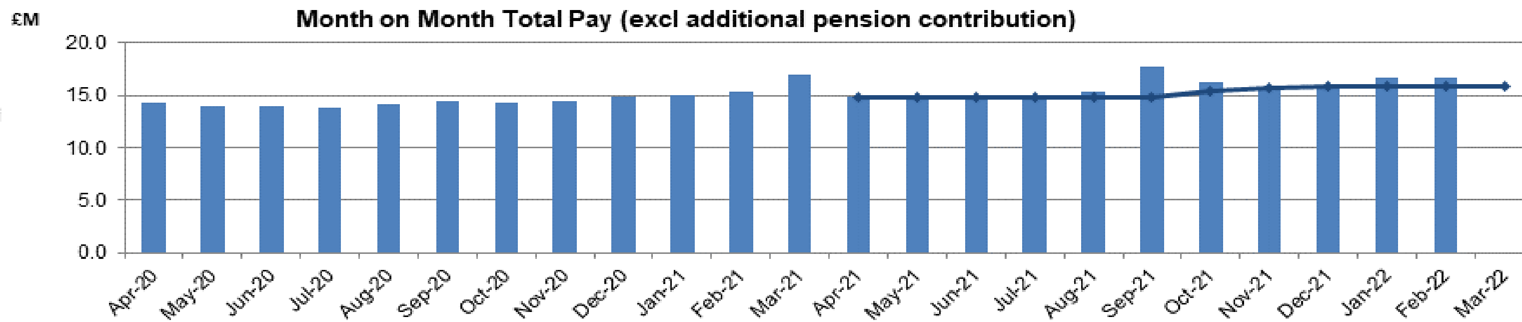
The original capital plan was based on a fairly even distribution of spend throughout the year. However, some building schemes have either been delayed or have been revised. A revised detailed profile plan of how all elements of the programme will be achieved by the end of the year has been developed. This will be challenging to achieve and further work is underway to identify the risks and issues associated with delivering this revised plan. Schemes to bring forward from 2022/23 have been identified to cover any potential slippage.

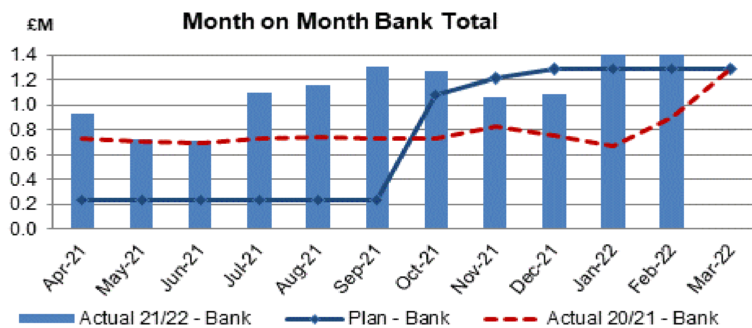
The trust has been notified that bids for additional capital, including through the Trust Investment Fund, totalling a further £3.6m, have been approved. Plans are underway to procure the equipment and works identified as part of these schemes, whilst continuing to ensure the remaining approved capital programme is delivered.

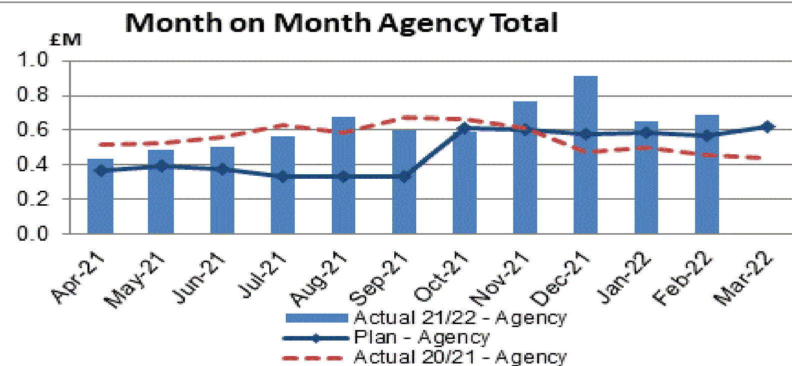
Workforce and Agency Spend

Pay: 

Use of Resources







Summary and Action

Pay costs remained broadly flat in month with a slight increase of only £4k between months 10 and 11. Expenditure on most staff groups fell in month, with the exception of Nursing, which saw a bank staffing incentive payment increase of £275k. Most of the increase in nursing expenditure can be accounted for in the Medicine division. Increased costs here continue to be driven by a number of issues including, last minute sickness , self isolation (children testing positive for Covid), vacancy levels (particularly band 5 nurses) and increased use of escalation.

The Trust has welcomed a further three overseas nursing recruits in February, bringing the total to 40 this year. The Trust is receiving funds to cover the costs of appointment, but supernumerary expenses in the first weeks are the Trust's responsibility: this equates to approximately £7.5k per recruit.

The Trust reported 13.7 WTE infrastructure support staff (cost £46k in month) over planned levels relating to the vaccination centre at Salisbury City Hall, where the plan is for staffing to be provided by RUH, but any staffing provided by SFT is considered 'out of envelope' and directly reimbursed through NHSEI. In addition, the TUPE of 50 procurement staff from RUH to form a single BSW team has been actioned in year.

CLASSIFICATION: UNRESTRICTED

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	3.1
Date of Meeting:	07 April 2022		

Report Title:	**Patient Experience Q3 Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Clinical Governance Committee – 22 February 2022			
Prepared by:	Deborah Stott, Head of PALS			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officer			
Appendices (list if applicable):				

Recommendation:
The Board to note the report.

Executive Summary:

This report provides a report of activity for Q3 2021/22 in relation to complaints and the opportunities for learning and service change.

- There has been a notable decrease in the percentage of complaint responses sent out within the agreed timeframe from 71% to 55%
- 42 complaints were received which is a complaint rate of 0.042%
- There are a significant number of complaints (19) that are significantly past their response time and are noted in section 2 (Overdue responses by division) The new PALS lead has identified some quick wins in reducing complaints times . It should be noted that the clinical pressures in the trust have been severe. The Trust with clinical teams is focused on providing safe care as a priority and this has impacted response times.
- The results from the urgent and emergency care 2020 survey and adult inpatient 2020 survey have been published by the CQC and full results can be found at Urgent and emergency care survey 2020 | Care Quality Commission (cqc.org.uk) and Adult inpatient survey 2020 | Care Quality Commission (cqc.org.uk)
- Unsatisfactory treatment is the main theme of complaints and concerns with attitude of medical staff showing a significant improvement from Q2.
- In Q3 we saw an increase in reopened complaints. In all cases complainants were unhappy with the response they had received.
- 98% of patients who completed their FFT questions in Q3 felt their experience was good or very good
- New NHS Complaint Standards have been published by the Ombudsman and will be introduced

across the NHS in 2022. Pilot sites have been asked to work with the Ombudsman to test the various aspects of the Standards and we have been accepted as an early adopter.

This report provides assurance that the Trust is responding and acting appropriately to patient feedback, however it is noted that responses sent in the correct timeframe is only 55%

Board Assurance Framework – Strategic Priorities	**Select as applicable**
Population: Improving the health and well-being of the population we serve	☐
Partnerships: Working through partnerships to transform and integrate our services	☐
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☐
Other (please describe) -	☐

Patient Experience Report - Quarter 3

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints from patients and demonstrate that learning and actions are taken to improve services in response to feedback.

To provide assurance of patient and public involvement in service co-design and improvement.

Background

Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care.”[1] Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative, including learning from feedback, transparency and honesty when healthcare goes wrong. This report provides some evidence of the patient experience feedback and activities in relation to self-improvement based on that feedback.

Making a complaint takes courage. Patients fear that speaking up could affect their care, but we are clear that this is not the case and welcome complaints as a means to improve our services.

The Trust takes concerns and complaints seriously. They are an important opportunity for us to learn and improve. Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where complaints are welcomed and learnt from.

1. Sharing Outstanding Excellence (SOX)

There is growing awareness nationwide that since complaints are a small minority compared to other PALS feedback, learning from what goes well in a Trust is as important as learning from complaints. In this Trust, a positive report is known as a SOX. The corporate governance team review all the SOX nominations and choose a selection to go forward to the Trust Board where recipients receive a certificate. This process is currently under review.

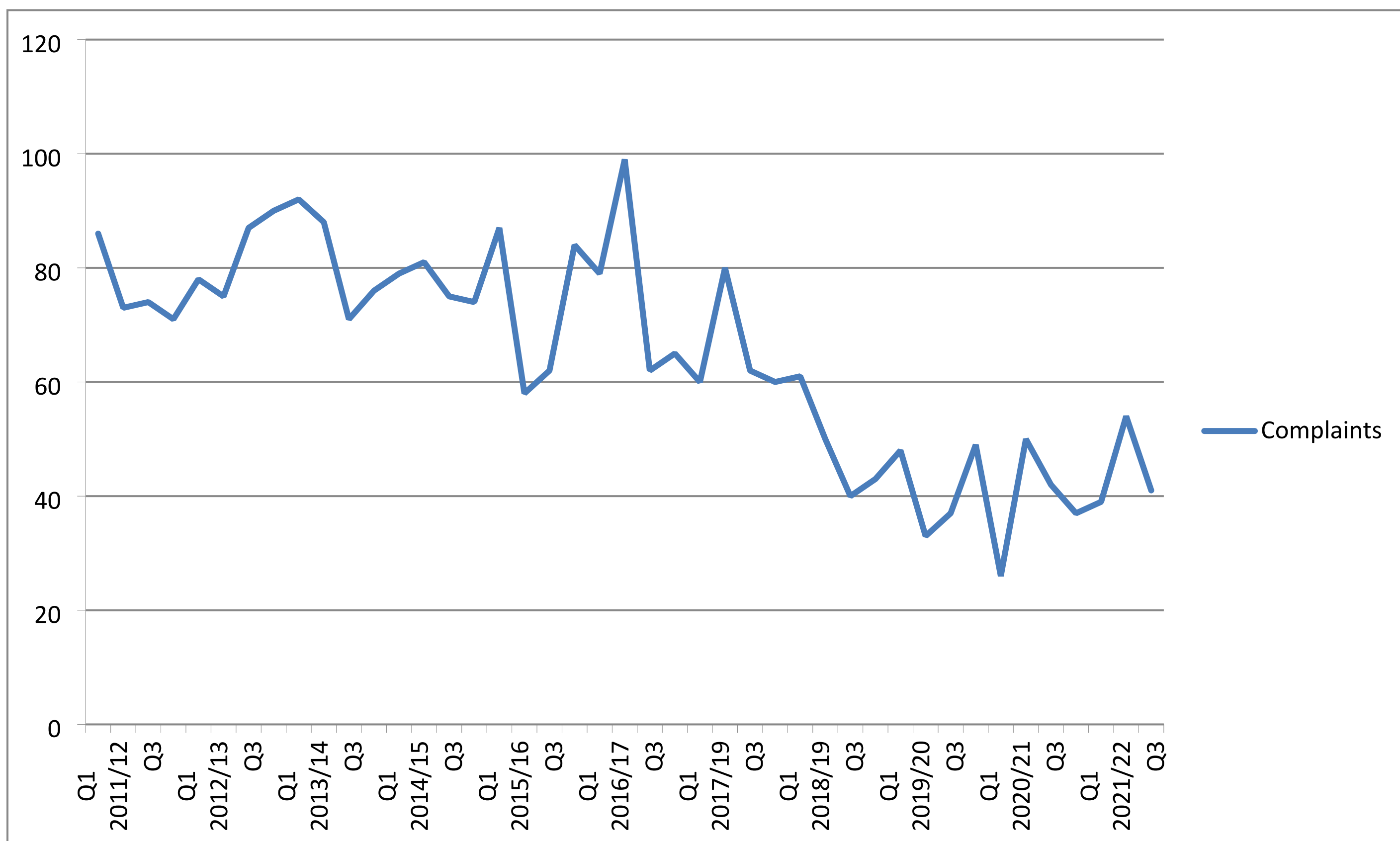
Increasingly we are seeing patients use the email address to give unsolicited feedback. For example:

- Went above and beyond to help a family try and get information on patient’s diagnosis which has devastated them all. She stayed three hours past her shift end time to try and get information for the family and to reassure them the patient is receiving the appropriate care.
- I would just like to say a huge thank you to the Audiology and ENT teams at Salisbury. Since I lost my hearing one side overnight they have been absolutely brilliant. Their professionalism, support and reassurance has been second to none! I have had a few issues with my good ear, which they have dealt with promptly. They truly understand how worrying things can be at a time like that. They welcome you with a smile and make you feel completely comfortable. A superb service from a superb team of people!

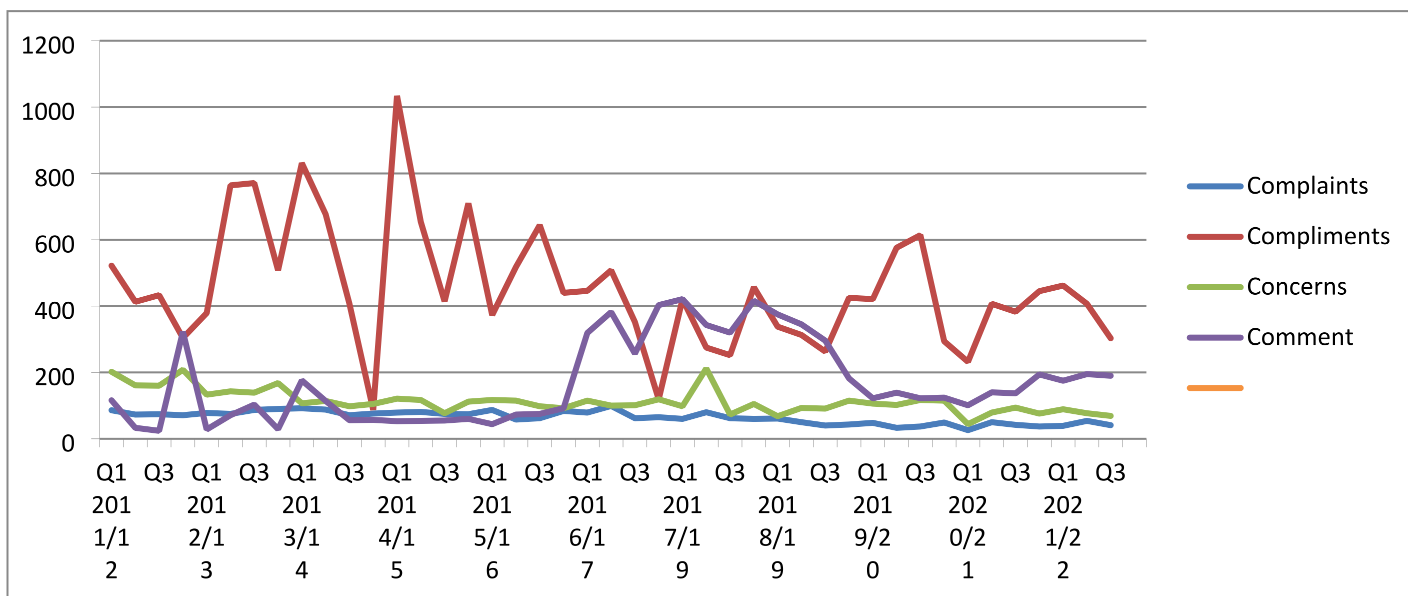
2. Complaints, compliments, concerns and comments

The graph below shows that complaints continue to show a downward trend and is also down on Q2 after a rise in Q2 from Q1.

Number of complaints overtime



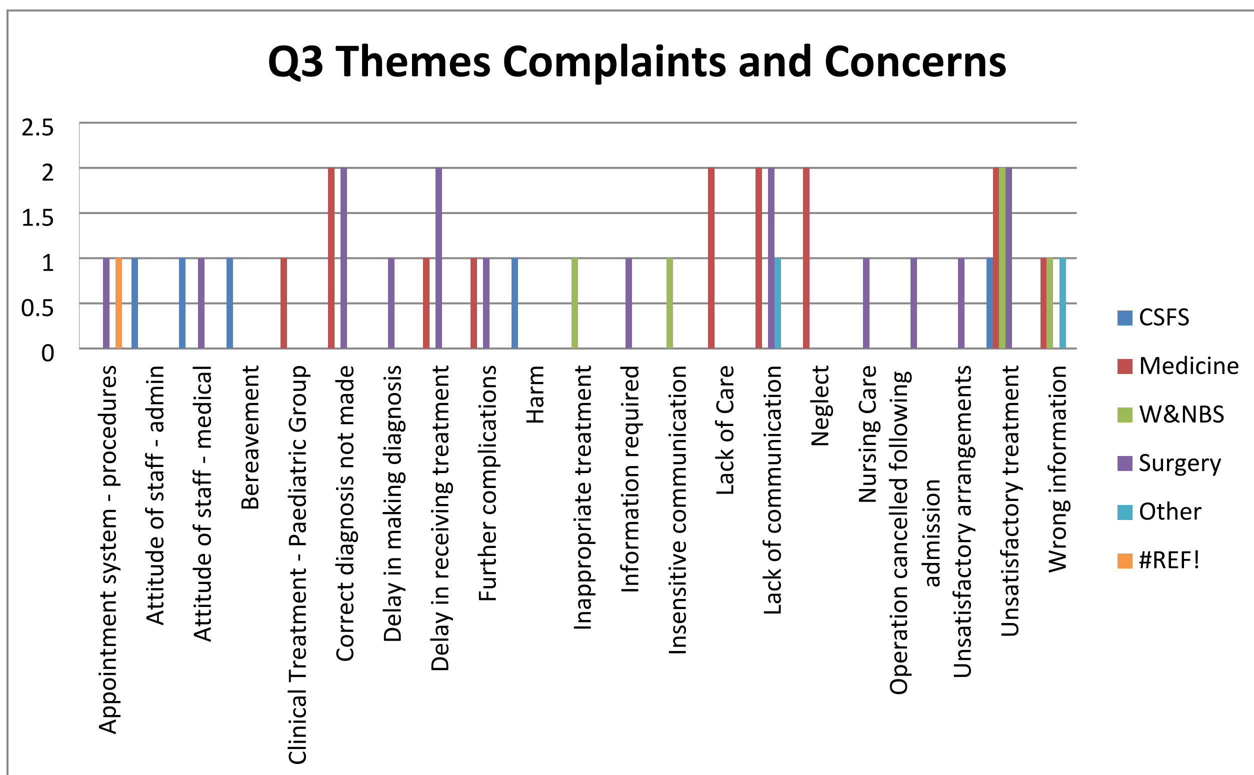
Number of Complaints, Compliments, Concerns and Comments



Themes from Q3 complaints and Concerns (Clinical)

Complaint/Concern	CSFS	Medicine	W&NBS	Surgery	Other	Total
Appointment system - procedures	0	0	0	1	0	1
Attitude of staff - admin	1	0	0	0	0	1
Attitude of staff - medical	1	0	0	1	0	2
Bereavement	1	0	0	0	0	1
Clinical Treatment - Paediatric Group	0	1	0	0	0	1
Correct diagnosis not made	0	2	0	2	0	4
Delay in making diagnosis	0	0	0	1	0	1
Delay in receiving treatment	0	1	0	2	0	3
Further complications	0	1	0	1	0	2
Harm	1	0	0	0	0	1
Inappropriate treatment	0	0	1	0	0	1
Information required	0	0	0	1	0	1
Insensitive communication	0	0	1	0	0	1
Lack of Care	0	2	0	0	0	2
Lack of communication	0	2	0	2	1	5
Neglect	0	2	0	0	0	2
Nursing Care	0	0	0	1	0	1
Operation cancelled following admission	0	0	0	1	0	1
Unsatisfactory arrangements	0	0	0	1	0	1
Unsatisfactory treatment	1	2	2	2	0	7
Wrong information	0	1	1	0	1	3
Total	5	14	5	16	2	42

As can be seen in the graph below unsatisfactory treatment and lack of communication are the main themes for this quarter. The deep dive into medical staff attitude undertaken by the CMO has had a positive influence on the number of complaints and concerns raised for Q3 and there were only 2 in the quarter as opposed to 9 in the last quarter. The findings of the deep dive did not raise any particular concerns and further interrogation of the classification of complaints and concerns will be undertaken



Themes from Q3 complaints and concerns (non-clinical divisions)

	Transformation & IM&T	Facilities	Total
Data protection	0	0	0
Lack of parking spaces	0	0	0
Patient Confidentiality	0	0	0
Building relations	0	1	1
Total	0	1	1

The 1 x IG report from 2021 has been closed

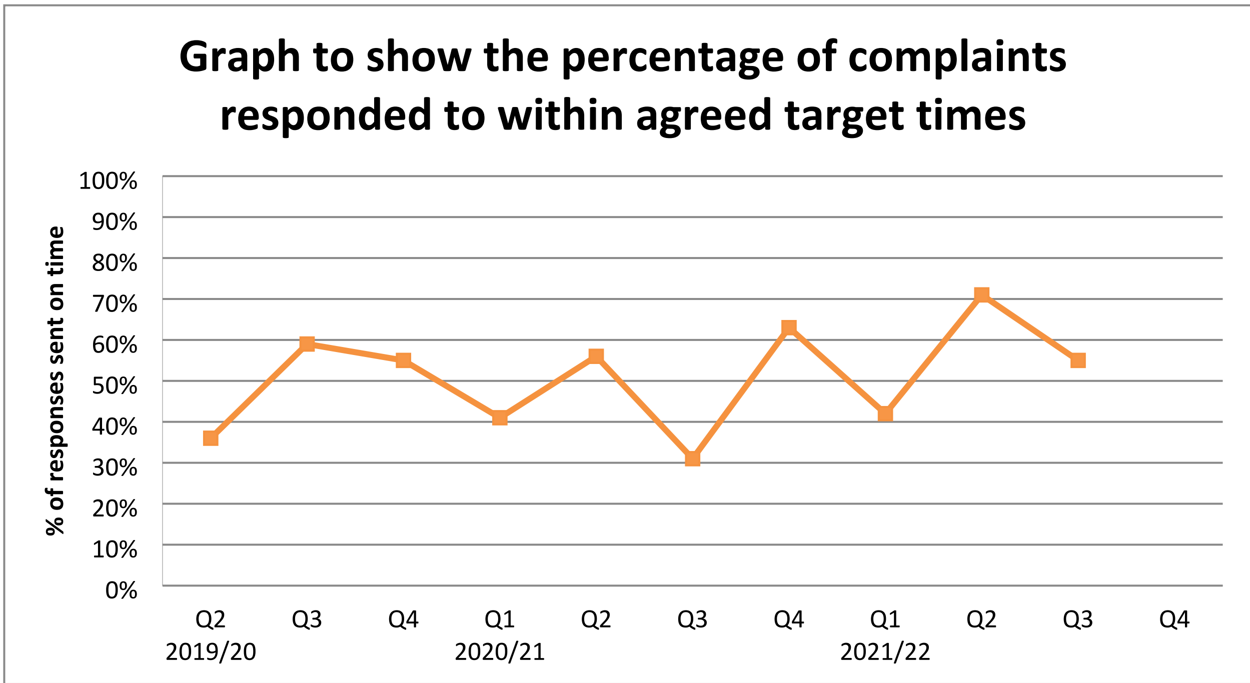
In Q3 the Trust treated 14,628 people as inpatients, day cases, non-elective and regular day attendees. Another 17,646 people were seen in the Emergency Department and 68,095 as outpatients (this excludes telephone calls). This is a total of 100,369 patients.

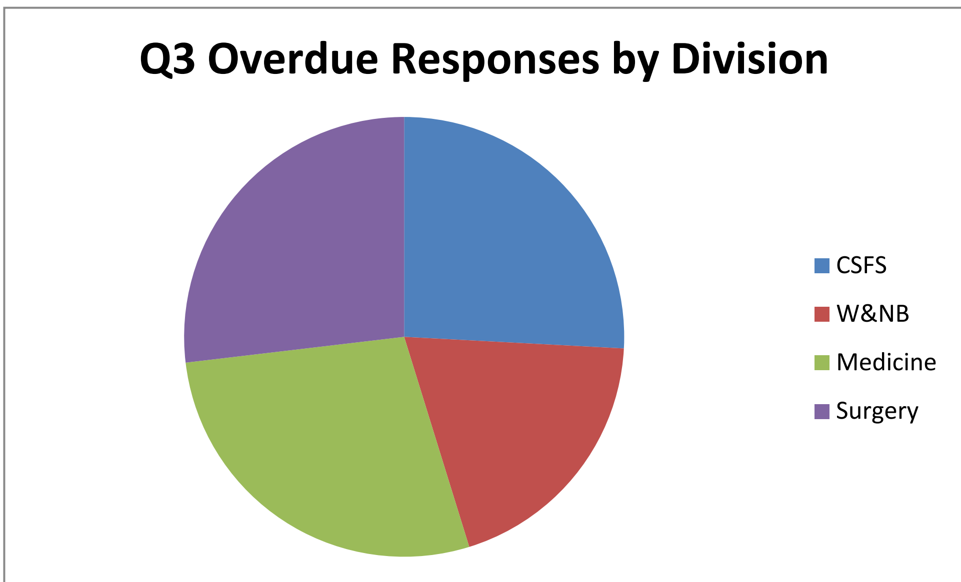
462 compliments were received across the Trust in Q3. Which is a compliment rate of 0.46%, those sent directly to the Chief Executive, PALS or via the SOX inbox are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the individual and their line manager.

Concerns, comments and enquiries closed

A total of 42 complaints, 194 comments, and 94 concerns and enquiries were logged by PALS for Q3

Closed within 10 working days of receipt Q3		
	No.	%
Not yet closed	44	6.60
0-10 working days	548	82.16
11-24 working days	37	5.55
25+working days	38	5.70
Total	**667**	



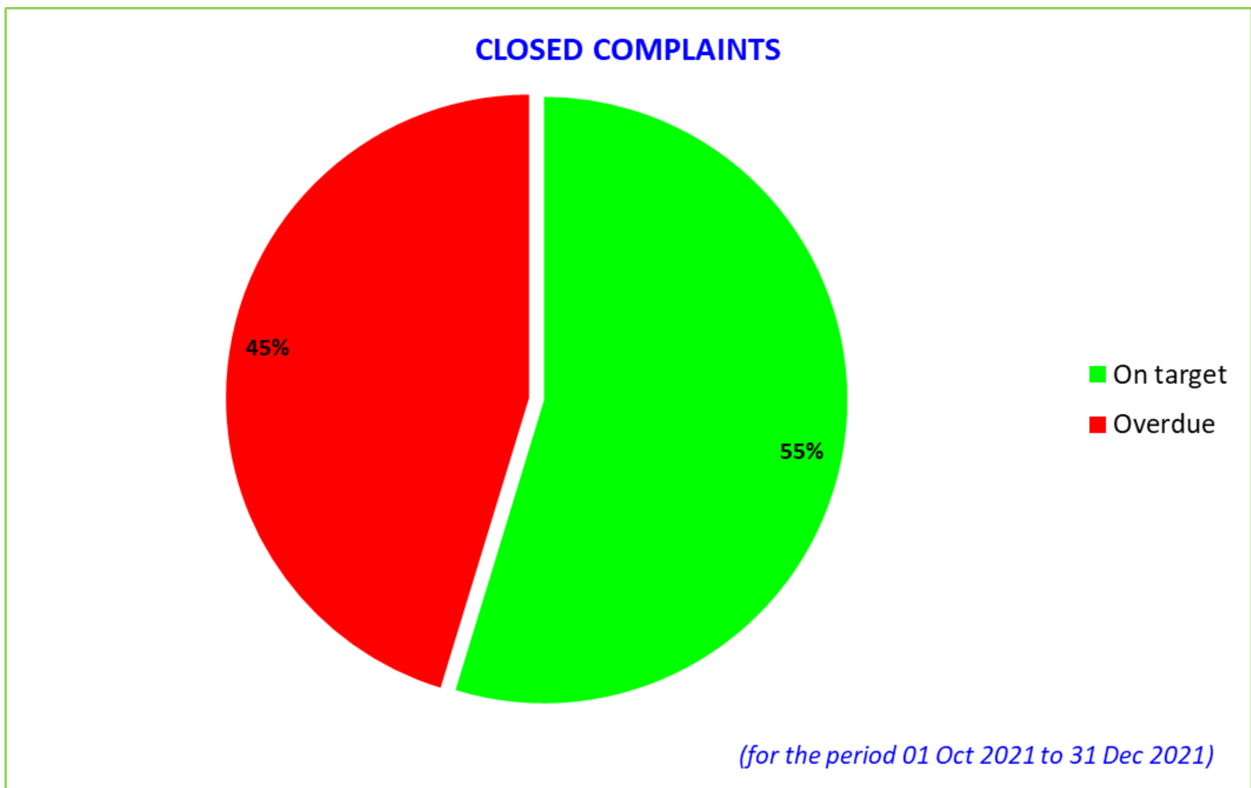


A weekly meeting has been set up with the Head of PALS and the two complaints co-ordinators to address overdue responses.

CLOSED COMPLAINTS

	On target	Overdue	Total	% compliance	
Green	*16*	*17*	*33*	*48%*	*(target: <=25 working days)*
Amber	*11*	*7*	*18*	*61%*	*(target: <=40 working days)*
Red	*2*	*0*	*2*	*100%*	*(target: <=60 working days)*
Total complaints	**29**	**24**	**53**	**55%**	

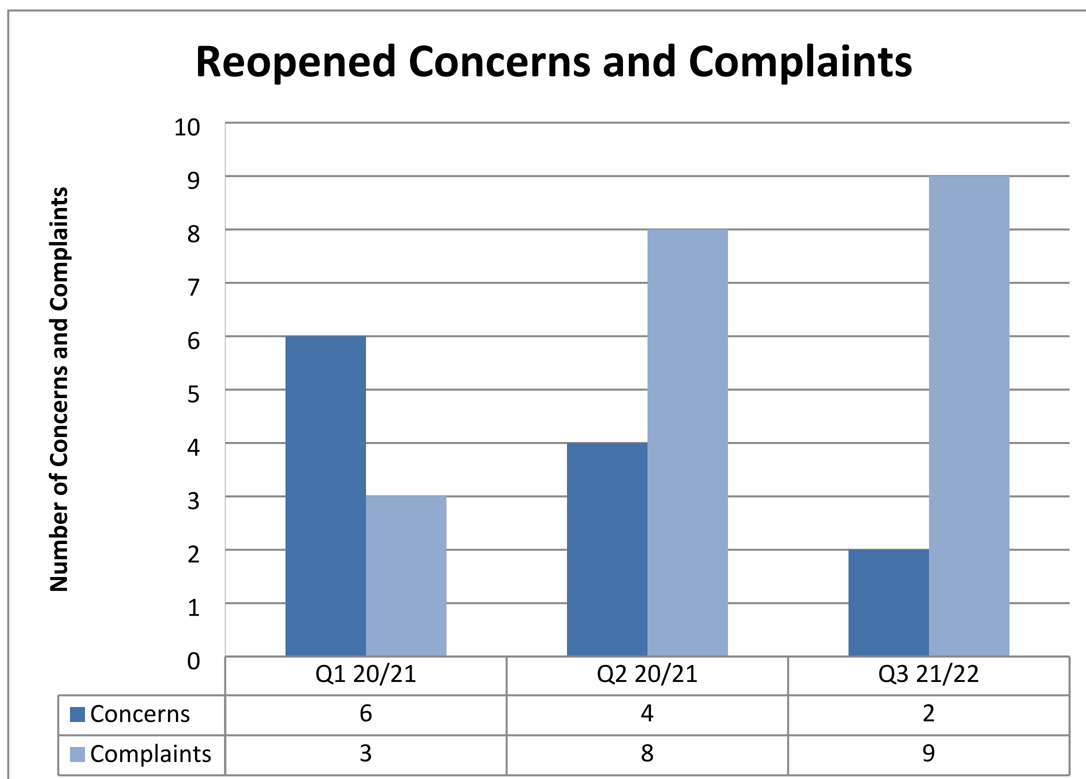
(for the period 01 Oct 2021 to 31 Dec 2021)



Example of actions from Q2 closures:

- PALS and Switchboard were getting inundated with calls from patients who were unable to get through to the Respiratory Department as they had no answer phone facility and a lack of staff to answer the phones. This was raised with the Divisional Management team in Medicine and also the Admin Lead for Medicine and they have now employed some further admin staff to deal with the inbox and phone calls which has really helped alleviate the pressures on the department and also PALS and Switchboard.
- Due to concerns raised by relatives unable to visit patients at end of life in ICU, disposable hoods have now been purchased that will enable them to visit in a safe manner.

Reopened Complaints and concerns for Q3



In Q3 there was an increase in reopened complaints which is an increasing trend over the previous 4 quarters although there is decreasing trend in concerns. In all cases complainants were unhappy with the response they had received.

3. COMPLAINTS BY DIVISION

CLINICAL SUPPORT AND FAMILY SERVICES

	Quarter 3 2020-21	Quarter 2 2021-22	Quarter 3 2021-22
Complaints	7	4	5
Concerns	17	10	5
Compliments	37	53	3
Re-opened complaints	0	0	1
% closed complaints responded to within agreed timescale	44%	60%	50%
Complaints closed in this quarter	9	5	4
% closed concerns responded to within 25	38%	63%	78%

working days			

- There were 5 complaints raised in Q3 and there is no particular theme for the subjects. There were two complaints for Radiology with the subjects being Harm and Unsatisfactory treatment. The other three areas for complaints were Sarum Ward (Attitude of staff – medical); Bereavement Service (Bereavement); Spinal X-ray (Attitude of staff – Admin).
- 4 complaints were closed in Q3; with 50% being responded to within the agreed timescale.
- 5 concerns were raised in Q3. Sarum Ward received 3 concerns. The subjects for these were Early discharge, Clinical Treatment and Unsatisfactory treatment. The other two areas for the concerns were Lloyds O/p Pharmacy (opening times) and Children's Outpatients (delay in making diagnosis).
- The PALS department received 14 comments and enquiries for CSFS in Quarter 3 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 36,445 and of this number 0.014% raised a complaint.
- There are no action plans outstanding from the division from 1 April 2021.

Themes and actions from concerns and complaints closed in this quarter

Q3 themes		
Department	**Themes**	**Actions**
Child Health	Communication, Attitude of Staff	Awaiting update from Child Health to CSFS DMT into complaints, concerns and themes following the re-implementation of their Governance meetings.
Update Q2 2021-22 themes		
Department	**Themes**	**Actions and updates**
Child Health	Attitude of Staff, Communication, Unsatisfactory Treatment	Deep dive completed into the complaints and concerns received within Child Health in the last 12 months. Deep dive reviewed by the CSFS DMT. Deep dive will be reviewed in the Child Health Business Meeting with actions being relayed to CSFS DMC via the incoming Lead Clinician.

Compliments

There were 3 compliments for CSFS in Quarter 3

Radiology = 3

WOMAN AND NEWBORN DIVISION

	Quarter 2 2020-21	Quarter 3 2021-22
Complaints	10	5
Concerns	10	8
Compliments	39	20
Re-opened complaints	1	1
% closed complaints responded to within agreed timescale	42%	62.5%
Complaints closed in this quarter	7	8
% closed concerns responded to within 25 working days	36%	62.5%

- There were 5 complaints raised in Q3.
- 8 complaints were closed in Q3; with 62.5% being responded to within the agreed timescale. The reason for delay on the others was due to clinical pressures.
- 8 concerns were raised in Q3.
- The top themes from complaints and concerns for Maternity were unsatisfactory treatment and insensitive communication.
- The PALS department received 14 comments and enquiries for Women and Newborn in Quarter 3 which were investigated, managed and responded to by the team

Themes and actions from concerns and complaints closed in this quarter

Q3 themes		
Department Maternity Department	**Themes** Unsatisfactory treatment and insensitive communication.	**Actions** Reminder to be cascaded out to the workforce to ensure that policies for post-natal review are followed. Personal reflection Ensure all women who have experienced an obstetric emergency receive an obstetric debrief. A reminder has been sent to the community midwifery team to ensure that when booking an unscheduled clinic appointment that they remind the women to bring in their hospital records. **Actions** Complaints and themes have been discussed at Consultant meeting in August and at the Governance meeting in September. This will be an ongoing action.
Update on Q2 themes **Department** Gynaecology	**Themes** Attitude of Medical staff.	**Update on actions –** All complaints related to the behaviours or conduct of the medical staff are sent to the Divisional Clinical Director. Supervised reflection is undertaken with the individual's line manager /or supervisor**.**

Compliments

Benson Suite (1), Labour (2), Maternity Admin (1), Maternity Community (3), Bereavement (7), NICU (5), Postnatal (2)

MEDICAL DIVISION

	Quarter 3 2020-21	Quarter 2 2021-22	Quarter 3 2021-22
Complaints	19	14	14
Concerns	36	19	27
Compliments	250	250	159
Re-opened complaints	2	5	2
% closed complaints responded to within agreed timescale	40%	62%	46%
Complaints closed in this quarter	15	8	15
% closed concerns responded to within 25 working days	68%	58%	81%

- 13 complaints were received in Q3. The Emergency Department received the most with 4. The main theme being incorrect diagnosis made.
- 15 complaints were closed in Q3 and of these 46% were responded to within the agreed timescale. Delays in responses being sent out on time were due to clinical pressures.
- 2 complaints were re-opened in Q3, this was due to the complainants not feeling their concerns were appropriately investigated and required further answers.
- There were 27 concerns raised in Quarter 3. The Emergency Department received the most with 11. The main theme being unsatisfactory treatment.
- The PALS department received 102 comments and enquiries for Medicine in Quarter 3 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 34,112 and of this number 0.03% raised a complaint.

Themes and actions from concerns and complaints closed in this quarter

Q3 21-22 themes		
Department/Ward	**Topic**	**Actions**
Emergency Department	Incorrect diagnosis not made and unsatisfactory treatment	- Some have been missed diagnosis as opposed to incorrect and this has been managed with individual reflection and learning as well as disseminating any relevant guidance across departmental Clinicians. - Nature of some complaints are that a diagnosis is not always possible but there is a need to rule out serious emergency pathology and this needs to be emphasised to patients when appropriate - Sustained pressure in the ED department has led to treatment that would not normally be accepted but the priority has been to prioritise the sickest and deliver time critical interventions. Staffing is looked at daily with agency filing gaps when available
Update on Q3 21-22 themes		
Department/Ward	**Topic**	**Actions**
Pitton ward	Lack of communication	Pitton ward now has a new band 7 manager in place and further work will be undertaken to improve communication skills within the department The Emergency Department (ED) has been under significant pressure with increased attendances and ambulance delays. Staff have raised safety concerns to The Division..
Emergency Department	Unsatisfactory treatment and clinical treatment	Any feedback around missed diagnosis are reviewed and reflected on. On review some are found to be part of the course of a disease process and it is not always possible to give a patient an exact diagnosis. Feedback to be used at the induction of junior staff alongside working under pressure and human factors. Communications to be entered into nursing diary for regular reminders on professional behaviours in the work place along with regular discussions by admin team The ED team will be working with the wider hospital system to support streaming / Same Day Emergency Care (SDEC) development and earlier specialty reviews to improve patient care

		and experience.

Compliments

Breamore (14), Emergency Department (4), Hospice (30), Pitton (26), Redlynch (16), Tisbury (29), Spire (33), Whiteparish (7)

SURGICAL DIVISION

	Q3 2020-2021	Q2 2021-22	Q3 2021-22
	Surgery	Surgery	Surgery
Complaints	16	24	16
Concerns	32	36	27
Compliments	88	79	92
Re-opened Complaints & Concerns	6	5	6
% closed complaints responded to within agreed timescale	37%	73%	48%
Complaints closed in this quarter	19	15	21
% closed concerns responded to within 25 working days	44%	55%	35%

- There were 16 complaints received this quarter which is a third reduction compared to the quarter 2 with Orthopaedics having the most with 4 complaints. Urology, Amesbury Suite and Plastic Surgery all had 2 complaints each. The main themes are correct diagnosis not made (2); Delay in receiving treatment (2); Lack of treatment (2); and Unsatisfactory treatment (2). These themes were not in any particular area of the division.
- There were 2 concern meetings held this quarter for surgery.
- There were 27 concerns raised in Quarter 3. Gastroenterology had 4 concerns. Plastic Surgery, Ophthalmology and Downton Ward had 3 concerns each. The main theme was for unsatisfactory treatment for 5 concerns. Pain management and attitude of staff – medical was a theme for three concerns each across the division.
- There were 5 complaints and 1 concern re-opened in Quarter 3. Four are still open and one is now closed after a meeting was held to try and resolve issues.
- The main theme for the 14 complaints closed in Q3 was further complications for 4 complaints and lack of communication for 3 complaints.
- The main themes for the 33 concerns closed in Q3 were; Appointment system - procedures (4) across 4 specialties and pain management (3) across 2 specialties; Gastroenterology (2) and Orthopaedics (1).
- The PALS department received 90 comments and enquiries for Surgery in Quarter 3 which were investigated, managed and responded to by the team with a slight decrease of 1 on the previous quarter.
- Total activity within the Division was 14,177 and of this number 0.11% raised a complaint.
- There are no action plans outstanding from closed complaints since 1st January 2021 for the Surgery Division.

Themes and actions from concerns and complaints closed in this quarter:

Q3 2021-2022 themes		
Department/Ward	**Topic**	**Action and update:**
Downton 8474	Further Complications	Unjustified complaint - Family have questions about sudden deterioration in patient condition and death on the Intensive Care Unit (ITU). Actions taken were carried outcted correctly but to the sudden deterioration in condition could not have been predicted. No actions necessary.
Plastics 8476 8523	Further Complications	Unjustified complaint – Patient was unhappy with the healing of a wound. No fault found and no actions necessary. Justified complaint - Patient unhappy with outcome of surgery and delay in follow up. Second opinion sought & now under care of a different surgeon for corrective t surgery. Complaint raised with the surgeon for self-reflection and learning.
Orthopaedics 8462	Further Complications	Unjustified complaint – Patient believes operation should not have been done without blood tests. Blood tests were carried out & hip was replaced due to chronic ongoing infection. . No actions necessary.
Orthopaedics 8485 8539	Lack of Communication	Partly justified – evidence of poor communication and discussion of treatment escalation, including Do Not Resuscitate plans between Salisbury Foundation Trust (SFT), community and Great Western Hospital. The roll out of the Record Summary Plan for Emergency Care and Treatment (ReSPECT)" across SFT will address these failings. This document will travel with an individual into all care settings; it will detail a clinical treatment escalation and resuscitation plan which has been discussed with an individual and their family in the event the patient is unable to make o their feelings known. It will be re-evaluated every time a patient is admitted to a healthcare facility. Justified - Orthopaedic surgery was cancelled as patient had not been advised to stop taking anticoagulant medication 7 days prior to surgery. Escalated to Divisional Management Team (DMT) to review different staffing options including deployment. Longer term, there will be improvements based on the Trust currently reviewing staffing per 1000 procedures to ensure it is line with other Trusts and national guidelines. It is also working at Integrated Care System (ICS) level to procure and install peri-operative specific software that will release savings in the administrative side of the department and thereby freeing up clinical time. Staffing issues are hoped to

		be resolved by the end of March 2022.
Urology 8519	Lack of Communication	Unjustified - Patient upset at failure of team members to return calls and provide updates on when surgery will be. No evidence found that calls were ignored. Spinal outpatient nursing team helpline number provided to patient for future use.
Central Booking 45078 45326 45047	Appointment system - procedures	Justified - Patient rang central booking department to chase a telephone appointment that was overdue. Central booking member of staff was over-familiar and unprofessional in their response to the patient, In person appointment made and apologies sent in response letter. Case highlighted with central booking team. Unjustified - Patient unhappy that their file had been "put to one side" following request for surgery to be delayed until after Sept 2021 This is normal practice as they were not yet at the top of the list for routine surgery. The patient has since been booked for surgery. Justified - Patient has a profound hearing impairment and was disappointed at Trust's inability to provide a British Sign Language (BSL)Interpreter at appointments. Although the central bookings department has comments in place to highlight the need for an interpreter when attending appointments on this occasion it was missed that one was required. .
Urology 45229	Appointment system - procedures	Unjustified - Patient unhappy that appointment was cancelled and would need to be re-booked after arriving late.
Gastroenterology 45409 45494	Pain management	Partly justified - Patient unhappy with advice for pain control pre-operatively and had to abandon the procedure due to pain. Patient feels staff should be more honest about pain relief required. Partly justified – Patient was in pain during endoscopic procedure and did not think they had been sedated. Conscious sedation was given. Explanation of how sedation can affect patients differently each time it is administered given along with an apology for the discomfort suffered.
Orthopaedics 45296	Pain management	Partly justified - Patient experienced extreme pain during spinal injection due to health condition and felt staff thought she was a nuisance. Request for sedation not met as unable to give sedation for this type of injection. Nursing staff reminded of importance of compassion to patients who are in pain. Patient referred to the Pain Team for further support and advice.

Update on Q2 2021-22 themes		
Plastics **8456** **Oral & Maxillofacial** **44693**	Patients refusing to comply with Covid protocols for elective/non-emergency surgery	Both cases discussed at Ethics Committee meeting. The Vaccination co-ordinator is going to produce an Action Card for Covid Protocols for elective patients who refuse to comply with the Trust's Covid Policy. **Update Q3 2021:** The Clinical Director for Surgery confirms that following further discussion, it is accepted that all patients with capacity have the right to refuse any test, procedure, or vaccination. These patients will be managed on a case-by-case basis as there are too many nuances for an action card or protocol.

Compliments

105 compliments were received in Quarter 3, the breakdown is as follows:

Odstock Ward = 28, Radnor Ward = 25, DSU = 17, Bowel Screening = 12, Urology = 11, Orthopaedics = 7, Laser Clinic = 2, Endoscopy = 2, Amesbury Suite = 1

Parliamentary and Health Service Ombudsman (PHSO)

There were no requests for information' made by the PHSO in Q3.

Update on PHSO complaint in Q1-This was closed in November 2020

For the first time the PHSO has published data about their recommendations for upheld and partially upheld cases. They have also published a data table of complaints received, assessed and investigated about NHS Organisations. This data will be published every quarter alongside their existing health complaints statistics report.

NHS Complaint Standards

The NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.

The Complaint Standards are based on My Expectations, which set out what patients expect to see when they make a complaint about health or social care services (see appendix 5). You can read a summary of the new Standards here.

4. Trust wide feedback

Friends and Family Test

Patients surveyed

A total of 1446 patients provided feedback during the quarter through the Friends and Family Test (FFT). We are encouraging areas to start displaying the FFT feedback forms again.

The possibility of using QR codes will be reviewed as an alternative method of collecting Friends and Family comments.

Friends and family test

Responses for the quarter are set out in the table below.

		Rating											
	Total Responses Received	Very good		Good		Neither Good nor poor		Poor		Very poor		Don't know	
Day Case	385	343	89%	36	9%	4		1		1		0	
Emer Dept	10	8	80%	2	20%	0		0		0		0	
Inpatients	428	352	82%	69	16%	4		1		1		1	
Maternity	46	39	85%	7	15%	0		0		0		0	
Outpatients	254	235	92.5%	13	5%	1		3		2		0	

Some feedback received this quarter

<u>What was good about your experience?</u>

- Exceptionally friendly and professional staff. Nice room and facilities. Very clean.
- The staff are very compassionate and helpful, nothing was too much trouble. The vegan and veggie food was excellent and the menu choices allowed for a very balanced diet to be maintained.
- 11/10 Lets all give them a medal, but more importantly the rise in salary they deserve so much.
- All staff polite and courteous, nothing seemed too much trouble whether during the day or night. Always had time to explain what was happening. Thoroughly pleasant stay, thank you.
- Staff in every department make this hospital from theatre, recovery, gynae, ward nurses, meal providers to very jolly cleaner. Unbelievable people doing a fabulous job.
- Be proud of all your nurses and the kindness and care they give to all the patients. True professionals giving excellent care. The NHS at it's very best and we must treasure it.
- Extremely Prompt. From GP referral to initial assessment; minor operation (on a Sunday morning); check up and discharge, all conducted in a timely efficient manner. Thank you

<u>What could we have done better?</u>

- Occasionally a staff member is impatient saying they don't have time to help. Please ensure all staff have an understanding of all issues relating to spinal cord injured patients. Many thanks.
- More staff are desperately needed to care for those specialist needs i.e. dementia. This puts a lot of pressure on staff trying to deal with all other patients as well.
- Maybe pre-inform how long it could take this is not a complaint, would just like the info.
- I was on my own without visitors so I missed services hospitals used to have - newspapers, books and other little luxuries. No mobile connection either!!
- Some sort of hook in wards and bathroom where you can put our crutches. They always fall over and cause obstructions. Trivial but would be good.
- Standing outside in the cold! A protective cover would have been appreciated.

- If appointment start at 8am then the reception desk should be manned. Very confusing and eventually we were aided by a passing nurse.

Patient and Public Involvement – national surveys

Urgent and emergency care survey 2020

The report has been published by the CQC and will be presented to the Patient Experience Group in march, then on to the CGC and Trust Board. For the full report please see Urgent and emergency care survey 2020 | Care Quality Commission (cqc.org.uk)

Adult inpatient survey 2020

The report has been published by the CQC and has been presented to the Patient Experience Group and CGC. For the full report please see Adult inpatient survey 2020 | Care Quality Commission (cqc.org.uk)

Children and young person's survey 2020

The report has been published by the CQC and will be presented to the Patient Experience Group in March hopefully.

Maternity survey 2020

We have received the headline report and are expecting the CQC publication in January 2022.

National Cancer Survey

This has now commenced and surveys are being sent out.

5. Health Watch Wiltshire feedback

Regular virtual meetings are held between PALS and Health Watch Wiltshire and any feedback they receive about this hospital is shared with us. There was no feedback for Q3

6. Patient Stories

Patient stories are taken to every public Board meeting.

7. Patient Experience Group

The new Patient Experience Group commenced in October 2021. Terms of Reference have been agreed and will be ratified at CMB in November 2021. A patient story will be shared at every PEG meeting.

8. Translation & Interpreting Services

Romanian ~ 37 ~ 47%
Polish ~ 13 ~15%
Nepali ~ 9 ~ 10%
Bulgarian ~ 6 ~ 6%
Arabic ~ 2 ~ 2%
Maternity ~57 ~ 66%
Endoscopy ~ 4 ~4%
Med/Surgery ~ 4 ~4%
Max Fax ~ 4 ~ 4%

Total calls made 86

9. Patient and public involvement (PPI)

The end of year update and progress against our engagement strategy has been deferred until the end of the year. This is because little engagement has taken place recently due to the difficulty of engagement events and social distancing.

PPI Projects are shared on the following web page on the Intranet:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

The PPI toolkit is available here: https://viewer.microguide.global/guide/1000000334#content,1df17a5a-25ee-4524-ab5e-96031930d247

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10. Social media

NHS Website feedback

There were 4 items of feedback posted on the NHS Website in Q3.

- Negative – 1 (ED waiting time to be seen)
- Positive – 4 (ED, Surgical admissions lounge and Orthopaedics)

11. All feedback is available here:

Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.2
Date of Meeting:	07 April 2022		

Report Title:	Q3 Learning from Deaths Report 2021 - 2022			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process (where has this paper been reviewed and approved)				
Prepared by:	Dr Ben Browne, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):				

Recommendation:
Assurance that the Trust is learning from deaths and making improvements.

Executive Summary:

- There were 237 hospital deaths in Q3 (2021/22). This figure is inclusive of patients who died in either the Emergency Department or the Hospice.
- There were 7 inpatient deaths from COVID in Q3 (death within 28 days of a positive swab result / COVID-19 reported on death certificate).
- There were 2 stillbirths and 3 neonatal deaths in Q3.
- There were no maternal deaths in Q3.
- There were no deaths reported in patients with a learning disability in Q3.
- There was 1 death identified in a patient with serious mental illness in Q3.

- 83 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 33 completed surveys were returned
  - 76% of respondents rated care as being either good or very good.

- The HSMR for the twelve month period ending in October 2021 is 111.0, and is statistically higher than expected.
- Weekday HSMR is 109.5 and weekend HSMR is 116 (within expected ranges respectively).

- The SHMI for Salisbury District Hospital for the twelve month period ending in August 2021 is 101.88.
- Since the last MSG meeting the following new alerts have occurred. These will be discussed at the next MSG meeting on 8th March 2022:
  - CUSUM alert for ***Cancer of pancreas***
  - Relative risk alert for ***Cancer of the stomach*** (5 obs vs 1.5 exp)
  - CUSUM alert for ***non-infectious gastroenteritis***
  - CUSUM alert for ***other connective tissue disease***
  - Relative risk alert for ***pathological fracture*** (4 obs vs 1.0 exp)
  - Relative risk and CUSUM alert for ***Other destruction of haemorrhoid*** (1 obs vs 0 exp)

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐
Other (please describe) -	☐

NHS
Salisbury
NHS Foundation Trust

Quarter 3 2021/22 Learning from Deaths report

February 2022

V1.1

GLOSSARY OF TERMS

CUSUM

A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR

The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ME

Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG

The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS

The Patient Advice and Liasion Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

SFT

Salisbury NHS Foundation Trust.

SHMI

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SII

Serious Incident requiring Investigation.

SJR

The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

SMR

A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX

Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

1. Purpose

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly report to a public board meeting.

2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3. Summary of Learning

The Trust MSG met on 08th December 2021 in Q3, where learning, improvement themes, and actions around in-hospital deaths were discussed. Some of the learning and themes discussed are summarised below.

3.1. SJRs

- The findings of 170 structured judgement reviews (SJRs) of patients who died of COVID-19 during the second wave (October 2020 to August 2021) were reviewed. Key themes related to delays in the monitoring and treatment of patients. Some delays in communicating COVID status with families and difficulties with communication to wards and staff were also identified. There were examples of excellent communication with families of the bereaved, with praise was given to wards and individual staff members caring for patients. Bereavement surveys were consistently offered to families when concerns about care had been raised. A full assurance report will be presented at the Clinical Governance Committee at the end of February. A further report of 24 SJR reviews of patients admitted to SFT between the dates of 12th December 2020 and 20th February 2021 was discussed (these patients all subsequently died, but COVID-19 was not identified as the main cause of death). The overall care of these patients was not considered to have been impacted by the pandemic. There were some examples of excellent care being provided by the hospice team in particular.

3.2. Formal Alerts and Reports

- Diagnosis and procedure groups with either negative CUSUM alerts (at a 99% detection threshold) or a statistically significantly higher than expected relative risk (for the most recent 12 month period) are routinely discussed at the Trust mortality surveillance group (MSG) meeting. A

statistically significantly higher than expected relative risk for Chronic Obstructive Pulmonary Disease (COPD) and bronchiectasis was recently identified. It was agreed that a case note review will therefore be undertaken for these cases (n=18) and the findings will be reported back to the MSG in the near future.

3.3. Serious Incidents Requiring Investigation (SIIs) / Case Reviews

- A case review was discussed regarding the delay in instigating non-invasive ventilation (NIV) for a patient. Agreed actions included ensuring that patients on NIV (non-COVID) are flagged and escalated early in their admission to avoid delaying their treatment, whilst taking into account transmission risk of COVID-19. Other actions included updating the Trust guidance for domiciliary NIV, and feeding back the findings of this case review to the leads of designated training for the deteriorating patient and prescription and administration of oxygen therapy.

3.4. Bereavement

- Difficulties in getting through to the wards and concerns regarding poor general communication were raised by families of the bereaved in Q3. Some new themes related to uncleanliness of the ward, nursing staff compassion, and delays in discharge during end of life. These new themes were reported at a time when exceptional operational pressures had been experienced at the Trust and these do not appear to be recurrent. These findings will therefore continue to be monitored through bereavement surveys and the hospital end of life steering group. Additional findings releated to bereavement can be found on page 7 of this report.

4. Summary of Mortality Data for Q3

- There were 237 hospital deaths in Q3 (2021/22). This figure is inclusive of patients who died in either the Emergency Department or the Hospice. This compares to 202 deaths occurring in Q2 (2021/22).
- There were 7 inpatient deaths from COVID in Q3 (death within 28 days of a positive swab result / COVID-19 reported on death certificate).
- There were 2 stillbirths and 3 neonatal deaths in Q3.
- There were no maternal deaths in Q3.
- There were no deaths reported in patients with a learning disability in Q3.
- There was 1 death identified in a patient with serious mental illness in Q3.

2021/22	Q1	Q2	Q3	YTD TOTAL
Covid Deaths	2	10	7	19
Stillbirth	2	1	2	5
Neonatal Deaths	1	1	1	3
Maternal Deaths	0	0	0	0
Learning Disability Deaths	0	2	0	2
Serious Mental Illness	2	2	1	5
TOTAL DEATHS	204	202	237	643

5. Medical Examiner (ME) and Structured Judgement Reviews (SJR)

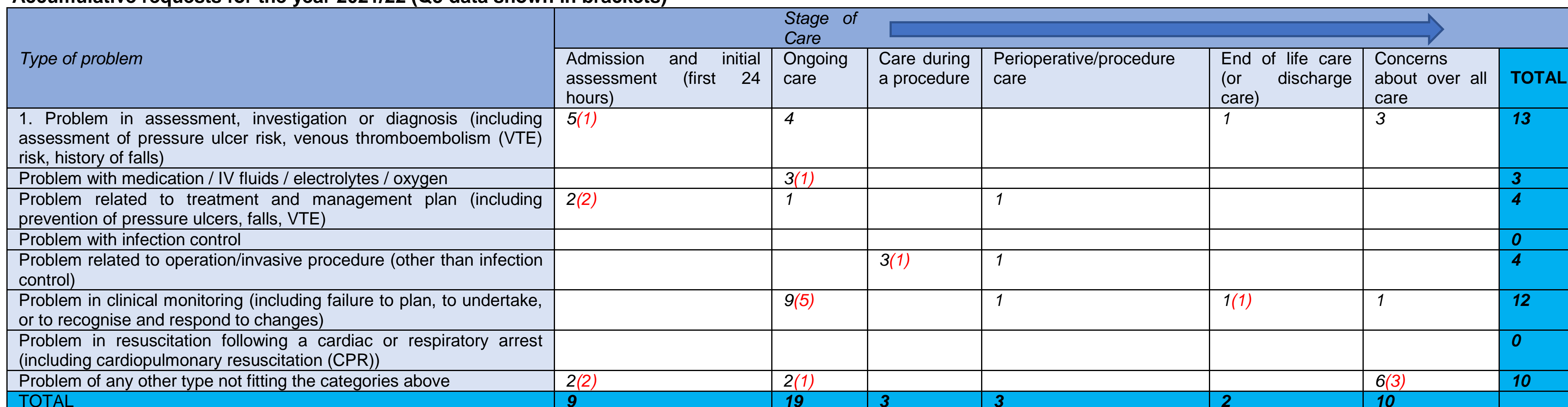
The ME system was introduced in April 2020 to ensure excellence in care for the bereaved, and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, however, the process currently excludes deaths occurring in the Emergency Department and some Hospice deaths at SFT. A local network of MEs exists to share learning and provide an independent review facility if needed.
The system was established in the Trust by August 2020.

- 17 Structured Judgement Reviews were requested by the medical examiner system in Q3. This includes reviews requested where concerns about the quality of care had been identified. This included 1 patient with a serious mental illness, and 2 unexpected deaths.

A summary of the reasons for each requested review has been outlined and cateogrised into problem themes and stage of care (see Table 1)

Table 1: Reasons for SJR Requests and Themes–Quarter 3, 2021-22

Accumulative requests for the year 2021/22 (Q3 data shown in brackets)



Type of problem	*Stage of Care* →						
	Admission and initial assessment (first 24 hours)	Ongoing care	Care during a procedure	Perioperative/procedure care	End of life care (or discharge care)	Concerns about over all care	**TOTAL**
1. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	*5(1)*	*4*			*1*	*3*	***13***
Problem with medication / IV fluids / electrolytes / oxygen		*3(1)*					***3***
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	*2(2)*	*1*		*1*			***4***
Problem with infection control							***0***
Problem related to operation/invasive procedure (other than infection control)			*3(1)*	*1*			***4***
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)		*9(5)*		*1*	*1(1)*	*1*	***12***
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							***0***
Problem of any other type not fitting the categories above	*2(2)*	*2(1)*				*6(3)*	***10***
TOTAL	***9***	***19***	***3***	***3***	***2***	***10***	

Summary of Cases
Pancreatitis following ERCP
Aspiration following anaesthetic
No glucagon available on the ward, medical documentation not clear, fragmented care
Patient fall and fractured neck of femur
Long stay in ED – disagreement over appropriate team to meet the patient's needs
A failed discharge
Patient management inconsistent with alert card
Patient not referred to gastro team on admission despite known cirrhosis diagnosis
Relative concern about patient care
Catheterised in ED, no documentation – discharged, readmitted Urosepsis
Delay in recognising cardiac arrest, patient expressed wish not to be resuscitated but was, albeit unsuuccessful.
Falls during admission (3 x cases)
Family concerns were raised about care
Patient with serious mental illness – Section 3 rescinded the day before the patient died.
Concerns regarding the timely administration of palliative medicines.

6. Your Views Matter Survey & End of Life Care

The your views matter survey is offered to all bereaved families, providing them with an opportunity to feedback their experiences of support given to themselves and the care given to dying patients in their last days of life.

- In Q3, 83 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 33 completed surveys were returned (compared to 77 and 26 respectively in Q2).
- 76% of respondents rated the overall end of life care as good or very good.
- Four surveys rated the care as poor or very poor. All of these respondents were contacted by the lead nurse for end of life care to discuss their concerns directly.

	Q1	Q2	Q3
Consent for survey to be posted	**101**	**77**	**83**
Completed surveys returned	**42**	**26**	**33**
% Rating care good or very good	**76%**	**81%**	**76%**
No. of surveys received where care was rated poor or very poor	**5**	**3**	**4**

General themes from feedback related to communication and difficulty with getting through to the wards. Three families were upset that they had not been properly informed that their loved ones may die. Two families were satisfied with the outcome of their call with the end of life care nurse and contributed to several proprosed actions, and two families were supported to raise formal complaints through PALs.

There was one serious concern related to staff not recognising an acute deterioration and the potential delay in escalation. Agreed actions included, a) sharing experiences to raise awareness of the issues, b) including concerns raised as part of end of life care teaching, c) presenting findings at the Trust Patient Experience Group, and, d) designing bedside communication posters to empower patients about the communication channels available to them.

7. Mortality Benchmarking

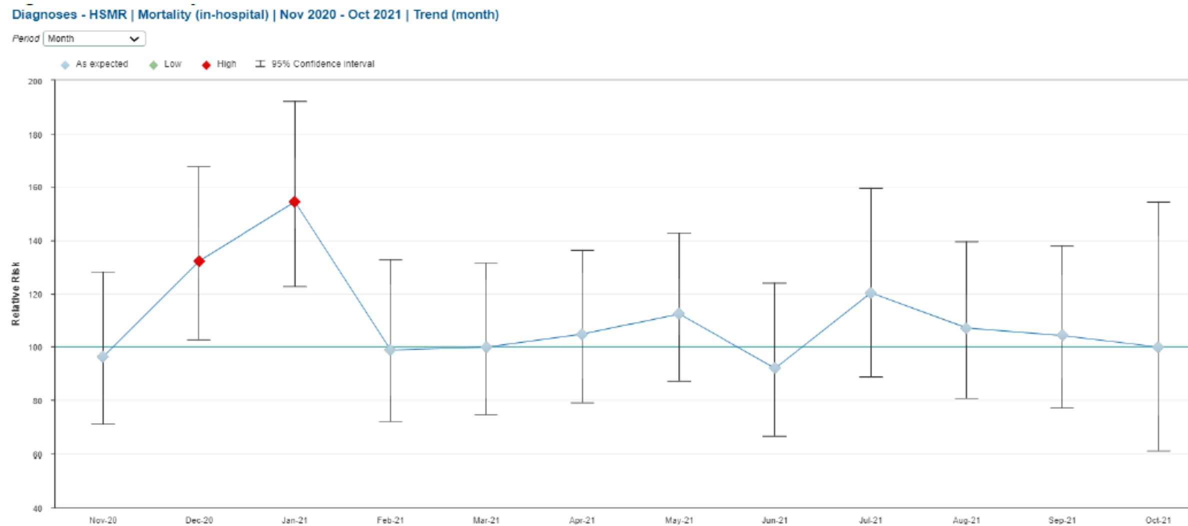
7.1. HSMR rolling 12 month trend to October '21

- **The HSMR for the twelve month period ending in October 2021 is 111.0 and is statistically higher than expected (102.5 – 120.0, 95% confidence limits).** The latest data has shown an increase in the relative risk figures, and this follows some changes in how the data is being reported by our mortality partners at Telstra Health UK. A representative from Telstra Health UK will be attending the Trust mortality meeting in March when these changes will be further discussed.

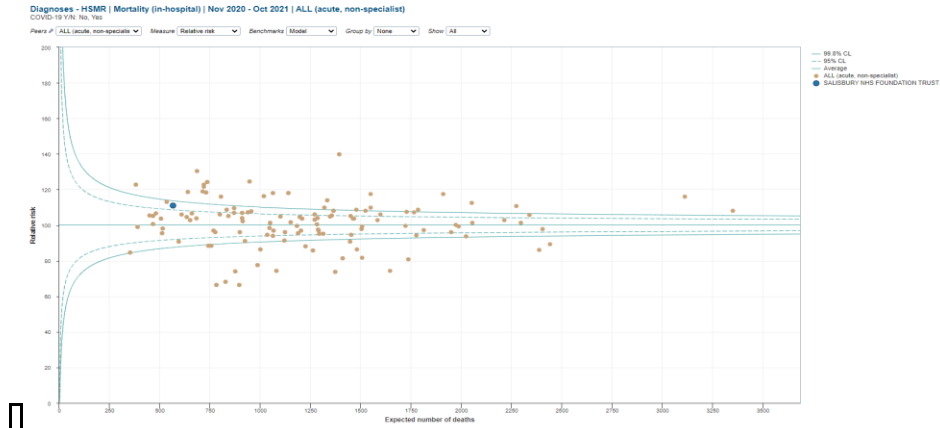
- **If COVID-19 activity is removed, the HSMR reduces to 105.0 (96.4 – 114.0) for the latest 12 month period, and this is within the expected range.**

- **Weekday HSMR is 109.5 and weekend HSMR is 116.0. Both are within their expected ranges respectively.**

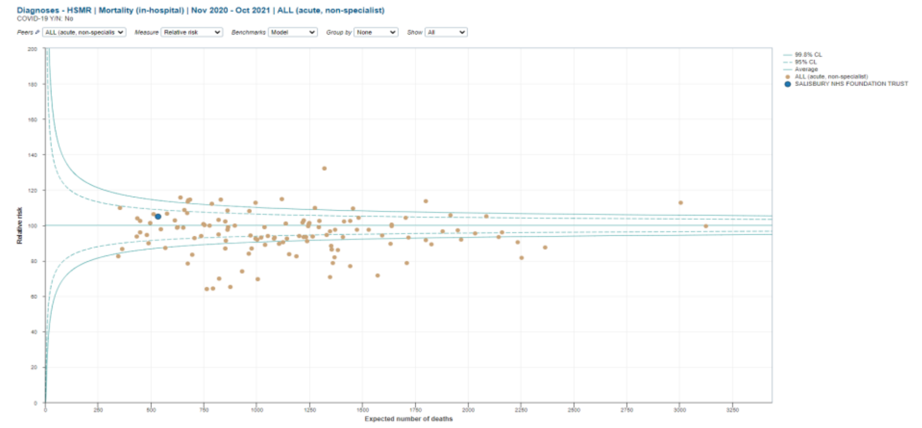
Monthly Trend in HSMR [graph taken from Dr Foster Toolkit, Telstra UK]

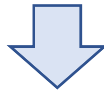


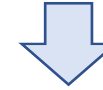
Peer comparison of HSMR including COVID-19 (year end October 2021)



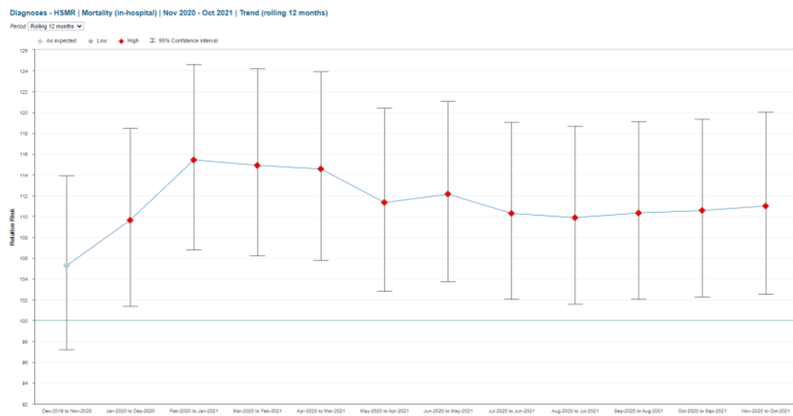
Peer comparison of HSMR excluding COVID-19 (year end October 2021)



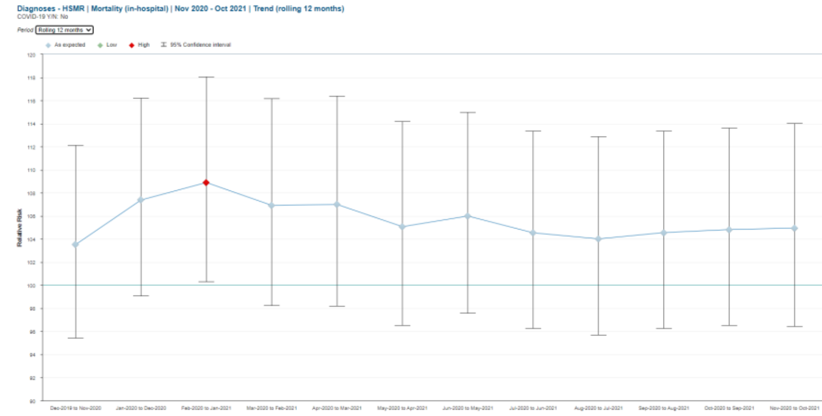




HSMR including COVID-19 (rolling 12-month trend)



HSMR excluding COVID-19 (rolling 12-month trend)



7.2. Summary Hospital-Level Mortality Indicator (SHMI) for September 2020 – August 2021

The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is published as an official statistic by NHS Digital. The latest available data is published in this report.

- **SHMI is 106.22 for the twelve month period ending in August 2021 for SFT. When comparing SHMI by site, Salisbury District Hospital is 101.88 and Salisbury Hospice is 240.61.** When compared with regional peers, the Trust has a SHMI within the expected range.

- The tables in the supplementary data pack show the SHMI data for SFT as a breakdown for specific conditions for the twelve month period ending May 2021. Of the **SHMI diagnosis groups that are banded by NHS Digital, all of these are within the expected range.**

7.3. New Alerts

- All new alerts are discussed at the MSG meeting, where a further review or investigation into these deaths may be requested. In the latest 12-month period (Nov-20 to Oct-21) there have been CUSUM alerts in 7 diagnosis groups (using a 99% detection threshold criteria).

- **Since the last MSG meeting the following new alerts have occurred. These will be discussed at the next MSG meeting on 8th March 2022:**

  - CUSUM alert for ***Cancer of pancreas***
  - Relative risk alert for ***Cancer of the stomach*** (5 obs vs 1.5 exp) *
  - CUSUM alert for ***non-infectious gastroenteritis***
  - CUSUM alert for ***other connective tissue disease***
  - Relative risk alert for ***pathological fracture*** (4 obs vs 1.0 exp) *
  - Relative risk and CUSUM alert for ***Other destruction of haemorrhoid*** (1 obs vs 0 exp) *

* These new relative risk alert are small numbers and should be looked at on an individual patient level.

8. Recommendations

The report is provided for assurance that the Trust is learning from deaths and making improvements.

Dr Belinda Cornforth,
Trust Mortality Lead & Consultant Anaesthetist

Dr Ben Browne,
Head of Clinical Effectiveness

Approved by Dr Peter Collins
Chief Medical Officer- February 2022

9. SUPPLEMENTARY DATA PACK

SHMI Data for the 12 Month Period Ending May 2021

SHMI - Summary Hospital Mortality Indicator

Period: Sep 20 - Aug 21

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: NHS ENGLAND SOUTH WEST (SOUTH WEST NORTH)

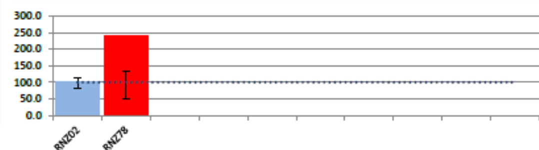
☐ Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

** click group name to filter; click header title to clear*

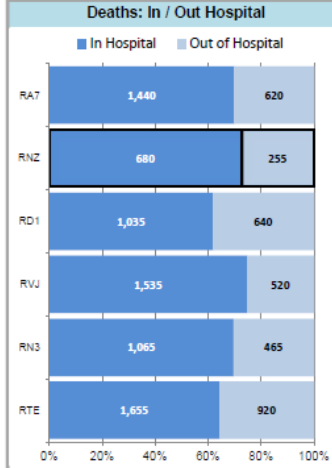
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTE	Gloucestershire Hospitals NHS Foundation Trust	100,350	2,575	2,540	35	101.32	89.92	111.20
RN3	Great Western Hospitals NHS Foundation Trust	54,470	1,530	1,725	-195	88.74	89.63	111.57
RVJ	North Bristol NHS Trust	82,570	2,055	2,150	-95	95.66	89.81	111.35
RD1	Royal United Hospitals Bath NHS Foundation Trust	55,920	1,675	1,610	65	103.94	89.56	111.65
RNZ	Salisbury NHS Foundation Trust	32,995	935	880	55	106.22	88.79	112.63
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	83,370	2,055	2,095	-40	98.23	89.79	111.37
Group		409,675	10,825	11,000	-175	98.41		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	32,895	865	850	101.88	85.93	116.37
SALISBURY HOSPICE	100	65	25	240.61	67.16	148.90

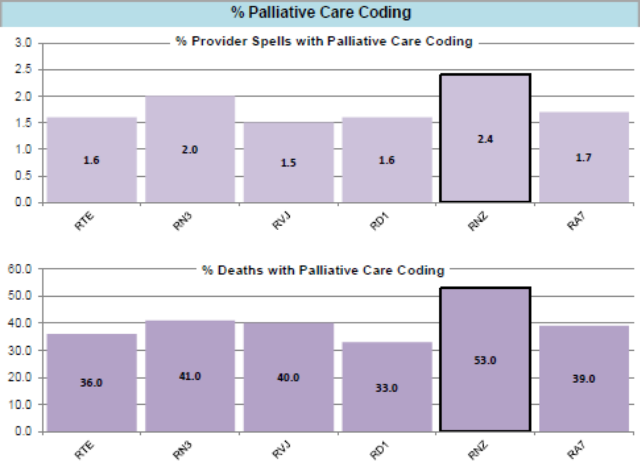


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	65	60.00	107.71	75.62 132.25
Cancer of bronchus, lung	25	20.00	119.94	63.92 156.45
Secondary malignancies	30	30.00	111.86	68.91 145.11
Fluid and electrolyte disorders	10	10.00	118.48	52.48 190.55
Acute myocardial infarction	20	20.00	90.38	65.50 152.66
Pneumonia	100	95.00	102.97	80.43 124.34
Acute bronchitis	10	15.00	94.19	57.75 173.17
Gastrointestinal haemorrhage	20	15.00	132.02	60.44 165.46
Urinary tract infections	15	20.00	82.38	62.32 160.45
Fracture of neck of femur (hip)	15	20.00	80.20	65.33 153.07

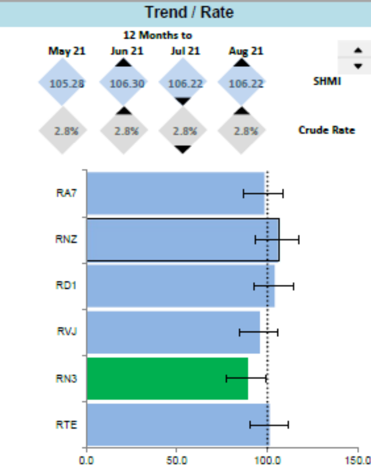
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(113) Other connective tissue disease	20	10	200.00	122.11 308.90
(42) Mental retardation, Senility and organic mental disorders	20	10	200.00	122.11 308.90
(75) Chronic obstructive pulmonary disease and bronchiectasis	25	15	166.67	107.83 246.04
(124) Intracranial injury	20	15	133.33	81.41 205.93
(13) Cancer of pancreas	20	15	133.33	81.41 205.93
(66) Acute cerebrovascular disease	55	60	91.67	69.05 119.32
(65) Congestive heart failure, nonhypertensive	30	30	100.00	67.46 142.76
(77) Aspiration pneumonitis, food/vomitus	25	25	100.00	64.70 147.63

* Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's

SHMI_Sep20_Aug21_170122

HEALTH | dr foster.

HSMR Data for 12 month period to October 2021 for SFT (Inclusive of Hospice Data)

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Oct-2021 as at 24/01/2022

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends

HSMR

Spells | In Hospital Deaths

Spells: 16000, 15500, 15000, 14500, 14000

Deaths: 700, 650, 600

Dec 20, Feb 21, Apr 21, Jun 21, Aug 21, Oct 21

HSMR

Crude Rate % | National Benchmark | Relative Risk

Relative Risk: 125, 115, 105, 95

Crude Rate: 5.0%, 4.5%, 4.0%, 3.5%, 3.0%, 2.5%, 2.0%, 1.5%, 1.0%, 0.5%, 0.0%

SMR

Crude Rate % | National Benchmark | Relative Risk

Relative Risk: 125, 115, 105, 95

Crude Rate: 2.0%, 1.5%, 1.0%, 0.5%, 0.0%

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		111.0	105.2	101.1
SMR		109.0	105.0	101.7
Non-elective (HSMR)		111.6	105.1	100.7
Weekday, emergency (HSMR)		109.5	103.0	98.9
Weekend, emergency (HSMR)		116.0	111.6	105.7
Saturday, emergency (HSMR)		114.2	108.9	105.2
Sunday, emergency (HSMR)		118.1	113.8	106.0
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)		53.8%	38.4%	38.4%
% Non-elective spells with palliative care (HSMR)		6.6%	4.5%	4.9%
% Spells in Symptoms & Signs chapter		10.3%	9.1%	7.8%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		45.4%	42.4%	41.1%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		14.5%	14.8%	15.6%
% Non-elective spells in Risk Band (0-10%) (HSMR)		84.5%	84.7%	84.3%

Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Other connective tissue disease	1	21	9.7	217.5	134.6	
Cancer of stomach	0	5	1.5	342.3	110.3	
Pathological fracture	1	4	1.0	384.2	103.4	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Other connective tissue disease	1	21	9.7	217.5	134.6	
Pathological fracture	1	4	1.0	384.2	103.4	
Cancer of bronchus, lung	1	19	12.8	148.0	89.0	
Other liver diseases	1	9	5.0	181.8	83.0	
Cancer of pancreas	1	11	7.9	138.6	69.1	
Cancer of ovary	1	3	1.5	198.3	39.9	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Gastrointestinal haemorrhage	1	19	13.6	139.3	83.8	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

HSMR Peer Comparison

GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST
ROYAL CORNWALL HOSPITALS NHS TRUST
NORTHERN DEVON HEALTHCARE NHS TRUST
NORTH BRISTOL NHS TRUST
PEER REGION (acute)
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
SALISBURY NHS FOUNDATION TRUST
SOMERSET NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST

0, 20, 40, 60, 80, 100, 120

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HSMR Data for the 12 month period to October 2021 for SFT (Excluding Hospice Data)

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Oct-2021 as at 24/01/2022

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends

HSMR

Spells | In Hospital Deaths

Spells: 16000, 15500, 15000, 14500, 14000, 13500

Deaths: 600, 550, 500

Dec 20 Feb 21 Apr 21 Jun 21 Aug 21 Oct 21

HSMR

Crude Rate % | National Benchmark | Relative Risk

Relative Risk: 115, 105, 95, 85

Crude Rate: 4.0%, 3.5%, 3.0%, 2.5%, 2.0%, 1.5%, 1.0%, 0.5%, 0.0%

SMR

Crude Rate % | National Benchmark | Relative Risk

Relative Risk: 115, 105, 95, 85

Crude Rate: 2.0%, 1.5%, 1.0%, 0.5%, 0.0%

Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Other connective tissue disease	1	18	8.7	207.6	123.0	
Pathological fracture	1	4	1.0	384.2	103.4	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Other connective tissue disease	1	18	8.7	207.6	123.0	
Pathological fracture	1	4	1.0	384.2	103.4	
Other liver diseases	1	8	4.1	193.4	83.3	
Systemic lupus erythematosus and connective tissue disorders	1	1	0.1	671.0	8.8	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	104.4	111.0	105.2	101.1
SMR	102.7	109.0	105.0	101.7
Non-elective (HSMR)	104.9	111.6	105.1	100.7
Weekday, emergency (HSMR)	102.0	109.5	103.0	98.9
Weekend, emergency (HSMR)	111.6	116.0	111.6	105.7
Saturday, emergency (HSMR)	117.2	114.2	108.9	105.2
Sunday, emergency (HSMR)	105.9	118.1	113.8	106.0
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)	46.7%	53.8%	38.4%	38.4%
% Non-elective spells with palliative care (HSMR)	5.2%	6.6%	4.5%	4.9%
% Spells in Symptoms & Signs chapter	10.3%	10.3%	9.1%	7.8%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	46.0%	45.4%	42.4%	41.1%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	14.2%	14.5%	14.8%	15.6%
% Non-elective spells in Risk Band (0-10%) (HSMR)	85.7%	84.5%	84.7%	84.3%

HSMR Peer Comparison

GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST
ROYAL CORNWALL HOSPITALS NHS TRUST
NORTHERN DEVON HEALTHCARE NHS TRUST
NORTH BRISTOL NHS TRUST
SALISBURY DISTRICT HOSPITAL (RNZ02)
PEER REGION (acute)
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
SALISBURY NHS FOUNDATION TRUST
SOMERSET NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST

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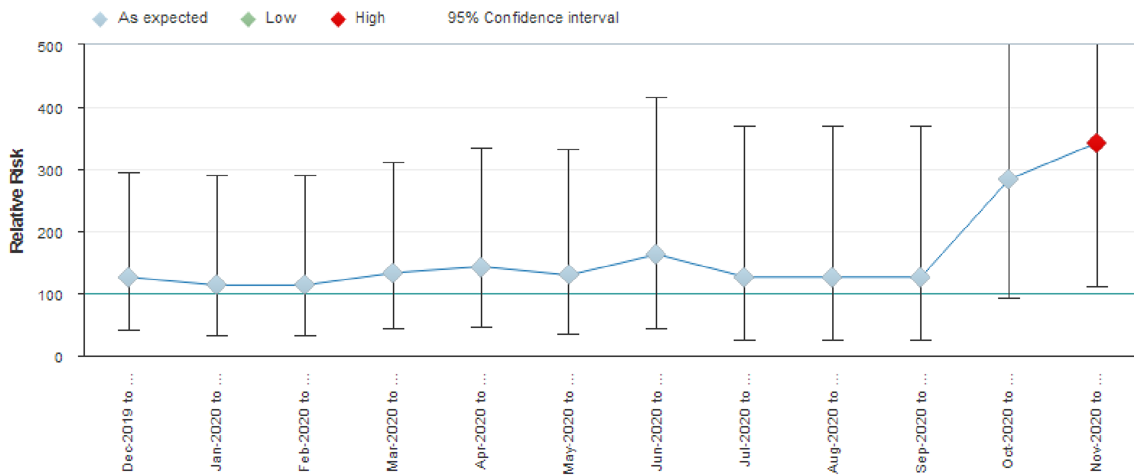
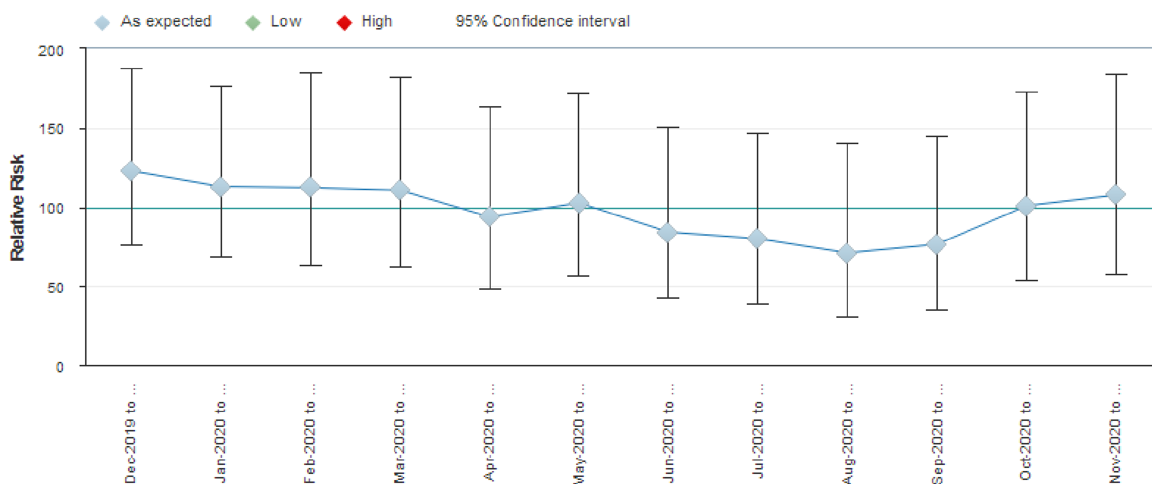
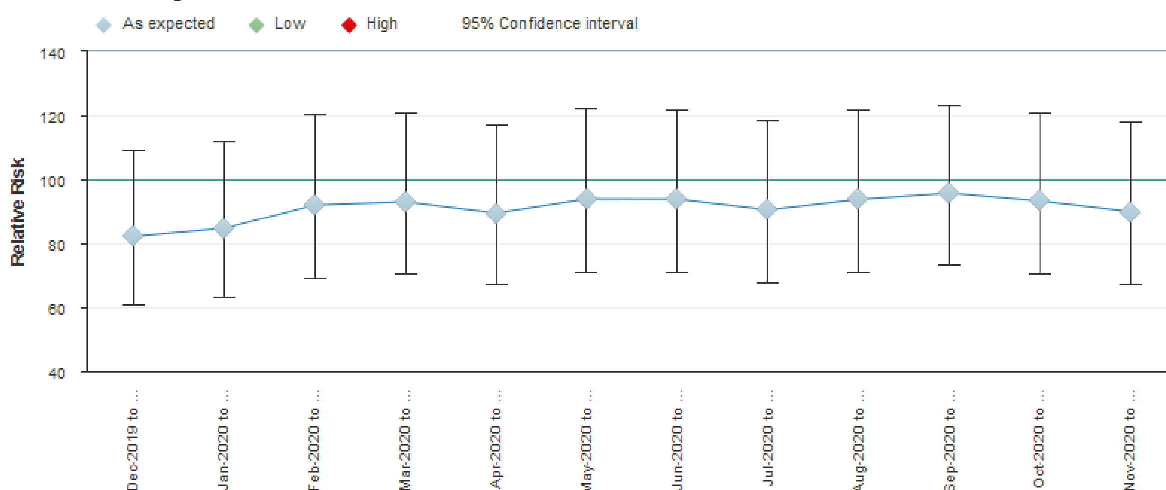
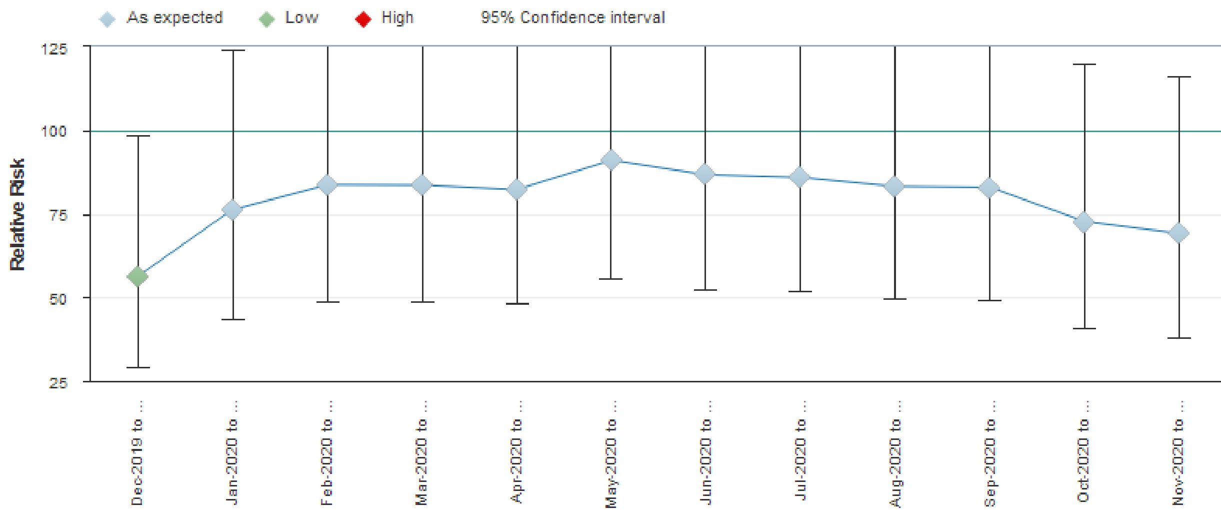
Diagnosis Group Alert – Cancer of Stomach



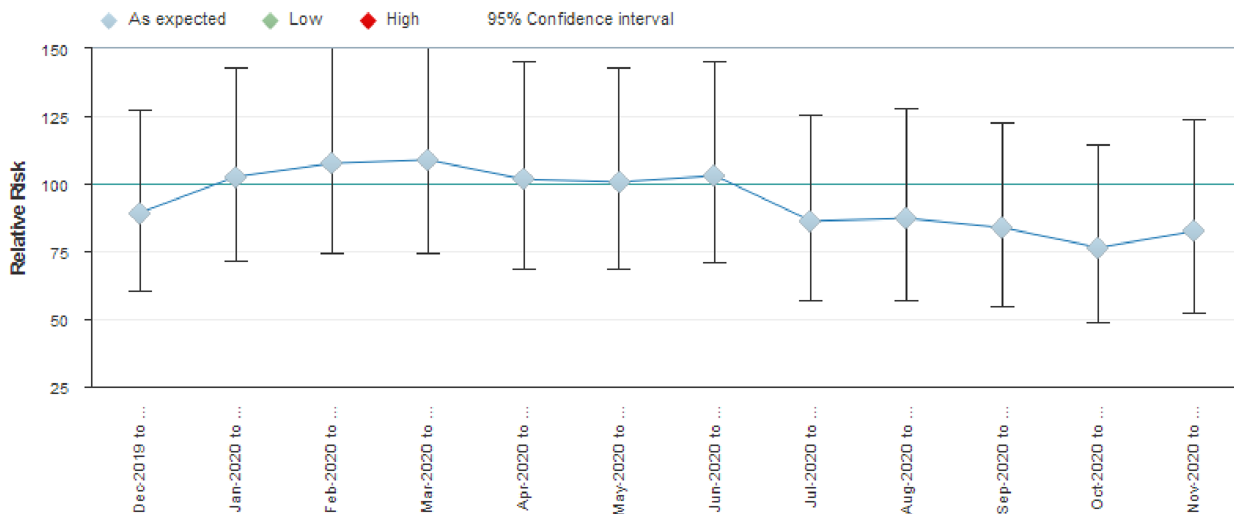
12-Month Trends in Relative Risk for High Risk Groups



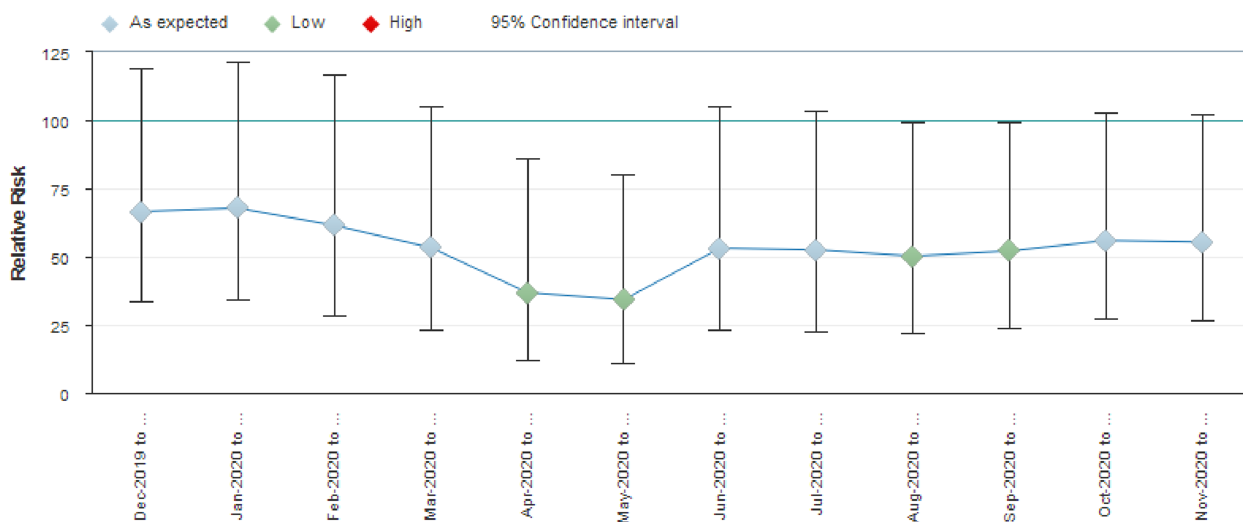




Acute myocardial infarction | Mortality (in-hospital) | Nov 2020 - Oct 2021 | Trend (rolling 12 months)
Diagnosis group: Acute myocardial infarction
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
125
100
75
50
25
Dec-2019 to ...
Jan-2020 to ...
Feb-2020 to ...
Mar-2020 to ...
Apr-2020 to ...
May-2020 to ...
Jun-2020 to ...
Jul-2020 to ...
Aug-2020 to ...
Sep-2020 to ...
Oct-2020 to ...
Nov-2020 to ...



Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Nov 2020 - Oct 2021 | Trend (rolling 12 months)
Diagnosis group: Congestive heart failure, nonhypertensive
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
150
125
100
75
50
25
Dec-2019 to ...
Jan-2020 to ...
Feb-2020 to ...
Mar-2020 to ...
Apr-2020 to ...
May-2020 to ...
Jun-2020 to ...
Jul-2020 to ...
Aug-2020 to ...
Sep-2020 to ...
Oct-2020 to ...
Nov-2020 to ...

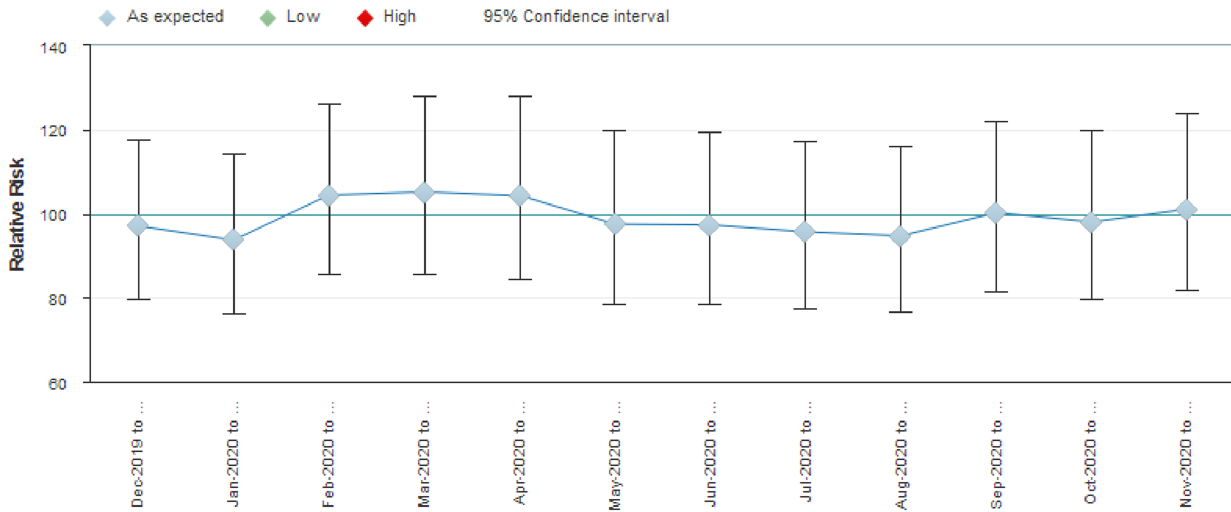


Fracture of neck of femur (hip) | Mortality (in-hospital) | Nov 2020 - Oct 2021 | Trend (rolling 12 months)
Diagnosis group: Fracture of neck of femur (hip)
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
125
100
75
50
25
0
Dec-2019 to ...
Jan-2020 to ...
Feb-2020 to ...
Mar-2020 to ...
Apr-2020 to ...
May-2020 to ...
Jun-2020 to ...
Jul-2020 to ...
Aug-2020 to ...
Sep-2020 to ...
Oct-2020 to ...
Nov-2020 to ...

Pneumonia | Mortality (in-hospital) | Nov 2020 - Oct 2021 | Trend (rolling 12 months)

Diagnosis group: Pneumonia

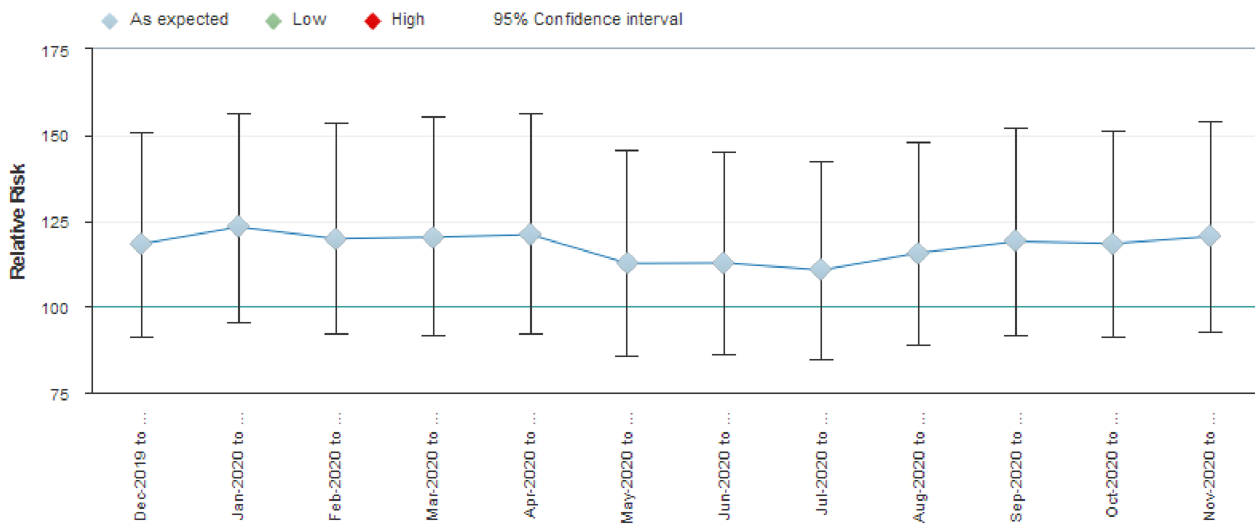
Period: **Rolling 12 months**



Septicemia (except in labour) | Mortality (in-hospital) | Nov 2020 - Oct 2021 | Trend (rolling 12 months)

Diagnosis group: Septicemia (except in labour)

Period: **Rolling 12 months**



END

CLASSIFICATION: UNRESTRICTED

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	07 April 2022		

Report Title:	Improving Together highlight report – Quarter 4 2021/22			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Approval Process (where has this paper been reviewed and approved)	n/a			
Prepared by:	Esther Provins, Director of Improvement & Partnerships			
Executive Sponsor (presenting):	Esther Provins, Director of Improvement & Partnerships			
Appendices (list if applicable):	Appendix A: Rollout timeline overview Appendix B: KPMG expenditure report			

Recommendation:
That the Board note this report and approve the reporting proposal outlined in Section 3.8.

Executive Summary:

The purpose of this report is to provide the Board with a quarterly progress update of the Improving Together programme. Operational pressures, staff sickness and annual leave are hampering progress in completing A3 structured problem solving analyses and are creating challenges for some operational colleagues to attend training and coaching sessions. Mitigations are in place and this is not currently impacting on project timescales. The impact of this from a staff engagement and programme quality perspective is under regular executive review. The programme status is currently rated amber due to these issues.

The programme launched officially on February 17th with various communication and engagement activities, and a visual identity for the programme has been designed and is in use.

Focussed work on developing a new style Integrated Performance Report (IPR) and new divisional and frontline scorecards is in progress. The new IPR will be presented for the first time at the Board meeting in May, reporting on data from the start of the new financial year.

Following discussions at various board committee meetings, this paper outlines a new reporting approach for approval, clarifying how assurance will be provided to the Board and Board committees in respect of performance against breakthrough objectives, strategic initiatives and corporate projects.

CLASSIFICATION: UNRESTRICTED

Utilising the current resource allocation and delivery methods; programme implementation – i.e. training all teams across the Trust, will currently take until summer 2026. The executive will review this timeline and associated risks, along with a related options appraisal during April.

Programme spend remains on track, with a slight underspend against planned run rate under the Trust's contract with KPMG.

The significant risk to the programme is the impact that operational pressures and staff absence may have on the success of the programme. Mitigations are in place, with the risk and impact under regular executive review.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

1.0 Introduction and purpose

1.1 The purpose of this report is to provide the Board with a quarterly progress update of the Improving Together programme.

1.2 This is the second Improving Together highlight report the Board have received, the first being presented at the Trust Board meeting in January 2022.

2.0 Background and context

2.1 Improving Together is a long term programme to embed a culture of continuous improvement across the Trust. It aims to introduce a new way of working that will help to remove blocks to outstanding patient experiences and enable all staff to feel empowered to do what is best for patients.

2.2 At its heart, the programme makes sure that Trust priorities are clear to all, and that our resources are utilised in the best possible way to deliver our vision of an outstanding experience.

3.0 Key highlights and achievements in Quarter 4

3.1 Strategic deployment

Breakthrough objectives are Trust priorities to be delivered in the next 12-18 months that can be delivered by frontline teams through operational management structures. The four breakthrough objectives that have been chosen and will be measured are as follows:

1. Harm: Reduction in falls (led by Judy Dyos, Chief Nursing Officer)
2. Waiting List: reduction in time to first appointment (led by Lisa Thomas, Chief Finance Officer)
3. Non elective care: same day emergency care pathways (led by Andy Hyett, Chief Operating Officer)
4. No criteria to reside: reduction in time to discharge (led by Peter Collins, Chief Medical Officer).

Each of the breakthrough objectives are supported by an A3 structured problem solving analysis document. This is an iterative process that is undertaken by a group of subject matter experts, with co-ordination and challenge being provided by Trust colleagues already trained in A3 thinking and supported by KPMG.

Development of the A3s for each of the breakthrough objectives is nearing completion; with the main outstanding area being benefits realisation. Finalising these A3s has been hampered by operational pressures, annual leave and staff sickness.

The A3 documents have been passed to divisions for them to utilise in their prioritisation processes.

Strategic initiatives are ‘must do, can’t fail’ Trust priorities for the next 3-4 years. Four strategic initiatives have been chosen as follows:

1. Improving Together (led by Esther Provins, Director of Improvement & Partnerships)
2. Delivering our people promise (led by Melanie Whitfield, Chief People Officer)
3. Digital care (led by Naginder Dhanoa, Chief Digital Officer)
4. Improving health and reducing inequalities (led by Peter Collins, Chief Medical Officer)

The A3s for the Improving Together programme and improving health and reducing inequalities are in their final stages and have made excellent progress. Reducing health inequalities has featured highly in national planning guidance and through the national planning team the trust has access to PWC (who are supporting many elective plans including how the NHS address health inequalities through elective recovery). These correlations have added to its momentum and will be echoed in the corporate plan for 22-23.

It is anticipated that all the strategic initiative A3s will be complete by the end of April; this is a revised timeline reflecting slower than planned progress.

3.2 Operational management system – divisional and frontline teams

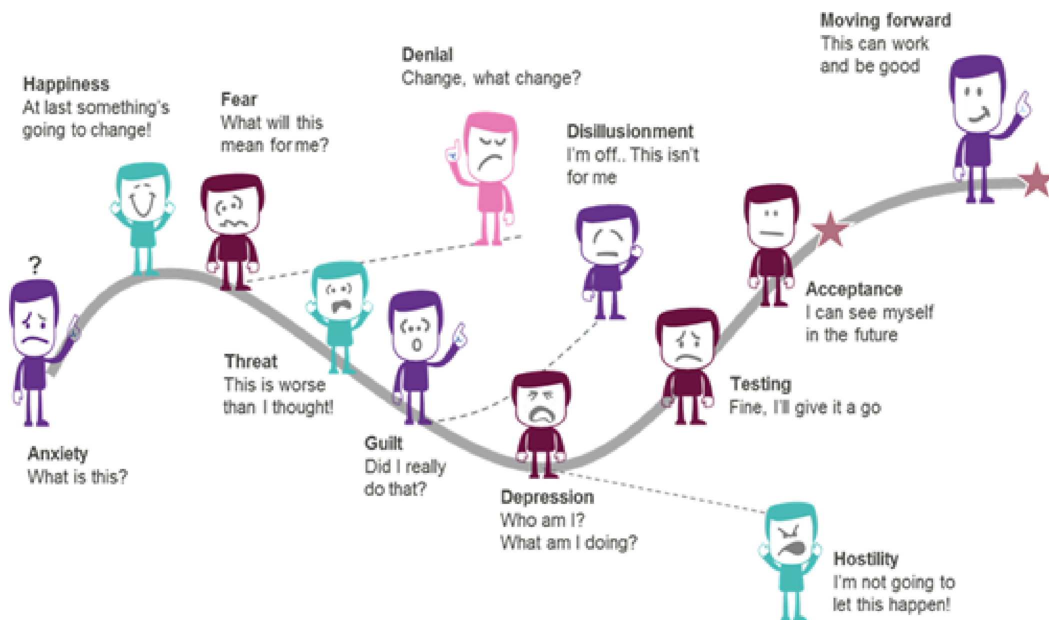
The five month modular training programme for divisions began at the beginning of February. This comprises of one day per month training followed by a 2 hour weekly coaching session for each individual team. These sessions are being co-delivered by KPMG and the Trust coach house team.

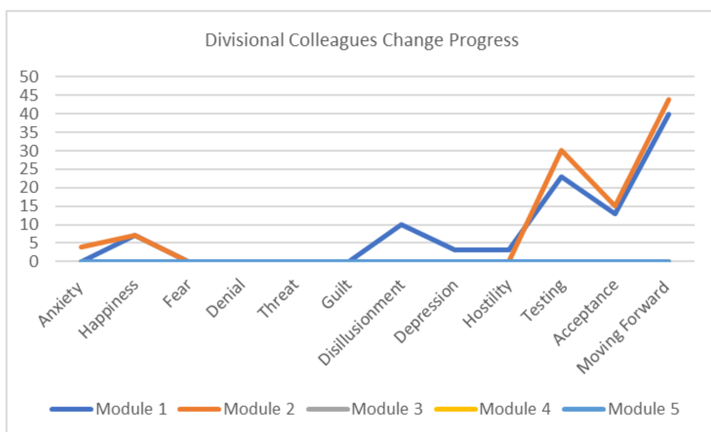
The engagement from divisional teams in the training and coaching sessions has been good. Attendance from CSFS and Women & Newborn divisions has been high, and although operational pressures combined with annual leave have impacted on the ability of Surgery and Medicine divisions to attend some sessions, both teams are actively engaged in the programme and have been progressing actions outside of these

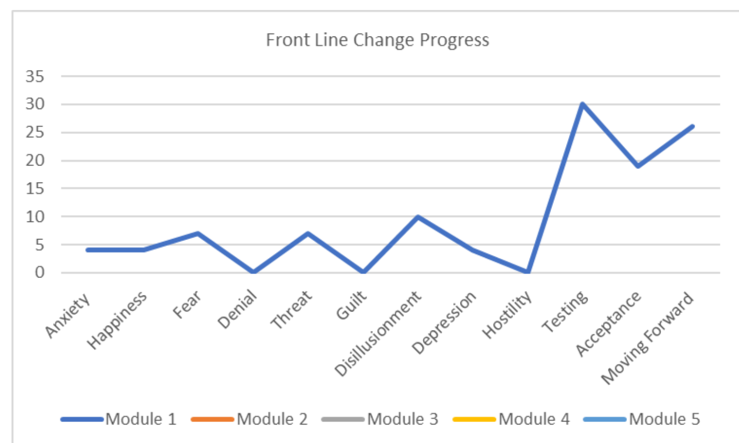
sessions. Extra sessions are being arranged to support continued progress where appropriate and have been welcomed by divisional colleagues.

The first module of training was delivered to front line team colleagues (Breamore, Amesbury / Chilmark, Pitton and Ophthalmology) on March 3rd. As with divisional colleagues, annual leave, operational pressures and rostering issues have impacted on some coaching sessions, and this is being addressed with divisional and team colleagues to support future attendance.

To gauge where individuals are within divisional and front line sessions, colleagues have been asked to rate themselves against the change curve. Results are identified below for both:







Specific Feedback from Divisional colleagues when asked 'What went well today?'

- '*The ongoing support is very much appreciated and I feel we're really moving forward with the program'*
- *'Divisional team development making good progress with good discussion and challenge'*

Specific Feedback from front line teams when asked 'What went well today?':

- ‘G*ood to get feedback and perspectives from our own team as we are in different roles, and also from the other wards departments and teams on the training also’*
- *‘Headspace and time away from the working environment’*
- *‘Relieved a lot of anxiety about the programme’*
- *‘A little bit more wiser as to what it’s all about’*

The first round of ‘scorecard agreement meetings’ took place on 23rd March. This is an new annual process culminating in a meeting at which divisions present their intended improvement priorities for the coming year to the Executive, and parties reach agreement on priorities and the content of a new style ‘divisional scorecard’ to measure improvement. This was the first opportunity the executive and divisions have had to use a new management system component, and put into practice new style leadership behaviours. In preparation for this meeting, divisions were able to review the A3s for the Trust’s agreed breakthrough objectives and apply them to their own teams and services, as well as select some additional divisional level priorities they feel are important.

These new scorecards will now go on to inform new style executive performance meetings commencing in April.

3.3 **Coach house**

The coach house team are continuing to take advantage of planned support and development to enable them to learn from KPMG and sustain the training and coaching needed to support programme rollout. The team is now fully formed and comprises of staff already employed by the Trust and colleagues joining the Trust from the private sector. The team consists of a Head of Quality Improvement and Coach House, 3 Senior Improvement Practitioners, 1 Improvement Practitioner and a Project Support Officer.

The Coach House Team have been working closely with KPMG to prepare training packs, facilitate and deliver training and coaching sessions for both divisional and front line teams. The team have developed evaluation material for front line teams. The team have received regular coaching and training sessions with KPMG as well as internally with colleagues within education, these continue to be arranged on a monthly basis. In addition, the team have been spending time forming as a ‘new team’, with more activities planned to support and enable this in the months to come. .

The Head of Quality Improvement and Project Support Officer have established close links and set-up weekly sessions with the Comms and Engagement manager to ensure sharing of knowledge and dissemination of information. The wider coach house team are also involved in this.

The Coach House are introducing elements of the Improving Together methodology within their core day to day working practices, which in turn will help when rolling out concepts to front line teams.

The Coach House has set up regular communication with the equivalent team at GWH to share learning and ideas across the two sites. KPMG are also facilitating links with other colleagues at other sites who are much further along in the process to share operational experience.

3.4 **Communications & engagement**

The programme launched officially on February 17th with an Executive message to all staff, introducing the programme formally. The Improving Together microsite has been launched and has featured dedicated news items (publicised in the daily bulletin) about the strategy creation, employment of the Coach House and various training events. An all staff briefing also took place on March 1st, with content delivered by the Chief Executive, Director of Improvement and Partnerships and the Chief People Officer, followed by an open question and answer session.

Following a successful procurement-led ITT, local company Unstuck Design won the commission to help SFT develop the Improving Together visual identity. The design is very much a development of the existing strategy deployment identity and this approach was taken because:

- By visually portraying the connection between the Trust's updated strategy and Improving Together, we help SFT colleagues to build their own understanding that there is a real connection between the two by presenting them consistently across a range of media.

- By creating something noticeably different to what SFT have had until now, we are signalling that the strategy and Improving Together are significant, long-term and here to stay.

Screen grab of the Improving Together visual identity:

We have begun the process of applying this identity to a range of items, including email headers and operational items. Other items such as lanyards and ID cards are in development.

The focus of the communications and engagement for the current period is deliberately internal, in order to give this new way of working the chance to become part of the fabric of the Trust's daily working and for tangible examples of successful change to start to emerge. Once these examples are ready for sharing, we will broadcast more widely to our populations and partners and the identity will become more widely visible and accessible to these external audiences.

3.5 **Corporate projects and transformation programmes**

A fundamental principle of Improving Together is a 'laser focus' on selected priorities and a ‘de-selection’ of other corporate improvement work being undertaken. For clarity, this comprises improvement projects that generally a) require corporate services to deliver and b) executive leadership to support. It does not include continuous improvement initiatives that are led and managed at a team level.

The aim of this process is to clarify which projects should be actively worked on as a priority and should be resourced immediately, and those which should be put on hold to wait for resources to become available.

A list of projects that are either underway, planned or requested has been drawn up and a series of workshops involving Trust senior leaders to prioritise and filter this list have been held. This prioritisation process uses Improving Together methodology, and aims to prioritise the current list of corporate projects based on either their importance in enabling the delivery of either a breakthrough objective, strategic initiatives or a mandatory issue.

Out of an original list of 242 unvalidated change initiatives initially recorded, the prioritisation process has identified a significantly shortened list of 42 projects as potentially mission critical or important. The Executive will receive more detailed information regarding project impact and resource allocation to enable further prioritisation during April.

A regular exercise to review new project requests and prioritise using the agreed approach is being planned. This is planned to be undertaken by senior Trust leaders with escalation to the executive.

3.6 **Leadership behaviours**

Leadership behaviours to support a culture of continuous improvement, as part of the NHS Leadership Compac, are central to the success of the programme. This is a core component of the modular training programme, with all colleagues, including the Board and executive as well as divisional and front line teams being supported to develop.

Both the executive and the Trust Board have benefited from focussed workshops regarding leadership behaviours required to embed a culture of continuous improvement. The executive have now commenced regular coaching sessions as a team, with the option to take up individual coaching sessions available.

A full Board workshop on Improving Together was held on February 3rd 2022, where the Board reflected on behaviours that support continuous improvement. The public board meeting on March 10th was observed by KPMG and feedback as a result of this process is due to be reviewed in the coming period.

3.7 **Business intelligence**

Focussed work on developing a new style Integrated Performance Report (IPR), new divisional and frontline scorecards is in progress. The new IPR will be presented for the first time at the Board meeting in May, reporting on data from the start of the new financial year. The executive will be receiving a draft IPR in the new format for review on 4tth April.

3.8 Governance and proposed reporting arrangements

There are two core elements of routine board reporting arrangements for consideration:

1. Improving Together programme progress as a whole; and
2. Priorities agreed as part of the new Improving Together way of working – i.e. progress against breakthrough objectives, strategic initiatives and corporate projects.

It has already been agreed that the Board will receive quarterly highlight reports on the Improving programme progress as a whole, as demonstrated by this paper.

In respect of the reporting arrangements for improvement priorities, the following is proposed:

- Breakthrough objectives: performance, progress and challenges will be a key part of the new Integrated Performance Report received by board committees and the Board on a monthly basis

- Strategic initiatives: progress, risks and issues will form part of the Strategy Delivery paper received by the Board on a quarterly basis and aligned to the BAF

- Corporate projects: progress, risks and issues will be reported to the relevant departmental oversight meeting with issues being escalated to TMC. The TMC escalation report to Board on a monthly basis will include any key issues regarding the delivery of corporate projects for escalation. Deep dives into corporate projects will be provided as appropriate on request, presented either at Board or at board committees.

Oversight of each of these individual components outlined above is maintained on a monthly basis at executive level, via executive team meetings.

Historically Board committees received a quarterly transformation report and it is proposed to stand this report down, streamlining key issues as part of the TMC escalation report to Board. This avoids duplication whilst still facilitating updates and assurance as appropriate.

The Board reporting elements being proposed are depicted by the diagram below:

Improving Together Programme

Board - quarterly

TMC - monthly

Executive Directors Meeting - weekly

Delivery of Strategic Initiatives / Breakthrough Objectives

Board - quarterly

Reported via the Integrated Performance Report (IPR) – monthly

Strategy Deployment Updates

Delivery of Corporate Projects

The TMC report is then escalated to Board - monthly

Any items for escalation are highlighted via escalation reports to TMC

Division/ department provide updates on progress of corporate projects at their departmental meetings (TMC sub-groups).

The second update for our Council of Governors took place on 28th February and good discussions regarding programme aspirations and progress was held.

7.0 Actions planned over next period

Work stream	Activities planned in coming period
Strategy deployment	• Strategic Initiatives A3s completed and signed off • Commence Integrated Performance Report use
Operational Management System – Divisions	• Continue with modular training programme • Hold first new style divisional executive performance meetings
Operational Management System – Frontline teams	• Continue with modular training programme
Leadership Behaviours	• Continuing to support Coach House team in their learning and facilitation through ALS, team dynamics and coaching sessions • Development and design of a cultural change support package for teams post frontline training
Coach House	• Finalise and approve plan for ongoing training programme roll-out (5 month prog, individual tools/methods) • Continue to take over activities from KPMG
Business Intelligence & Analytics	• Finalise development of divisional scorecards • Commence development of frontline team scorecards • Support the development of A3s for Strategic Initiatives • Complete development of new style IPR
Comms & Engagement	• Continuing to build awareness and engagement: • Beginning to build advocacy for this new way of working,
Board & Governance	• Continue to build Governors awareness programme • Ensure alignment of PRMS throughout Trust

	• Agree content and design of new IPR • Reflection of current Board practices • Board workshop planning
Transformation projects	• Embed regular process for corporate project prioritisation • Review and agree resource allocation and proposals for corporate project delivery in 22/23

4.0 Programme status

4.1 The Improving Together programme is currently rated amber due to slower than planned progress with developing the A3s for Trust wide level breakthrough objectives and strategic initiatives. This is being exacerbated by operational pressures and staffing challenges.

4.2 Adjustments are being made to planned training and coaching sessions to ensure maximum flexibility; both KPMG and the coach house are revising support to suit operational colleagues as much as practicable.

4.3 The critical elements of each trust wide level A3 have been focussed on to ensure no delays to programme timescales. For example, the core elements of exploring the problem, the current situation, agreeing targets and understanding root causes have been prioritised over the latter sections regarding detailed actions and benefits. This is to enable divisions and frontline teams to review these A3s and develop their own team level A3s with detailed action plans and benefits analysis with no delay.

4.4 With current mitigations in place, delays are not expected to impact significantly on overall programme timescales.

5.0 Improving Together Implementation timeline

5.1 As part of the Improving Together business case, the Board approved funding for the following additional implementation resources:

- Coach House improvement coaching team of 5 wte (4 new posts partly funded by re- design of two posts within existing Transformation team)
- Cultural change and OD team – strengthened by 3 wte on fixed term contracts to work as integrated team with the Coach House;
- An additional Communication specialist post on a fixed term contract to support the programme on a full-time basis
- A short term informatics post (18-24 months) to support the enhanced Operational management system processes whilst transitioning to the full implementation of a BI intelligence reporting tool

5.2 A hybrid model of implementation, being co-delivered by KPMG and Trust internal colleagues in partnership is in progress. This maximises sustainability of the approach whilst still exploiting KPMG's skills and experience as much as possible. KPMG are due to complete their formal support to the Trust in mid July.

5.3 The current delivery approach is a five month training and coaching programme, and our current level of resources allows for a maximum of 8 teams per cohort to be trained, with two cohorts per year.

5.4 The final cohort will complete their training in the summer of 2026, meaning that it will take four years to rollout out the Improving Together programme to the whole Trust. A summary gantt chart depicting this is contained in Appendix A.

5.5 Based on learning from wave 1, tweaks to the implementation approach may be desirable. For example, It may be beneficial to make training in certain critical elements of the programme more widely available to all colleagues (e.g. structured problem solving approaches and A3 thinking). Making tools available needs to be carefully balanced with supporting colleagues in adopting and embedding a new way of working; the latter generally requires proactive coaching and action learning.

5.6 It is noted that training in Improving Together needs to be transitioned to business as usual and become part of our general training whether that be through induction, refresher training and other means.

5.7 The executive supported by KPMG are due to consider the risks of the indicative timeline along with proposals to expedite critical programme elements in April and will consider what revisions, if any, are felt to be beneficial.

6.0 Benefits realisation

6.1 The business case considered by the Trust Board in Sept 2021 outlined summary projected benefits based on evidence from other Trusts adopting this programme.

6.2 Estimated financial benefits derived from delivering agreed priorities in 2022/23 are in the process of being evaluated and will be included in the 2022/23 operational plan.

6.3 A consistent approach to assessing potential benefits and reporting benefits realisation throughout the programme lifecycle is being worked up with GWH, as part of our commitment to sharing resources and lessons learned. Learning from other Trusts who are further in their journey to embed this programme is also being considered.

6.4 Divisions and frontline teams will be supported by the coach house team to track benefit realisation at a local level.

6.5 A trust wide view of benefits realisation will be co-ordinated by the coach house and transformation team and reported to Board via this quarterly update.

7.0 Programme expenditure

7.1 The current finance position in terms of our contract with KPMG is reporting as running very slightly underspent. A detailed account of KPMG milestones delivered and project finances is contained in Appendix B.

7.2 Additional recurrent and non-recurrent funding was approved to recruit to the coach house team, increase capacity in the communications, organisational development and business intelligence teams.

7.3 In addition to cost outlay under the KPMG contract, other programme expenditure in 2021/22 is detailed in the table below:

	FY 21-22 to Feb
Pay (coach house, comms, BI etc)	147,122
Non pay (venue hire, branding, stationery etc)	15,659

10.0 Programme Risks and Issues

10.1 The following key risk is acknowledged:

Risk	**Mitigation**	**Mitigated score**
There is a risk that operational and severe staffing pressures result in an inability to support the current planned training dates or a significant lack of attendance.	Training dates agreed early and as much notice as possible (8+ weeks) provided. Frontline team dates agreed and communicated prior to Christmas and proactive checks on staffing and backfill. Regular review with the executive team / programme board regarding national incident and local impact.	12 (Likelihood = possible, impact = major)

10.2 The following issue is currently being experienced:

Issue	**Mitigation**
Reduced capacity of operational colleagues to support the A3 structured thinking process, resulting in delays to A3 development.	Support being provided by corporate colleagues and KPMG, weekly escalation to delivery group, SRO and programme board. Critical path elements

11.0 Recommendation

11.1 The Trust Board note this highlight report, and

11.2 The Board of Directors approve the proposed reporting arrangements outlined in Section 3.8.

Appendix A

Indicative Implementation timeline

Front line training	Delivered by	cumulative total	Start Date	End Date	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Sep-22	Sep-23	Mar-24	Sep-24	Mar-25	Sep-25	Mar-26
Divisional Training	AY/HO	5	02/02/2022	08/06/2022												
Wave 1 frontline OMS Rollout	CB/PL	9	03/03/2022	07/07/2022												
Cohort 2	CB/PL/AY/HO	15.5	07/09/2022	11/01/2023												
Cohort 3	CB/PL/AY/HO	24	01/03/2023	05/07/2023												
Cohort 4	CB/PL/AY/HO	32	06/09/2023	10/01/2024												
Cohort 5	CB/PL/AY/HO	40	06/03/2024	03/07/2024												
Cohort 6	CB/PL/AY/HO	48	04/09/2024	08/01/2025												
Cohort 7	CB/PL/AY/HO	56	05/03/2025	09/07/2025												
Cohort 8	CB/PL/AY/HO	64	10/09/2025	14/01/2026												
Cohort 9	CB/PL/AY/HO	72	05/03/2026	08/07/2026												

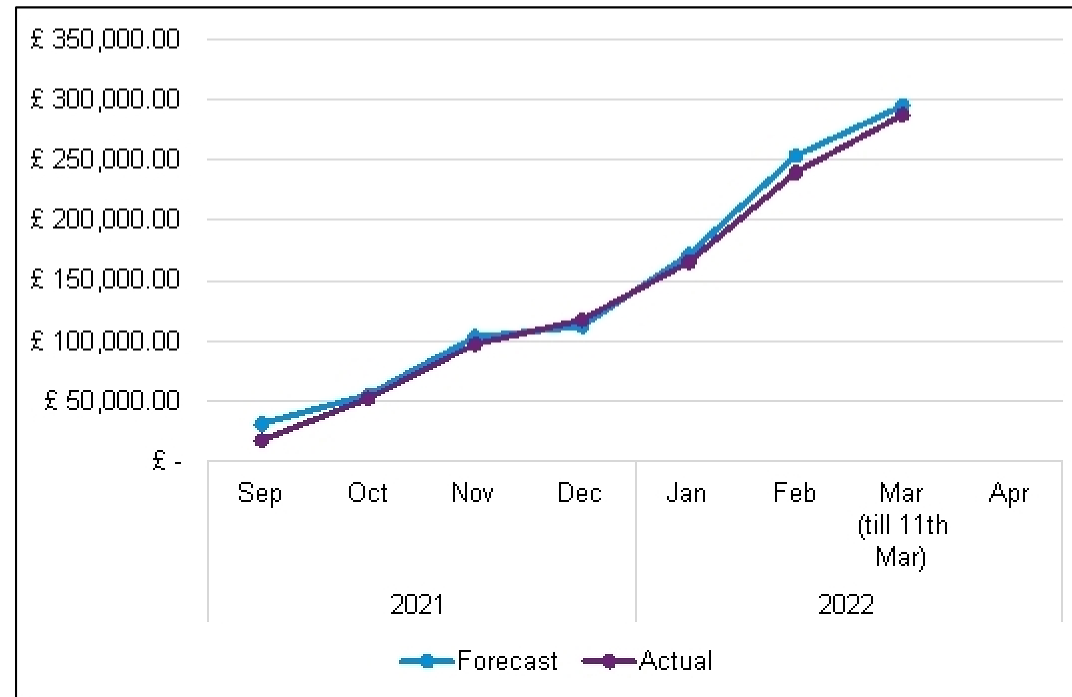
Assumptions:

- circa 70 teams to be trained
- based on current resource levels and rollout approach

Project Finances

NHS
Salisbury
NHS Foundation Trust

Cumulative								
	2021				2022			
	Sep	Oct	Nov	Dec	Jan	Feb	Mar (till 11th Mar)	Apr
Forecast	£ 31,230.00	£ 55,072.00	£ 103,387.00	£ 112,204.00	£ 171,421.00	£ 253,288.00	£ 294,534.00	
Actual	£ 17,419.13	£ 52,107.76	£ 97,439.45	£ 117,561.95	£ 165,401.95	£ 239,592.45	£ 287,188.33	
Spend	Under	Under	Under	Over	Under	Under	Under	
Variance	£ 13,810.87	£ 2,964.24	£ 5,947.55	-£ 5,357.95	£ 6,019.05	£ 13,695.55	£ 7,345.67	



NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	07 April 2022		

Report Title:	Review of Standing Financial Instructions			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Simon Bruce, Head of Financial Planning and Reporting			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	Appendix 1: Current Standing Financial Instructions Annex 1 Appendix 2: Recommended revised approval levels. Appendix 3: Proposed SFI document with 'track changes'			

Recommendation:
To accept the recommendation of Audit committee on the proposed amendments to the Salisbury NHS Foundation Trust's Standing Financial Instructions, including changes to the delegated limits set out in the document and to update the text accordingly.

Executive Summary:
Following a review of the Trust's Standing Financial Instructions two amendments are being proposed: (i) an increase to the delegated revenue approval limit of Deputy Directors of Operations (DDOs) from £10 to £25k; and (ii) to give Capital sub-groups delegated authority to approve movements of funds up to £20k between schemes. The objective of these amendments is to improve responsiveness in decision making through targeted changes to delegated authorisation limits. A proposal to grant a £500 electronic approval limit at a junior level was removed following discussion at Audit Committee. The SFIs have also been expanded to explicitly state the requirement on exercising Emergency Powers (Chair's Action).

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐

Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

1 Purpose

1.1 The purpose of this report is to brief the Board on the review of the Trust's Standing Financial Instructions, and to recommend amendments as appropriate:

2 Background

2.1 The Trust's Standing Financial Instructions (SFIs) have been in place since March 21. The SFIs are issued for the regulation of the conduct of the Trust's members and officers in relation to all financial matters with which they are concerned.

2.2 The SFIs should be reviewed for effectiveness and appropriateness on a regular basis, the last such review of the Trust's SFIs was in March 2021.

2.3 Where the Board does elect to set delegated limits, the Chief Executive Officer remains ultimately accountable to the Board as Accountable Officer, retaining overall responsibility for the Trust's activities. All delegated powers can be re-assumed by the CEO should the need arise.

3 Implementation of Oracle R12

3.1 The implementation of Oracle R12, hosted by NHS Shared Business Services, in July 2021 has provided the Trust with an opportunity to reconsider the electronic approval hierarchy for the purchase of goods and services. The levels set up in the approval hierarchy have been based upon Annex 1 to the SFIs (appended as Appendix 1 to this paper) which sets out delegated limits of authority to approve expenditure.

3.2 Seven levels of approval were initially embedded into the Oracle R12 hierarchy, consistent with the levels identified in SFIs Annex 1: £500, £3000, £10,000, £50,000, £100,000, £350,000 and unlimited (relating to CFO and CEO). The £350,000 level relates to the authority of the Director of Procurement to place orders. Consistent with SFIs, approval limits up to the level of Deputy Director of Operations (DDO) had 3 levels: £500, £3,000 and £10,000.

3.3 Oracle R12 will not allow self-approval of requisitions which must now be at least on a 'one over one' basis. This means that one user must act as a requisitioner and one as an approver (provided they have sufficient authority). The establishment of the approval hierarchy has proved to be one of the more challenging aspects of implementation given the fluid nature of some of the management structures. Work is in hand to refine the approval hierarchy in line with divisional requirements.

3.4 Based on feedback and lessons learned so far, a requirement for additional approval levels has been identified, and these are now identified as 11 discrete levels linked to roles. There needs to be sufficient resilience built into the system so that the hierarchy is able to withstand staff absences at all levels. The recommended revised hierarchy is outlined in Appendix 2, and a key change is a recommended increase in DDO approval to £25,000.

4 Delegated limits

.1 Current SFIs identify the Divisional limit for revenue expenditure approval to be £10,000. This limit has remained the same since before the organisational structure was changed to reflect the formation of more autonomous clinical divisions, each headed by a Clinical Director. Indeed, the narrative in the current SFIs refers to directorates, and Directorate Managers (DMs) rather than the current job title of Deputy Directors of Operations (DDO).

4.2 Moreover, there is a mis-match in the current SFIs between Divisional authority to approve revenue spend as outlined in Annex 1(£10,000), and the delegated authority of Divisions to commit to revenue expenditure as part of business cases (£25,000).

4.3 In the time between the Oracle r12 system going live at the beginning of July 21 and mid-February 22, there were 282 requisitions raised for amounts greater than £10,000, which required approval at DDO level. These requisitions also required further authorisation at the level of either Chief Operating Officer or Financial Controller. If the approval level of DDOs were raised to £25,000, the number of requisitions requiring further approval would have fallen to 65.

4.4 Given the separation of responsibilities built into the Oracle r12 system, and the requirement for all requisitions to be approved, there would be minimal risk in increasing the approval level of DDO to £25,000. Doing so would add efficiency and resilience into the approval hierarchy, and the Audit Committee are asked to approve this recommendation. A tabular comparison of existing limits and the recommended replacement is at Table 1. Procurement limits relating to the authority to place orders would remain unchanged.

Table 1: Financial Approval Hierarchies

Current SFIs

Level		Examples of staff
Level 1	**£ 500**	**nurses, ward assistants***
Level 2	£ 1,000	requisitioning staff in larger departments
	£ 2,000	ward sisters
	£ 3,000	**supervisors***
	£ 5,000	departmental managers
Level 3	**£ 10,000**	**Directorate Senior Nurses, Directorate Managers***
Level 4	£ 50,000	Financial Controller, Deputy Director of Finance
Level 5	£ 100,000	Directors
Level 6	>£100,000	Chief Executive, Finance Director

* levels initially set up in Oracle r12

Recommended revised approval levels

Level		**Indicative Role/Band**
Level 1	£0	Requisitioner only. Preferably Band 2 or 3 (several per sub service)
Level 2	£1,000	Band 5 / 6
Level 3	£2,500	Band 7
Level 4	£5,000	Band 8a+ or Clinical Lead
Level 5	£9,999	Band 8b or above (8a if delegated DMT member)
Level 5A	£10,000	Band 8b or above (8a if delegated DMT member)
Level 6	£25,000	Band 8d or 9 (DDO/Head of Legal Services)
Level 7	£50,000	Deputy Director of Finance / Financial Controller
Level 8	£100,000	Chief Operating Officer / Director of Nursing / Medicial Director / Director of OD&P
Level 9	>£100,000	Chief Executive / Director of Finance

4.5 Additionally, the Committee is asked to approve extending the same approval level of £25,000 to the Head of Legal Services. Most legal transactions are undertaken on a non-Purchase Order basis, and the post holder applies specialist knowledge to assess and approve these invoices. Escalation to DDO or director level for approval of invoices between £10,000-£25,000 is not an efficient use of resource.

5. Delegated Capital Limit

5.1 The Building and Infrastructure Group (BIG) is has recently been established as a sub-group of the Trust's Capital Control Group (CapCG). The BIG will lead on the identification and delivery of capital schemes for estates, buildings and infrastructure and identify capital funds required to support the delivery of Facilities Services.

5.2 As part of the reviewing terms of reference for the BIG, it has been identified that the ability for the group to transfer funds of up to £20k between projects would improve operational flexibility and effectiveness. The Committee is therefore asked to approve giving delegated authority for each of the CapCG sub-groups (BIG, Medical Devices Management Committee and IT sub-group) to move expenditure of up to £20k between individual capital schemes.

6. Emergency Powers (Chair's Action)

6.1 It has become apparent that although covered by the Trust's constitution, the requirements and process around Emergency Powers is not explicitly covered by the SFIs. It is therefore proposed to address this by including the wording of the constitution in the 'Responsibilities and Delegation' section of the SFIs, and to add a fourth annex detailing the required steps to be taken when exercising the powers.

6.2 Annex 8, section 4.3 of the constitution states:

'The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

This paragraph will be included witin section 1.2.11 of the SFIs.

6.3 Annex 4 of the SFIs will read as follows:

Emergency Powers (Chair's Action)

1. A recommendation to utilise Emergency Powers must be made by the Chief Executive (or Deputy Chief Executive if responsibilities have been delegated) by email to the Chair and at least two other Non-Executive Directors.

2. The request must include the justification for the recommendation, and the reasons for the need to override normal governance procedures.

3. Agreement to proceed is contingent on the approval of CEO, Chair, and at least two Non-Executive Directors. Evidence of the approval must be recorded (email records are sufficient).

4. The exercise of emergency powers shall be reported to the next formal meeting of the Board in public or private (as appropriate) for ratification.

5. Utilising Emergency Powers does not remove the need to subject the recommendation to Trust governance procedures. Business cases, recommendation reports, and any other paper falling within the scope of the Scheme of Delegation should still be reviewed in the forums and committees as set out in the SFIs as a matter of good practice and to ensure risks, mitigations, and benefits have been appropriately explored and challenged.

6. A schedule of decision taken under Emergency Powers should be presented to Audit Committee on a quarterly basis. This schedule should include the reasons for the escalation, as set out in (2.).

7. Recommendation

7.1 It is recommended that the Committee accept and recommend to Board the changes to the SFIs set out in this paper.

7.2 A full 'track changes' version of the SFIs is in appendix 3 of this report.

Appendix 1

Annex 1
Authorisation Levels For Electronic Requisitioning System

1.1 All staff authorised to approve the purchase of goods or services, and signing of invoices where appropriate, will be allocated an authorisation level. Each Directorate can set its own authorisation levels under Level 3 below (Levels 1 and 2 are shown as suggested levels only)

1.2
Level 1 - Up to and including £500 per total requisition (e.g. nurses, ward assistants, staff with requisitioning responsibility in smaller departments)

Level 2 - £501 - £5,000 per total requisition. The actual level of authority will depend on the work area and the following are examples**:**
- £1,000: requisitioning staff in larger departments
- £2,000: ward sisters
- £3,000: supervisory levels in departments, requisitioners in theatres, staff club manager
- £5,000: catering manager, medical physics manager, deputy head in genetics

Level 3 - £5001 - £10,000 per total requisition
- £10,000: DSNs, DMs, heads of larger departments
- £10,000: Head of Facilities

Level 4 - Up to £50,000 per total requisition: Deputy Director of Finance, Financial Controller

Level 5 - Up to £100,000 per total requisition: Chief Operating Officer, Director of HR, Director of Nursing, and Medical Director

Level 6 - Over £100,000 per total requisition (but subject to any other limits approved by the Trust Board): Chief Executive, Director of Finance

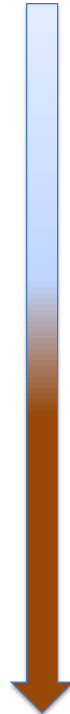
1.2 Each Directorate is responsible for compiling their own authorised signatories list, including determining which staff should be given authorisation below level 3. Amendments to the above levels of authorisation may be approved in specific cases but will need to be approved by the Director of Finance.

1.3 The Finance Department will maintain a database of staff on each authorisation level per Directorate. Directorates will be responsible for notifying the Finance Department of any additions, deletions or other changes to their authorised signatories' lists. The Finance Department will ensure the database is amended to reflect the changes and ensure the computer security is amended accordingly**.**

1.4
Authorisation Levels for Electronic Ordering System

2.1 All requisitions will be converted to Orders and processed within the Procurement Department where individual staff will have specific levels of authorisation below that of the Head of Procurement's £50,000 level. The electronic requisition will have already been authorised at the appropriate level within the organisation prior to receipt by Procurement.

2.2 The Director of Procurement will have authority to process orders up to - £350,000. Any orders beyond this amount will need to be authorised by the Chief Executive or Director of Finance.



Hierarchy	Abbreviated	iProc Function	Role	Indicative Band for Responsibility	Financial Approval Authority Limit (Financial approval limits are gross (including tax) based on value of transaction)	Non PO Invoice Approval Hierarchy	R12 Invoice Approval Position
Level 1	L1R	Requisitioner	Any	Preferably Band 2 or 3 (several per sub service)	£0	No	RNZ_INVOICE_APPROVER_0000000
Level 2	L2A	Approver	Band 5 if A&C or Band 6 if clini	Band 5 / 6	£1,000	Yes	RNZ_INVOICE_APPROVER_0001000
Level 3	L3A	Approver	Ward Lead or Sub-Service Ma	Band 7	£2,500	Yes	RNZ_INVOICE_APPROVER_0002500
Level 4	L4A	Approver	Head of Service or Clinical Lea	Band 8a+ or Clinical Lead	£5,000	Yes	RNZ_INVOICE_APPROVER_0005000
Level 5	L5A	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£9,999	Only for escalation	RNZ_INVOICE_APPROVER_0009999
Level 5A	L5AA	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£10,000	Only for escalation	RNZ_INVOICE_APPROVER_0010000
Level 6	L6A	Approver	Divisional Director of Operations (DDO)	Band 8d or 9	£25,000	Only for escalation	RNZ_INVOICE_APPROVER_0025000
Level 7	L7A	Approver	Deputy Director of Finance / Financial Controller/Director of Procurement		£50,000	Only for escalation	RNZ_INVOICE_APPROVER_0050000
Level 8	L8A	Approver	Chief Operating Officer / Director of Nursing / Medicial Director / Director of OD&P		£100,000	Only for escalation	RNZ_INVOICE_APPROVER_0100000
Level 9	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999
Level U	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999

Procurement authority to process pre-authorised orders

		Approver	Director of Procurement		£350,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000
		Approver	Deputy Director of Procurement		£50,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000

NHS
Salisbury
NHS Foundation Trust

Standing Financial Instructions

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Signature of authorising Committee:	
Ratification Committee (Category 1 documents):	
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Standing Financial Instructions

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STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Salisbury NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1stJune 2006, following authorisation by "NHS Improvement", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS Improvement, which this document represents).

1.1.3 The Single Oversight Framework details how NHS Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in The Audit Code for NHS Foundation Trusts, and the Department of Health Group Accounting Manual (DH GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors.

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the Director of Finance, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Trust Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Director of Finance (DOF)

1.2.4 The Chief Executive and DOF will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive to ensure that Members of the Trust Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

The Director of Finance

1.2.7 The DOF is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the DOF include:

   i) Provision of financial advice to other members of the Trust Board and employees;

   ii) Design, implementation and supervision of systems of internal financial control;

   iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

Board of Directors and Employees

1.2.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS Improvement, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.9 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the DOF.

Emergency Powers

1.2.11 The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

1.2.12 The process on utilising Emergency Powers, detailing required documentation, is set out in Annex 4.

2. AUDIT

2.1 Director of Finance

2.1.1 The DOF is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHS Improvement's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit Committee. The report(s) must cover:

  i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DH, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Annual Governance Statement" and also provides assurances to the Audit Committee;

  ii) Any major internal financial control weaknesses discovered;

  iii) Progress on the implementation of internal audit recommendations;

  iv) Progress against plan over the previous year;

  v) A detailed work-plan for the coming year.

2.1.2 The DOF and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access during normal working hours to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

  i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

  ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations / project work agreed with and under terms of reference laid down by the DOF;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DH;

i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the DOF must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.

2.2.4 The Head of Internal Audit or equivalent title, will normally attend Audit Committee meetings and has a right of access to Audit Committee members, the Chairman and Chief Executive.

2.2.5 The reporting system for internal audit shall be agreed between the DOF, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DH Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee.

2.3.2 The Audit Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.3.6 Prior approval must be sought from the Audit Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the DOF is required to authorise expenditure.

2.3.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive and DOF shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to NHS Protect's standards.

2.4.2 The DOF is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Protect anti-crime Standards.

2.4.4 The LCFS shall report to the DOF and shall work with staff in NHS Protect, in accordance with the NHS Protect anti-crime Standards, the anti-fraud manual and NHS Protect's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the DOF to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Protect.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the DOF and outcomes fed back to the Audit Committee.

2.4.8 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Protect.

2.4.9 The Trust will report annually on how it has met the standards set by NHS Protect in relation to anti-fraud, bribery and corruption work and the DOF shall sign-off the annual self-review and authorise its submission to NHS Protect. The DOF shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHS Protect's standards.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHS Protect anti-crime standards.

2.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management

2.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD). who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Trust Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in patient care activity, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS Improvement (NHSI).

3.1.2 The annual plan must be approved by the Trust Board and submitted to NHSI in accordance with their requirements.

3.1.3 All executive directors, directorate management teams and corporate service managers shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

3.1.4 The DOF will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Trust Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Business Plan;

b) Accord with patient care activity and manpower plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks and mitigating actions;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

3.1.5 The Trust Business Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.6 The DOF shall monitor financial performance against budget, and report to the Finance and Performance Committee and Trust Board of Directors.

3.1.7 All budget holders must provide information as required by the DOF to enable budgets to be compiled.

3.1.8 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to forecast will be made in year for those that are subsequently approved. Table 1 sets outs the delegated limits for the approval of business cases:

'In year' revenue value	Authorisation to approve
<£25k	Division Management Team
£25k to <£250k	Trust Management Committee Chief Executive
£250k to <£750k	Finance and Performance Committee
>£750k	Trust Board

Table 1

3.1.9 The DOF has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive, through the DOF, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

e) Achievement of planned levels of service;

f) Authority to exercise virements.

g) The provision of regular reports.

3.2.2 Except where otherwise approved by the Chief Executive, taking account of advice from the DOF, budgets shall only be used for the purpose for which they were provided.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the DOF, subject to guidance on budgetary control in the Trust.

3.2.4 Non-recurring budgets shall be agreed by the Chief Executive or the DOF and should not be used to finance recurring expenditure without their authority in writing.

3.2.5 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.6 Clinical Directors or Service Leads, who are responsible for 'trading activities' must ensure the integrity and supply of information to other users. Price increases in such departments should be monitored by the DOF to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

3.3.1 The DOF will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Finance & Performance Committee and Trust Board of Directors in a form approved by the Trust Board of Directors containing sufficient information to allow the Finance & Performance and the Trust Board of Directors to ascertain the financial performance of the Trust. This may include the following:
   i) Income and expenditure to date, showing trends and the forecast year-end position;
   ii) Workforce spend and WTEs;
   iii) NHS commissioner's contractual performance to date;
   iv) Movements in working capital (including cash);
   v) Capital project spend and projected outturn against plan;
   vi) Explanations of any material variances from budget;
   vii) Details of any corrective action where necessary and the Chief Executive's and/or DOF's view of whether such actions are sufficient to correct the situation;

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial, workload and manpower budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.3.2 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget-holder must account to their Directorate Management Team or line manager for the overspending and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.

3.3.3 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Trust's Vacancy Control Panel, other than medical and nursing staff provided for within the budgeted workforce establishment.

3.3.4 The Chief Executive will delegate to budget holders responsibility for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with NHS Improvement's Single Oversight Framework, finance and use of resources metrics.

3.4 Capital Expenditure

3.4.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.5 Performance Monitoring Forms and Returns

3.5.1 The DOF on behalf of the Chief Executive, will ensure that the appropriate monitoring forms and returns are submitted to NHSI in accordance with the national annual timetable. The performance figures to the Trust Board of Directors should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The DOF, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS Improvement and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS Improvement as to their technical accounting content and information/data shown therein, before submission to NHS Improvement.

4.2 The Chief Executive will prepare the Annual Report in accordance with the guidance in the DH Group Accounting Manual.

4.3 The Director of Nursing will prepare the Annual Quality Report in the format prescribed by NHS Improvement/Care Quality Commission and in accordance with the DH Group Accounting Manual. The Quality Report presents a balanced picture of the Foundation Trust's performance over the financial year and up to the agreed submission date.

4.4 The Trust's Annual Report, Annual Accounts and financial returns to NHS Improvement and Annual Quality Report must be audited by the external auditor in accordance with appropriate international auditing standard, where relevant.

4.5 The Annual Report, Accounts and Quality Report (including the auditor's report), shall be approved by the Board of Directors after review by the Audit Committee. The Clinical Governance Committee will also review the Quality Report prior to its submission to the Audit Committee.

4.6 The Annual Report, Accounts and Quality Report (including the auditor's report) is submitted to NHS Improvement (in accordance with its timetable) by the DOF and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.7 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.8 The Chief Executive, Chairman and DOF, as appropriate, will sign the various documentation relating to the Annual Report, Annual Accounts and financial returns to NHS Improvements and Annual Quality Report on behalf of the Trust Board.

4.9 Where a subsidiary is owned or partially owned by the Trust in a manner to require consolidation under the requirements of IFRS then the annual accounts of the subsidiary will be completed as a part of undertaking the consolidated accounts for the Trust. Should the Trust be involved with an Associate Company the results will be reported in line with recognised accounting requirements.

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The DOF is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The DOF will review the banking needs of the Trust at regular intervals to ensure they reflect current business patterns and represent value for money.

5.1.3 The Trust Board will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The DOF is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made, or there is a right of set-off with another account held with that bank;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

f) Monitoring compliance with NHS Improvement or DH guidance on the level of cleared funds;

g) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The DOF will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit, if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The DOF must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The DOF will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The DOF is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The DOF is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the “Payment by Results” (“PbR”) financial regime determined by the DH where applicable.

6.2.2. The DOF is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Responsibility for arranging the level of property rentals, and for reviewing rental and other charges regularly shall rest upon the Director of Finance who shall take into account independent professional advice on matters of valuation. The Director of Finance shall be consulted about the pricing of goods and services offered for sale.

6.2.3 All Employees must inform the DOF promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Annex 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust’s policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The DOF is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits;

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £10,000	Financial Controller
£10,001 to £100,000	DOF
£100,000 plus	Audit Committee

The limits apply to individual items. A schedule of written off debt shall be presented to the Audit Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit Committee should be presented to the Trust board for information.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The DOF is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The Director of Finance shall be responsible for the arrangements for security and issue of bulk stocks of cheques.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the DOF.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss, and written and signed “declarations of indemnity” must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 14 Disposals and Condemnations, Losses and Special Payments).

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.

For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.

A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.

Table 2

Contract Value (Excl VAT)	**Quotations/Tenders**	**Min number invited to Quote/Tender where available**	**Form of Contract**
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 - Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage

of the procurement process.

Threshold limits represent the contract's lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 method and authorisation).

The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above)

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

7.3 Placing Contracts

Authorisation to sign a Contract and recommendation report requirements are detailed in Table 3 below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table 3.

Table 3

Contract Value	Recommendation Report Requirement	Authorisation To Place or sign Contract
<£10,000 (Inclusive of zero nominal value)	No	As per purchase order system approval hierarchy approval
£10,000 – £24,999	Recommendation report required only if contract has not be awarded to the most economically advantageous offer	As per purchase order system approval hierarchy approval
£25,000 - £99,999	Yes	Head of Procurement
£100,000 – £249,999	Yes	Director of Procurement
£250,000 - £499,999	Yes	Director of Finance
£500,000 - £999,999	Yes	Finance Committee
>£1,000,000	Yes	Trust Board/Chairman

The Director of Finance, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

7.4 Electronic Tendering

All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal.

All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.12 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.

All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

7.5 Manual Tendering – General Exception Rules

No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);

Or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.6 Receipt, Safe Custody and Record of Formal Tenders submitted manually

All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

The appropriate officer shall designate an officer or officers, not from the

originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.7.

7.7 Opening Formal Tenders

As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

Every tender received shall be stamped with the date of opening and if manually opened they shall be initialed by two of those present at the opening.

A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record, where a manual process has been conducted.

Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialed by two of those present at the opening.

A report shall be made in the record if, on any one tender, price alterations are considered so numerous as to render the procedure set out in the paragraph above unreasonable.

7.8 Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Director of Finance, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

Tenders received after the due time and date may be considered only if the Director of Finance or Director of Procurement or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Director of Finance, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re- tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. All decisions in relation to tenders received after the due time and date should be recorded in the procurement log.

Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Director of Finance or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.8.

Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Director of Finance.

Where only one tender/quotation is received the Director of Procurement /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (within 7.10 below).

All tenders should be treated as confidential and should be retained for inspection.

7.9 Extensions to Contract

In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

7.10 Quotation & Tendering Procedures

Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2 and will involve procurement department in line with Table 2.

Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.

No tender shall be considered which bears any mark or name indicating the sender.

Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise through the appropriate portal in line with Public Contracts Regulations and must subsequently ensure the respective award is also published.

Where the total contract value exceeds the Public Contracts Regulations Thresholds then the Trust is committed to conducting a legally compliant procurement process in line with the Public Contracts Regulations.

Where appropriate, pharmacy orders will be placed against National or Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2

Tender lists for building and engineering works will be compiled in conjunction with the Director of Corporate Development from “Construction line” the Trust’s approved list of Contractors.

Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Director of Finance for further instructions.

The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

Quotation/tenders will be completed accordance with these SFIs.

Adjudication must be made in accordance with SFI 7.8 recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.

Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2).

All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact.

The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

A flow chart outlining the legally compliant competitive tendering process and contract requirements is outlined at Annex 2.

7.11 Quotation & Tendering Procedures Summary - Contracts

Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

No Pre Qualifications stages should be conducted in accordance with Public Contract Regulations
Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Signed Contracts will be required for all Single Tender Action waivers over £25,000.

Quotations/ tenders shall be invited for all purchases over a period of time in line with Table 2 in specified in SFI 7.2.

Quotations/ tenders will be issued in accordance with these SFI’s and shall

incorporate standard NHS Terms and Conditions of Contract.

After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.8.

A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Table 2 in SFI 7.3 according to delegated limits.

All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee on a six monthly basis highlighting all waivers over £10,000 in line with STA's approved by the Director of Finance.

All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and published in line with Public Contracts Regulations.

All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source To Contract System. Any exceptions to this are at the discretion of the Director of Procurement.

7.12 Waiving or Variation of Competitive Tendering/Quotation Procedure

Signed Contracts will be required for all Single Tender Action waivers over £25,000.

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

Formal competition need not be applied (and therefore a waiver is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value out in in SFI 7.2 Table 2

b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with

c. The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (eg/ change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor

d. The expenditure relates to agency pay however internal governance and authorisation will apply

e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health

f. A direct award to a supplier on a national or regional framework is

permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with SFI 7.3 Table 2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust

g. The requirement is to attend a seminar, conference or similar unique event

h. A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed

j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement but the nominated Officer must still ensure value for money

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Trust Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the NHS England (NHSE) or NHS Improvement are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

(a) Costing and pricing (in accordance with Payment by Results) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff. Any local price should be at least equal to the appropriate cost of the service being provided.

8.1.7 Any local changes in the counting and coding of patient activity will need to be notified to the DOF prior to implementation

8.1.8 The DOF shall produce regular reports detailing actual and forecast income.

8.1.9 The DOF shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

Annex

8.1.10 The authorisation limits for signing service contracts are set out in Annex 3.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs

and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where SFT is a competing body)

8.3.1 Where SFT participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Directorate Management Team	**Trust Management Committe**	**Finance & Performance Committee**	**Trust Board**
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£5m	<£15m	>£15m
Annual value	£20k pa	<£1m pa	>£1m<£5m pa	>£5m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to Executive Directors for noting.

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration Committee

9.1.1 The Trust Board shall establish a Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and most Senior Manager Posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director Posts above the salary of the Prime Minister (currently circa £150k) must be referred to NHS Improvement and onward ratification by the Secretary of State.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Workforce Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees

after consultation with their Human Resources Manager and job evaluation has taken place in accordance with Trust policy.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off payroll engagements must be approved by the DOF prior to contract signature.

9.2.3 Each employee shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be submitted to the Director of Finance at the earliest opportunity.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the intranet.

9.2.6 A "Notification of Termination" form and such other documents as the Director of Finance may require, shall be completed and forwarded to the payroll department immediately upon the date of; an employee's resignation, retirement, or termination, being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Payroll Manager shall be informed immediately.

9.2.7 Changes forms covering an Employee's Personal Details i.e. Name, Address or Job Details shall be completed and forwarded to the payroll department immediately upon the Manager becoming aware of the change.

9.2.8 The Trust Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its Managing Implications of Organisational Change Policy.

9.2.11 The Trust must seek approval from NHS Improvement before commissioning Management Consultants above a cap of £50k.

9.3 Processing Payroll

9.3.1 The Director of Finance shall be responsible for the final determination of monetary pay, (including the verification that the rate of pay and relevant conditions of service are in accordance with Trust employment contracts), the proper compilation of the payroll and for payments made. No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the Director of Finance.

9.3.2 All pay sheets, and other pay records including travel expense claim forms supported by vouchers/receipts where appropriate, shall be in a form approved by the Director of Finance (manual or electronic) and shall be certified and submitted in accordance with his/her instructions.

9.3.3 The Director of Finance shall determine the dates on which salaries and wages shall be paid.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed otherwise by the Director of Finance.

9.3.5 Payment shall not be made in advance of the pay dates determined as in 9.3.3 above except where prior approval has been obtained from the Chief Executive, Director of Finance (or duly appointed representative) or the Director of Organisational Development and People. In such cases the payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 Where the Trust HR Policies so allow, loans may be made to staff and recovered in accordance with arrangements that the Director of Finance and Director of Organisational Development and People shall determine jointly.

9.3.7 The Director of Finance shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.8 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under/ over payments is contained in the Trust's Pay policy. This policy sets out that pay claims in excess of normal contractual hours will only be paid within 3 months of the extra shift/ hours. Any claims over 3 months old will need to be approved by the DOF.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Director of Finance will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 1.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust Director of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the DOF shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition. Only for agreed goods and services (i.e. agency staff and utilities) should a good or service be obtained without a purchase order.

10.3.3 The DOF or if delegated, the Financial Controller, shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.4 The DOF will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are

evidenced;

- In the case of contract for building and engineering works which require payment to be made on account during process of the works the DOF shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the DOF and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the DOF of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

10.3.5 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The DOF must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.6 Managers must ensure that they comply fully with the guidance and limits specified by the DOF and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the DOF in advance of any commitment being made;

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the DOF on behalf of the Chief Executive;

c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the DOF;

e) Petty cash records are maintained in a form as determined by the DOF;

f) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement; and

g) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the DOF who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Where managers are unsure of the VAT status of any particular transaction advice will be provided from the Finance Department.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS Improvement's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Trust Board and will only be made by the DOF or a person with specific delegated powers from the DOF. Use of such loans or overdraft facilities must be approved by the DOF.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the DOF.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 Any application for an increase in public dividend capital on behalf of the Trust shall only be made by the Director of Finance or their nominated representative and will be notified to the Trust Board or the Finance and Performance Committee on the Board's behalf.

11.2.2 The Trust will comply with the guidance on dividend payments contained in the DH Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 Investment of cash on a short or long term basis shall be in accordance with the Trust's Treasury Management Policy as approved from time to time by the Finance and Performance Committee. The Director of Finance shall compile and regularly review the Trust's Treasury Management Policy and advise the Finance and Performance Committee of any necessary changes.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Trust Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS Improvement and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Finance and Performance Committee on an annual basis.

11.3.5 The DOF is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Finance and Performance Committee.

11.3.6 The DOF will prepare detailed procedural instructions on the operation of

investment accounts and on the records to be maintained.

11.3.7 The DOF (or a senior finance manager with specific delegated powers from the DOF) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Finance and Performance Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Strategic Capital Committee (SCC) chaired by the Director of Finance to oversee its allocation of capital investment. The DOF will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.1.2 The SCC will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.1.3 The DOF shall establish systems to ensure that approved capital schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.1.4 The financial performance of the Capital Programme shall be reported to the Trust Board on a monthly basis with fuller details of the larger schemes on a quarterly basis.

12.2 Approval of Capital Business Cases

12.2.1 Approval of Capital Business Cases will be as follows:

Table 4

Capital Plan	***Approval to proceed, or changes to previously approved Capital.***	**Forum**
N/A	<£20k	Buildings & Infrastructure Group, Medical Devices Management Committee, IT Capital Group
N/A	<£100k	CapCG (SCC~~TMC~~ informed via minutes)
N/A	£100k to <£350k	Strategic Capital Committee Director of Finance
N/A	£350k to <£500k	TMC Chief Executive
N/A	£500k to <£750k	Finance and Performance Committee
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	£750k+ Any proposed major scheme within FT compliance arrangements	Trust Board
Any proposed major scheme	Any proposed major scheme	NHS England &

within FT compliance arrangements	within FT compliance arrangements	Improvement

Where a capital scheme is approved within the annual capital plan, full and final approval to proceed is still required as set out in the delegated limits in table 4.

Approvals for capital projects over £350k, will be itemised in a schedule to Trust Board on a quarterly basis.

Programme allocations within Capital Plan	**Group/ individual responsible for approval**
Building and Works	The Building and Infrastructure ~~Works~~ Group
Medical Equipment	Medical Devices Committee
Information Systems	Information Systems Steering Group

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Investment Group for approval or review prior to request for approval by the Finance and Performance Committee or Trust Board if required.

12.4 Asset Registers

12.4.1 The DOF is responsible for the maintenance of registers to record capital fixed assets. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The DOF shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) Properly authorised and approved agreements, architect’s certificates, supplier’s invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the DOF. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the DOF who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust’s premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for Equipment on loan.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust’s Estate must receive the prior approval of the Trust Investment Group and Trust Executive Committee.

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £200,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £200,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £200,000 each (excluding VAT) may be authorised by the Chief Executive, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £100,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets requires the approval of NHS Improvement.

12.6.11 Major divestments as defined in the Foundation Trust Compliance Framework requires the approval of NHS Improvement.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £200,000

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net reliable value. Inventory shall be controlled on a First in First out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the DOF for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the DOF. The control of pharmaceutical stocks shall be the responsibility of the Chief Pharmacist; and the control of fuel oil the Head of Estates.

13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Logistics Manager wherever practicable; stocks should be marked as Health Service property.

13.1.4 The DOF, in conjunction with the Associate Director of Procurement, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.5 Stocktaking arrangements shall be agreed with the DOF and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the DOF.

13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the DOF.

13.1.7 The Director of Procurement shall be responsible for a system approved by the DOF for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the DOF (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net reliable value. The write down shall be approved by the DOF and recorded.

13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Director of Procurement shall identify those authorised to requisition and accept goods from the store.

13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The DOF shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice or the assistance of the Procurement department where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the DOF;

b) Recorded by the condemning officer in a form approved by the DOF which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the DOF.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the DOF, who will take the appropriate action.

14.1.5 Disposals of assets valued between £100,001 - £200,000k (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

14.2.1 The DOF must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DH Group Accounting Manual and prepare a register.

14.2.2 The DOF must also prepare a ‘fraud response plan’ that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See the Trust’s Fraud, Bribery and Corruption Policy).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust’s Fraud, Bribery and Corruption Policy.

14.2.4 The DOF is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHS Protect.

14.2.5 The Directorate or Service Manager shall inform the DOF of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the DOF shall inform the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The DOF shall be authorised to take any necessary steps to safeguard the Trust’s interests in bankruptcies and company liquidations.

14.2.8 For any loss, the DOF should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust’s Losses Register, to be maintained by the DOF and investigated in such a manner as the DOF may require. Write-off action shall be recorded against each entry in the register.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Senior Information Risk Owner (SIRO), supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The DOF shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The DOF shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the DOF shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the DOF shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Informatics Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the Informatics department.

It will be at the discretion of the Director of Corporate Development or the Director of Informatics whether a case requires discussion at ISSG.

16. PATIENTS' PROPERTY

16.1 Patients’ Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as “property”) handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients’ possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust’s policy that the Trust will not accept responsibility or liability for patients’ property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients’ property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The DOF will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients’ property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient’s money.

16.1.4 Where Department of Health instructions require the opening of separate accounts for patients’ monies, these shall be opened and operated under arrangements agreed by the DOF.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines.

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), and is responsible for the management of funds it holds on trust. For the purposes of these SFI's the Trust Board members shall be termed Trustees. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust with the exception that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and be made only with the approval of the Fund Manager appointed by the Trustees or the Trustees themselves. This section covers those instructions which are specific to the management and governance of funds held on trust.

17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The DOF has primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.

17.2 Administration of Charitable Funds

17.2.1 The DOF shall:

a) Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust Board as Trustees of charitable funds. These shall be maintained in accordance with legislative requirements and any directions from the Charity Commission.

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within designated or restricted accounts in accordance with charity law;

e) Periodically review the funds, rationalise funds within statutory guidelines, and report changes to the Salisbury District Hospital Charitable Fund Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals to the Salisbury District Hospital Charitable Fund Committee at their quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Salisbury Hospital Charitable Funds Committee and the Charity Commission.

17.3 Fundraising and Incoming Funds

17.3.1 All gifts, donations and proceeds of fund raising activities are the responsibility of the Trustees and shall be handed immediately to the DOF to be banked in the Charitable Funds bank account.

17.3.2 All gifts accepted shall be receipted and held in the name of the Trustees and administered in accordance with the Trustees' policies, subject to the terms of specific trusts. As the Trustees can accept gifts only for all or any purposes relating to the Health Service, managers shall, in cases of doubt, or where there are material revenue expenditure implications, consult the DOF before accepting gifts.

17.3.3 The DOF shall advise the Trustees on the financial implications of any proposal for fund raising activities which may be initiated, sponsored or approved.

17.3.4 The DOF shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. All correspondence concerning legacies shall be dealt with on behalf of the Trustees by the DOF who alone shall be empowered to provide an executor a good discharge.

17.4 Investments and Investment Income

17.4.1 The Trustees shall be responsible for:

a) Appointing investments advisors to manage investments and provide relevant investment advice on these. Charitable funds shall be invested in a manner to maximize medium term value,

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

17.4.2 The DOF will allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Expenditure

17.5.1 Expenditure from any Charitable Fund shall be conditional upon the item being within the terms of the appropriate trust, the procedures approved by the Trustees and sufficient funds being available.

17.5.2 Day to day management of individual expenditure is delegated to Fund Managers who shall not enter into any transaction which will result in any fund under their control becoming overdrawn without first obtaining authorisation in writing from the DOF.

17.5.3 The DOF shall act on behalf of the Trustees in ensuring that all expenditure incurred is in accordance with the purposes identified by the donor.

17.5.4 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.5 A connected multiple orders could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.6 **Levels of Authority**

No expenditure can take place without the approval of the following:

£	**Orders can only be processed once the following people give their authority**
Up to £10,000	The Fund Manager
Over £10,000	The Fund Manager + The Salisbury District Hospital Charitable Funds Committee (reported to the Trust Board)

17.5.7 Where charitable fund expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.6 Asset Management

17.6.1 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.

17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure.

17.6.3 The Charity shall not be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The DOF will be responsible for updating an annual risk register for

agreement by the Salisbury District Hospital Charitable Funds Committee. This will address the following key areas of risk for the charity:

a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;

b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;

c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;

d) External risks – e.g. Public perception and adverse publicity, government policy;

e) Compliance with law and regulation – e.g. Breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers and any other person associated with the Trust are made aware of, and comply with, the Trust's Conflicts of Interest Policy. This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Head of Corporate Governance for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors.
It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Conflicts of Interest and Freedom to Speak Up: Raising Concerns policies, available via the intranet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS Improvement / DH guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	Held By
Property Deeds	Director of Corporate Development
Building & Engineering Contracts	Director of Corporate Development & Director of Procurement
Estate Maintenance Contracts	Director of Corporate Development & Director of Procurement
Maintenance Contracts	Director of Procurement
Commissioner Contracts	Director of Finance
Contracts for goods and services other than the above	Director Procurement

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be held by other Managers must be reported to the Director of Procurement for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest NHS Improvement / DH guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or DOF. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Board and its delegated sub committees with responsibility for Risk Management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control

cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current Department of Health /NHS Improvement guidance.

20.2 Insurance

20.2.1 On an annual basis, the DOF shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Financial Controller shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.

20.2.3 The Financial Controller shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Financial Controller shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.3 Clinical Risk Management/CNST

20.3.1 The Director of Nursing shall:

a) Provide a central point of contact within the Trust for NHSLA/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where the NHS Resolution (formerly NHS Litigation Authority)/Claims Handler considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the trust within the excess of £3k will be notified to the Head of Litigation and Insurance Services for acknowledgement only.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the Salisbury NHS Foundation Trust as the defendant.

Up to £100k	NHSLA/Claims handler	Head of Litigation
£100k-£250k	NHSLA/Claims handler	Director of Nursing
£250k-£500k	NHSLA/Claims handler	Chief Executive
>£500k	NHSLA/Claims handler	Trust Board

The DH must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made contrary to legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is Salisbury NHS Foundation Trust the act provides that SFT is exempt from repaying their “own” costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Director of HR.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Director of HR and the DOF. In certain cases, additional approval should be sought from NHS Improvement and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Director of Human Resources advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	Approval
Up to £30,000	Director of Human Resources
£30,001 to £100,000	Chief Executive
£100,000 plus	Trust Board

22.4 NHS Improvement must be consulted before making any special payments that are novel, contentious or repercussive. The Director of HR, in the case of any compromise agreements, shall submit a business case to be approved by Treasury. Any payments made against/contrary to legal advice must be approved by the Trust Board.

23. WHOLLY OWNED SUBSIDIARIES

23.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

24. RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, 'Attributing the costs of health and social care research and development' (AcoRD DH2012) using the national costing guidance/templates. Excess treatment costs should be submitted to CRN:Wessex for funding.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 The Standing Orders and other sections of the SFIs apply equally to the undertaking of research and this includes declaration of interests, security of assets, budgetary control, purchasing and contracting, charitable funds, and the section on casual gifts, hospitality and commercial sponsorship.

24.5 The submission of grant applications to support research shall be signed by the Director of Finance or designated representative.

24.6 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

24.7 The principles governing probity and public accountability shall apply equally to work undertaken through research.

Annex 1

Authorisation Levels For Electronic Requisitioning System

Hierarchy	Abbreviated	iProc Function	Role	Indicative Band for Responsibility	Financial Approval Authority Limit (Financial approval limits are gross (including tax) based on value of transaction)	Non PO Invoice Approval Hierarchy	R12 Invoice Approval Position
Level 1	L1R	Requisitioner	Any	Preferably Band 2 or 3 (several per sub service)	£0	No	RNZ_INVOICE_APPROVER_0000000
Level 2	L2A	Approver	Band 5 if A&C or Band 6 if clir	Band 5 / 6	£1,000	Yes	RNZ_INVOICE_APPROVER_0001000
Level 3	L3A	Approver	Ward Lead or Sub-Service Ma	Band 7	£2,500	Yes	RNZ_INVOICE_APPROVER_0002500
Level 4	L4A	Approver	Head of Service or Clinical Le	Band 8a+ or Clinical Lead	£5,000	Yes	RNZ_INVOICE_APPROVER_0005000
Level 5	L5A	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£9,999	Only for escalation	RNZ_INVOICE_APPROVER_0009999
Level 5A	L5AA	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£10,000	Only for escalation	RNZ_INVOICE_APPROVER_0010000
Level 6	L6A	Approver	Divisional Director of Operations (DDO)	Band 8d or 9	£25,000	Only for escalation	RNZ_INVOICE_APPROVER_0025000
Level 7	L7A	Approver	Deputy Director of Finance / Financial Controller/Director of Procurement		£50,000	Only for escalation	RNZ_INVOICE_APPROVER_0050000
Level 8	L8A	Approver	Chief Operating Officer / Director of Nursing / Medicial Director / Director of OD&P		£100,000	Only for escalation	RNZ_INVOICE_APPROVER_0100000
Level 9	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999
Level U	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999
Procurement authority to process pre-authorised orders							
		Approver	Director of Procurement		£350,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000
		Approver	Deputy Director of Procurement		£50,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000

~~**1.1** All staff authorised to approve the purchase of goods or services, and signing of invoices where appropriate, will be allocated an authorisation level. Each Directorate can set its own authorisation levels under Level 3 below (Levels 1 and 2 are shown as suggested levels only)~~

~~**Level 1** - Up to and including £500 per total requisition (e.g. nurses, ward assistants, staff with requisitioning responsibility in smaller departments)~~

~~**Level 2** - £501 - £5,000 per total requisition. The actual level of authority will depend on the work area and the following are examples:~~
~~- £1,000: requisitioning staff in larger departments~~
~~- £2,000: ward sisters~~
~~- £3,000: supervisory levels in departments, requisitioners in theatres, staff club manager~~
~~- £5,000: catering manager, medical physics manager, deputy head in genetics~~

~~**Level 3** - £5001 - £10,000 per total requisition~~
~~- £10,000: DSNs, DMs, heads of larger departments~~
~~- £10,000: Head of Facilities~~

~~**Level 4** - Up to £50,000 per total requisition: Deputy Director of Finance, Financial Controller~~

~~**Level 5** - Up to £100,000 per total requisition: Chief Operating Officer, Director of HR, Director of Nursing, and Medical Director~~

~~**Level 6** - Over £100,000 per total requisition (but subject to any other limits approved~~

by the Trust Board): Chief Executive, Director of Finance

1.2 Each Directorate is responsible for compiling their own authorised signatories list, including determining which staff should be given authorisation below level 3.

Amendments to the above levels of authorisation may be approved in specific cases but will need to be approved by the Director of Finance.

1.3 The Finance Department will maintain a database of staff on each authorisation level per Directorate. Directorates will be responsible for notifying the Finance Department of any additions, deletions or other changes to their authorised signatories' lists. The Finance Department will ensure the database is amended to reflect the changes and ensure the computer security is amended accordingly.

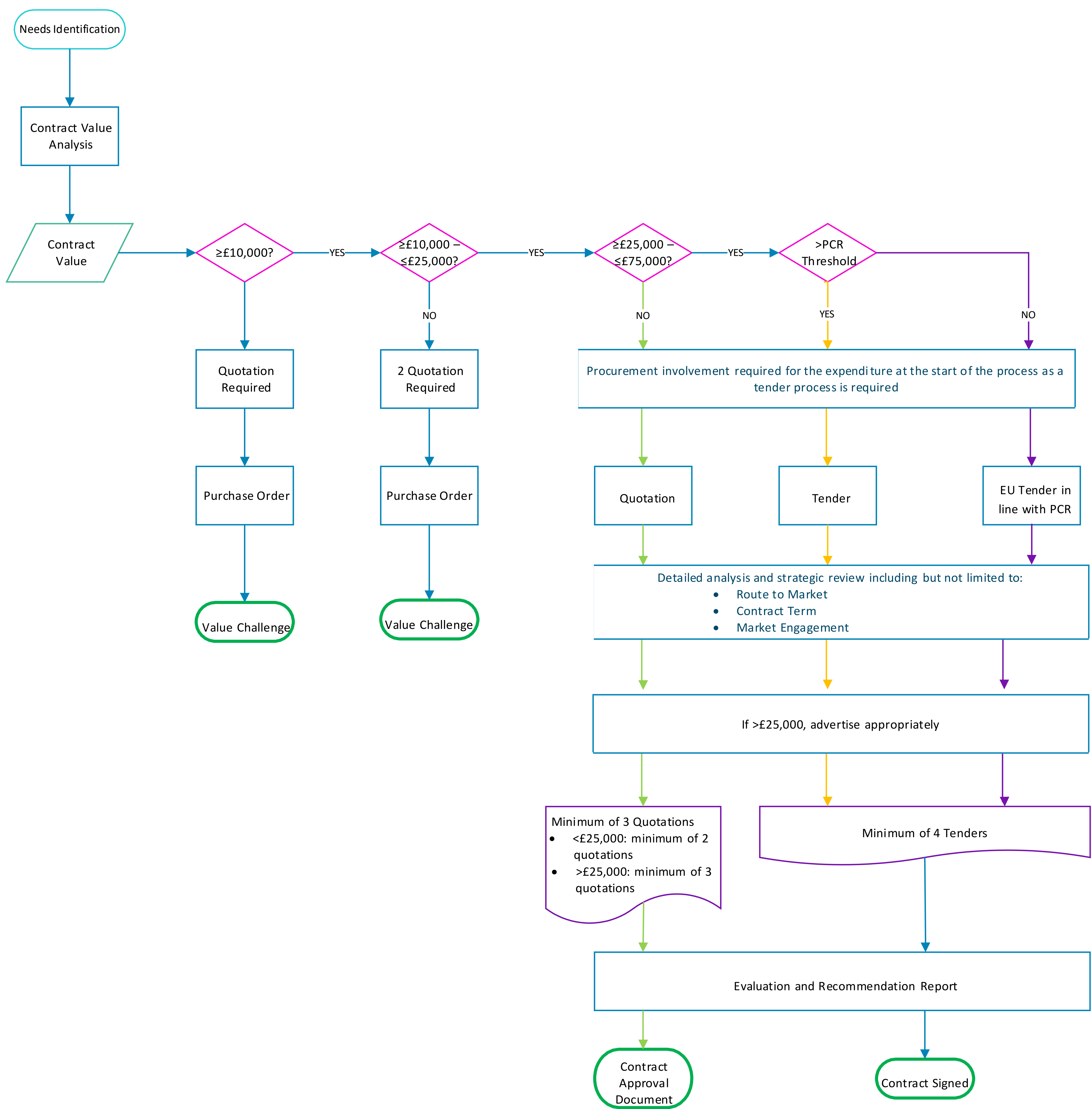
Authorisation Levels for Electronic Ordering System

2.1 All requisitions will be converted to Orders and processed within the Procurement Department where individual staff will have specific levels of authorisation below that of the Head of Procurement's £50,000 level. The electronic requisition will have already been authorised at the appropriate level within the organisation prior to receipt by Procurement.

2.2 The Director of Procurement will have authority to process orders up to - £350,000. Any orders beyond this amount will need to be authorised by the Chief Executive or Director of Finance.

Annex 2 Tendering & Contracting Procedures (where SFT is the procuring body)

Competitive Tendering Process Requirements



Annex 3

Contracting for Income - Financial Limits

NON NHS
All limits **exclude** Value Added Tax where applicable.

Lifetime Contract value	**Approval**
Up to £20,000 (Inclusive of zero nominal value)	**Deputy Director of Finance/Director of Procurement**
£20,000 to < £300,000	**DOF**
£300,000 to <£1.5million	**CEO**
£1.5m +	**Trust Board**

Lifetime Contract value (NHS)
Service Level Agreements
Up to £100,000,000 Director of
Finance
Over £100,000,000 Chief Executive

Annex 4

Emergency Powers (Chair's Action)

1. A recommendation to utilise Emergency Powers must be made by the Chief Executive (or Deputy Chief Executive if responsibilities have been delegated) by email to the Chair and at least two other Non-Executive Directors.

2. The request must include the justification for the recommendation, and the reasons for the need to override normal governance procedures.

3. Agreement to proceed is contingent on the approval of CEO, Chair, and at least two Non-Executive Directors. Evidence of the approval must be recorded (email records are sufficient).

4. The exercise of emergency powers shall be reported to the next formal meeting of the Board in public or private (as appropriate) for ratification.

5. Utilising Emergency Powers does not remove the need to subject the recommendation to Trust governance procedures. Business cases, recommendation reports, and any other paper falling within the scope of the Scheme of Delegation should still be reviewed in the forums and committees as set out in the SFIs as a matter of good practice and to ensure risks, mitigations, and benefits have been appropriately explored and challenged.

6. A schedule of decision taken under Emergency Powers should be presented to Audit Committee on a quarterly basis. This schedule should include the reasons for the escalation, as set out in (2.).

CLASSIFICATION: UNRESTRICTED

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.1
Date of Meeting:	07 April 2022		

Report Title:	Annual Medical Education Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
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Approval Process (where has this paper been reviewed and approved)				
Prepared by:	Dr Emma Halliwell, Director of Medical Education			
Executive Sponsor (presenting):	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):	None			

Recommendation:
Report for noting recent developments and challenges in medical education.

Executive Summary:
With Covid 19 continuing to dominate the health agenda, our main challenge this year has continued to be the impact of the pandemic on the education, training and well-being of our junior doctors, the effects of which will be with us for many years to come. The educational fraternity and Trust have worked together to prioritise education and training, alongside service recovery. Well-being and resilience remains a concern both in the short and long term. The senior clinicians have been acutely aware of the need to support our trainees through the recent difficult times. New curricula are being implemented in many specialties, which will be a challenge for both the trainees and their supervisors, at least initially. These are highlighting further the requirement for trainees to have allocated 'self-development' time as part of their work schedules, which can be a real tension for some departments, as the clinical pressure that they are under only seems to increase. Dr Georgina Morris, Foundation Programme Director, and Dr Annabel Harris, Associate Clinical Sub-Dean, have jointly set up an innovative programme designed to give formal training in teaching to the Foundation Doctors, so that they can lead meaningful educational sessions with our medical students on placement. This has had been recognised nationally as an example of excellent practice. Miss Rashi Arora, our SAS/LED development lead, has instituted some exciting initiatives this year – a SAS development day, review of the appraisal process (alongside Dr Zoe Cole) and support for CESR trainees. We have had our first intake of Physician Associate students from Bournemouth University and Dr Gail Ng is taking the lead on this programme.

We have a new team of Medical Education Administrators, who are settling well into their roles – Emma Freeman, Medical Education Manager; Anna Spicer, PA to DME and FPD; and Janice Seller, GP VTS and Medical Students.

Board Assurance Framework – Strategic Priorities	**Select as applicable**
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

Salisbury NHS Foundation Trust

Director of Medical Education
Annual Medical Education Report
August 2020 to August 2021

Produced by: **Dr. Emma Halliwell, Director of Medical Education**

November 2021

Acknowledgements

Ms. Rashi Arora, Specialty and Associate Specialist, and Locally-Employed Doctor Development Lead

Dr. Annabel Harris, Associate Clinical Sub-Dean

Dr. Georgina Morris, Foundation Programme Director

Dr. Ellen Neale, GP Vocational Training Scheme Programme Director

Mr. Paul Woodhouse, Salisbury DF1 Programme Director and Wessex Dental Postgraduate Tutor

Members of the Medical Education Training Committee

Administrative Staff, Medical Education Department, Education Centre

Distribution List

Ms. Stacey Hunter, Chief Executive, Salisbury NHS Foundation Trust

Dr. Paul Sadler, Post-Graduate Dean, Health Education Wessex

Dr. Peter Collins, Chief Medical Officer, Salisbury NHS Foundation Trust

All members of the Medical Education Training Committee (METC)

All members of People and Culture Committee

Posted on the Medical Education page of the Trust Intranet

Executive Summary

When I penned this report 12 months ago, I had not envisaged how life in the NHS, and the world in general, would continue to be completely dominated by the global Covid-19 pandemic. It has been a difficult time for all those working in the health and care sectors with ongoing, unprecedented pressure at work coupled with limitations in opportunities for 'down time' outside.

Therefore, perhaps unsurprisingly, our main challenge this year has continued to be the impact of the pandemic on the education, training and well-being of our junior doctors. These aspects of our trainees' working lives have had to be addressed alongside an ever-changing operational situation in the Trust and in the wider NHS.

The second wave of Covid proved to be a greater challenge for Salisbury than the first. The number of Covid positive patients being looked after by the Trust at any one time was approximately quadruple what we had experienced during the first wave. Junior doctor redeployment was inevitable over this period but was undertaken in a more intelligent way than earlier in 2020. The on-call rotas across all specialties were preserved and the main redeployment was to bolster the daytime cover in medicine/intensive care. The Educational Faculty again were intimately involved in decision-making around redeployment, and I remain exceedingly grateful to my consultant colleagues across the board for always supporting the trainees with appropriate clinical supervision.

The need for the educational fraternity and employing organisations to work together to prioritise education and training, alongside service recovery, has becoming increasing paramount. It is clear that the effects of the pandemic on both service and training are going to be with us for many years to come. The more junior grades have fared better in terms of their education as the capabilities that they are required to demonstrate are more generic and achievable regardless of where they are working. It is recognised that the more senior trainees in the craft specialties (e.g. surgery, endoscopy, etc.) have struggled to gain experience. I'm pleased that the Trust has supported trainees to have access to training opportunities at both New Hall, our local private hospital, and during the weekends at SDH.

Well-being of our junior doctors remains a concern both in the short and long term. The senior clinicians have been acutely aware of the need to support our trainees through the recent difficult times. In addition, we are hopeful that, now that socialising, face-to-face teaching etc. is possible, they will also gain from more freely available peer support.

I am pleased to report that all the educational appointments that we made last year are settling in well to their new roles and I am grateful for all they have achieved in the last 12 months.
Dr. Georgina Morris, as Foundation Programme Director, provides exemplary support to our most junior doctors and is working hard with their Educational Supervisors to embed the new Foundation Programme Curriculum into practice. Dr. Annabel Harris, Associate Clinical Sub-Dean, continues to support our medical students and the

undergraduate clinical faculty that trains them. Dr. Harris and Dr. Morris have jointly set up an innovative programme designed to give formal training in teaching to the Foundation Doctors, so that they can lead meaningful educational sessions with our medical students on placement.

Ms. Rashi Arora, SAS and LED Development Lead, has been working hard to empower our SAS group of doctors and is looking at ways we can support more of them through the CESR route to join the specialist register. She has also developed a training and development policy for any LEDs that stay with us for over 12 months. This aims to provide them with educational opportunities, mentorship, career progression and a robust appraisal process.

In July, Helen Clemow, PA to the Director of Medical Education and Foundation Programme Director, resigned in order to take on an increasing role in the library. We are grateful that she agreed to stay with the education team through the July and August inductions. Anna Spicer has been appointed as her successor and has settled in well.

New curricula are being implemented in many specialties, which will be a challenge for both the trainees and their supervisors, at least initially. These are highlighting further the requirement for trainees to have allocated 'self-development' time as part of their work schedules. We have made much progress in implementing this formally within departments, but it is acknowledged that it is a real tension for some, as the clinical pressure that they are under only seems to increase.

There are two exciting developments that are happening at the moment. Firstly, we have begun training four Physician Associates (PAs) students on placement from Bournemouth University. Secondarily, we are going to explore how we can develop a support programme for the increasing number of International Medical Graduates (IMGs), whose first job in the NHS is with us in Salisbury.

My tenure as Director of Medical Education to date has been a genuinely unsettlingly time for the NHS and those that work in it. Despite this I am convinced that those involved in education in Salisbury have gone 'over and above' to protect the education and training of our junior doctors, and to support their well-being. They have done this with enthusiasm and expertise, and I am extremely grateful to them all. At the same time, I am proud of the flexibility, professionalism and maturity that has been shown by our trainees when such unprecedented demands have been placed upon them. I believe all have risen to the unexpected challenges they have faced.

Dr. Emma Halliwell
Director of Medical Education

1.0 Introduction

This report gives an overview of medical and dental education in Salisbury NHS Foundation Trust (SFT) for the past 12 months from August 2020 until August 2021. These activities are assessed against our strategic objectives which are as follows:

Objectives

1. **Maintain accreditation of training**
2. **Accreditation of medical and dental student placements via university medical schools**
3. **Maintain a strong educational and training environment for doctors**
4. **All Educational and Clinical Supervisors to be accredited in line with GMC requirements and trainees only allocated to those supervisors fully recognized**
5. **Keep the Trust management informed of national policy pertaining to doctors in training and the impact these polices will have on service delivery**
6. **Clinical Governance Framework and Patient Safety**
7. **Pastoral care, equality, diversity and personal development including career guidance**
8. **Medical Education incorporated into Directorate Annual Plans**
9. **Ensure good quality Trust and Departmental Induction with appropriate evaluation of these.**
10. **Quality of training maintained in light of the European Working Time Regulations (EWTR) plus changes that result from trainee reductions, The Shape of Training, Broadening the Foundation Programme and the new Junior Doctors' Contract implemented from October 2016 and renegotiated 2019.**
11. **Ensuring trainees feel valued and are an integral part of the Trust.**

All these objectives have proven particularly challenging this year due to the ongoing Covid-19 pandemic and its impact on both training and well-being. They are likely to remain so for the foreseeable future.

2.0 The Medical Education Department

The Medical and Dental Tutors are:

Dr. Emma Halliwell	Director of Medical Education (DME)
Ms. Rashi Arora	SAS and LED Development Lead
Dr. Annabel Harris	Associate Clinical Sub-Dean (ACSD)
Dr. Georgina Morris	Foundation Programme Director (FPD)

Dr. Ellen Neale GP Vocational Training Scheme (GPVTS) Programme Director
Mr. Paul Woodhouse Salisbury DF1 Programme Director

The Education Centre, based on Level 5 of the hospital, is managed by Yvonne Donovan and there are 3 administrators for Medical Education:

Mrs. Helen Clemow	Medical Education Administrator and PA to the DME and FPD
Mrs. Sarah Shales	Medical Education Administrator and PA to the Associate Clinical Sub Dean
Mrs. Kelly Budgell	Medical Education Administrator

3.0 Quality Assurance Methods

The standards and outcomes for postgraduate medical education and training are set by the General Medical Council (GMC).

These standards form the basis for monitoring and implementing education and training of medical staff at Salisbury Foundation NHS Trust. Quality Assurance processes are in place to monitor and support the development of medical and dental education both at a local and regional level (Health Education England - Wessex). These processes are usually augmented by the annual GMC trainees and trainers' survey, and triggered visits from the various 'schools' to programmes at the Trust when issues arise.

The Director of Medical Education is required to complete an 'annual return' to HE Wessex as part of the Quality Assurance process.

4.0 Accreditation of Medical Training Posts

4.1 Foundation Programme

The past year, 2020/21, has obviously been difficult for everyone. However, our Foundation Trainees have coped admirably and definitely risen to the challenge – from recent graduates joining the workforce early as interim F1s (FiY1s), to F1s and F2s in

community and surgical placements undergoing redeployment to more acute areas e.g. ED, Medicine and ITU, during both the first and second waves of Covid 19.

Ten of our 21 August 2021 intake F1s undertook FiY1 posts either in Salisbury (7) or in a different Trust (3). Overall, their experiences of taking up this opportunity were incredibly positive – in keeping with results obtained nationally and published recently (see report below). Participants faced challenging experiences during their FiY1 posts, clinically, emotionally, and socially, but these were seen as formative and not viewed negatively as they felt well supported through induction, peer- mentoring (F1 'buddies') and clinical and educational supervision. FPDs, medical education administrators and FiY1 Wellness Champions also provided additional assistance.

It has been acknowledged by supervisors locally and nationally that those F1s who completed a FiY1 placement are generally more confident clinically than 'non-former FiY1' peers and performing at a level above expected at this stage of training. This bodes well for 2021/2, as they move into F2 roles, and the future.

FiY1-final-signed-off-report_pdf-8683679

Although causing disruption to continuity of placements for some F1s/F2s, redeployments due to the Covid pandemic were as short as possible, mostly under 6 weeks, and Foundation doctors were able to gain valuable experience that contributed to developing capabilities within the broad Foundation Programme Curriculum. Thus, most Foundation trainees have progressed as expected to successful outcomes at the recent ARCPs. The few exceptions were trainees who either had to shield for health reasons and thus missed out on clinical experience or had training difficulties unrelated to the Covid 19 situation.

Salisbury continues to be a popular place for trainees to undertake the Foundation Programme. We continue to be able to recruit a good standard of trainees from medical schools through the national competitive entry process and, for August 2021, as in previous years, have filled all 21 of our standard F1 posts. As a result, we were approached by the Foundation School to take up to 6 additional F1s from the national waiting list. In the event, 4 extra F1s will be joining us – 3 in August 2021 and 1 in December 2021. In addition, we successfully retained our 6 stand-alone F2 posts that were created in August 2020, and 5 F2s have been appointed to these posts recently (1 dropped out post recruitment). We will thus have 27 F2s in total for 2021/2, including a trainee joining us from Jersey.

All incoming F1s have been provided with an extra week of shadowing in their employing Trusts this year, starting from 21st July, in recognition of missed clinical placement time earlier in the year. I am extremely grateful to Melissa Speed in Medical HR and the Accommodation Team for going to great lengths to ensure trainees received

all their contract and induction paperwork in good time despite the increased logistical pressures.

The number of international medical graduates (IMGs) applying to join the UK Foundation Programme has significantly increased in the past few years and this is reflected in our local cohort. IMG trainees require a more in-depth induction and increased supervision for their first placement. HE Wessex currently provides induction webinars for IMGs new to NHS practice and financial support is available to Trusts for increased supervision. This year 2 weeks extra paid shadowing was available for IMG F1s.

A new UK Foundation Programme Curriculum is being launched for Aug 2021. Key changes include removal of mandatory core procedure sign offs in F1, trainee continuous reflection (summary narrative) that will link into more specific, targeted supervised learning events, requirement for trainees to have 2 hours a week for 'self-development time' and redevelopment of the core teaching programme. Our Health Improvement/Quality Improvement Programme (HIMP) continues strongly, remains an exceptional learning experience for our Foundation Doctors and is highly regarded at Deanery level. It puts us ahead of the curve as a formal QI programme is now specified in the new Curriculum. In addition, we are maximizing the opportunities for simulation training, as this receives very positive feedback from trainees. Our simulation suite continues to develop and thrive under Claire Levi's leadership.

I am extremely grateful to our experienced, dedicated and expanding educational faculty (both Educational and Clinical Supervisors), who facilitate and underpin the entire programme. I also wish to thank Helen Clemow, our Foundation Programme Administrator, for all her time and endeavours in organising inductions, managing Horus and supporting trainees with their queries. Helen joined us last year and is leaving in August to take up an expanded role in the SFT library following retirement of a senior colleague there. I am pleased to report that we have very recently appointed Anna Spicer as Helen's successor and extend a very warm welcome to her.

Dr. Georgina Morris
Foundation Programme Director

4.2 Medical Posts within Salisbury NHS Foundation Trust

Trainee posts within SFT are currently as follows:

F1	28
F2	29
Core trainees	38
GP VTS	18
Specialty Trainees	50
Locally-employed doctors	72
Total	215

4.3 General Practice Training

2020-2021 has been a successful if somewhat unusual year for GPVTS training at Salisbury District Hospital with the coronavirus pandemic.
Financial cutbacks unfortunately continue to feature in medical education.

Coronavirus pandemic.
GP trainees were deployed as required during early 2021 by SDH in response to the pandemic.

Teaching.
The half day monthly ST1&2 teaching schedule was successfully delivered virtually for the past academic year (August 2020 - August 2021), receiving positive feedback from trainees. Many thanks to those departments who have contributed to this virtual teaching schedule and a pre-emptive thank you to those who agree to teach in future sessions. A virtual teaching schedule for the next academic year (August 2021 - August 2022) has been established, with speakers being contacted and confirmed.

Recruitment.
All GPVTS posts were successfully filled at recruitment for August 2021 commencement onto the new 24:12 GP training programme. 3 year GP training will now consist of 24 months in Primary Care posts and 12 months in Secondary Care posts.
In mid-Wessex we continue to proactively contact all newly appointed trainees, prior to commencing their GP training, who have a non-UK medical degree to explore their NHS working experience and whether any additional support would be beneficial.

The challenges of LTFT doctors and placing them in hospital posts remain.

I would like to take this opportunity to express my thanks and gratitude to Sarah Shales for her admin support and assistance with the mid-Wessex GPVTS trainees.

Dr E Neale
GP & Mid-Wessex TPD (Salisbury ST1&2)

5.0 Accreditation of Medical and Dental Student Placements

5.1 Medical student placements

I took over as ACSD, from Dr. Georgina Morris, in June 2020 just as the new cohort of final year medical students arrived in Salisbury. This report is covering the academic year 2020-2021.

I am pleased to state that, despite the challenges that Covid-19 brought to the Trust and to the delivery of education, we managed to provide all the training required to the medical students on placement. The flexibility of the clinicians, other health care professionals and administration staff to accommodate the students in clinics, theatre and on the wards was impressive and I am hugely grateful for the positive, 'can-do' attitude of everyone.

In addition, we formed a junior doctors' undergraduate education group and were also able to provide extra educational opportunities with junior doctors, simulation teaching and a hybrid (virtual, face-face) Mock OSCE. This team was able to provide virtual and face to face teaching throughout the final year medical student placement. The teaching program, simulation and Mock OSCE went down well with the students and received excellent feedback.

The medical school ended up cancelling the final year OSCE at the start of 2021- so the practical assessment was based purely on the ACCs (the assessments done on their rotational placements) and this has just highlighted the importance and value of these assessments for the students.

Through our doors we hosted 12 final year medical students for 6 months. Throughout the year we also saw 11x 4th year students in O&G, 8x 4th years in child health and 24x 4th year students in acute care modules. There was also a new module in assistantship - medicine and surgery that started this year- we had 20 students doing their assistantships with us.

Another thing for Salisbury to be proud of this year is our response to Southampton’s plea for elective placements. The medical students were unable to go abroad on their electives due to Covid-19. We are usually a popular site for electives in plastic surgery here at Salisbury, but this year we hosted electives in plastics (x4), surgery (x4), emergency medicine (x2), anaesthetics (x1), trauma and orthopaedics (x1) and child health (x1). It was great to see people offer to help with this and I know that the students and the university were happy with the response to this request.

I would like to thank Dr. Manas Sinha, who is stepping down in his role as Medicine Lead from July 2021, for his contribution to medical student education. He will continue to teach and supervise students but the lead role in medicine has now been handed over to Dr. Chris Pandya. We are pleased and excited to welcome is to the undergraduate education team.

We have received some lovely feedback over the past year. This one highlights the good work that has been done.
“I really enjoyed my placement in Salisbury, all the staff were very friendly and helpful, and I felt like I had great clinical experience and opportunities. Sarah Shales was brilliant at organising our learning and we felt well supported by her….”

Many thanks to Sarah Shales, Dr. Georgina Morris, Dr. Emma Halliwell, Claire Levi and the undergraduate faculty, the teaching block/rotation leads and everyone involved in providing high quality supervision and teaching to the medical students 2020-2021.

Dr. Annabel Harris
Associate Clinical Sub-Dean

5.2 Dental student placements

This year COVID-19 has continued to disrupt the Foundation Dentists clinical training and their study day programme with all courses remaining online.

It is hoped that they will be able to attend face-to-face study days at SDH in the near future.

Mr. Paul Woodhouse
Dental Foundation Training Programme Director

6.0 Strengthen the Education Environment

6.1 SAS/Locally-Employed Doctors Training and Development Lead

This was my first year as the new 'Training and Development Lead for SAS and LEDs'. This post replaced the previous SAS Tutor role with the overall responsibility for the training and development of the 'non-deanery' doctors.

An updated database of 30 SAS and 49 LEDs was created with the support from HR and Education Centre in September 2020.

Activities for SAS group

1. **SAS Survey**
   All SAS Doctors were invited to fill a survey monkey questionnaire in November 2020 to provide an over-view of their expectations, challenges and suggestions. Response was received from 10 doctors (3AS/1SG/6SD) with following key findings-
   a. 90% of SAS Doctors were satisfied with the job planning arrangements
   b. 30% of SAS Doctors stated they felt discriminated because of their post and had concerns over workplace experience
   c. 50% were not aware that there was a dedicated Training and Development fund
   d. 40% were stopped from attending educational activities
   e. 20% asked for more support with the appraisal process

2. **Quarterly Teams meetings with SAS group**
   I meet the group quarterly on Teams in a more informal and open environment. In the last Teams meeting the new SAS Contract was discussed.

3. **CEA for SAS Doctors**
   The PILOT modified CEA (clinical excellence award) scheme for SAS group was a local initiative to promote the SAS Doctors working at SFT. This Deanery funded project (£5,000 successful bid) recognised the contributions of the SAS Doctors who go 'over and beyond'. On 1st March 2021, the results were announced by the MD and DME and contributions of five successful SAS Doctors were acknowledged. This project was very well received locally as well as regionally.

4. **Deanery promoted courses and educational activities**
   SAS Doctors have availed the opportunity to attend Deanery-funded activities and courses including eCLiPs, PG certificate in career development at Edinburgh Napier University, King's Fund, Coaching programme etc.

LED group

1. **Development of LED Training and Education policy**
   The key change with this policy is the introduction of Training and Education Cycle, which will be made mandatory for any LED with the Trust for more than a year; with a more robust process and additional support system for CESR trainees. The policy is in process of going through necessary approvals.

On a personal note, I'm very much enjoying the challenge of this new role and would wish to thank everyone who has supported in the journey.

Ms. Rashi Arora
Trust Training and Development Lead for SAS and LEDs

6.2 Medical Education Training Committee (METC)

This committee includes medical and dental tutors, specialty education leads (College Tutors), and staff from the Education Centre and Medical Personnel. During the past 12 months the Committee met on 6 occasions and, as in previous years, has been proactive in its approach to sharing information and implementing changes to medical education and training. This has been especially relevant this year as new curricula are being introduced across many medical specialties. These meetings also provide a forum for the educational faculty to be made aware of concerns and issues in the various departments with regards to training.

These meetings have been particularly helpful during the last 12 months, as they have ensured that we have a Trust-wide approach to supporting our trainees during the COVID pandemic and to aid their training recovery going forward.

The Medical Education and Training Committee reports to the OD and People Management Board and the minutes of meetings held are therefore submitted here for review and if necessary, action.

6.3 Quality Assurance Monitoring Data

Local processes to quality assure in addition to the annual GMC survey of trainees include:

1. Local (optional) survey of trainees who started in August 2021 will be undertaken to establish their views of the induction process, educational and clinical supervision and overall support provided by senior members of the Trust. The equivalent survey

for the August 2020 cohort did not take place as its distribution date coincided with the start of the second wave of Covid.

2. Annual feedback sessions with both the Foundation Year 1 and Foundation Year 2 doctors – summarised and distributed as appropriate by the FPD.

3. Formal feedback from GP VTS trainees at the end of each year - forwarded to the individual departments.

4. Formal evaluation of the main August induction – **Appendix B**

5. Regular informal departmental visits by the DME to meet with trainees and discuss their training experience.

Over the last 12 months there have been not any triggered visits from HE Wessex to the Trust.

6.4 The Hospital Round

The Hospital Round has not happened in the last 12 months due to the COVID pandemic.

As attendance had been poor even prior to the pandemic, its long-term viability will need to be assessed prior to any attempt at restarting the programme.

6.5 Educational Supervision

All Educational Supervisors in Wessex are required to have undertaken 'The Essentials' course. Historically, this is the 2-day course run by HE Wessex that equips Educational Supervisors for their role. All new supervisors will continue to be required to 'attend' the HE Wessex induction course, although this is now running as a combination of E-learning and virtual tutorials. The DME needs to recommend any individual to attend this course due to current capacity limits.

The process for maintaining recognition as a trainer is now based upon a requirement to undertake 10 hours of educational CPD (8 hours of which must be face-to-face) within a five year period. An individual's training role must be discussed at their appraisal, after which a signed form is sent to HE Wessex to confirm that the trainer has met the requirements for ongoing recognition.

There are many examples of what could be classed as CPD e.g. equality and diversity training, attendance at ARCP panels, career guidance, exam support, supporting trainees through SIIs etc.

Several 'Trust Refresher' courses have been facilitated by senior educationalists at SFT, which can form part of this CPD. The two that have been run over the last 12 months had good attendance and received excellent feedback – **see Appendix C**

Trainers recognised for these roles are now identified on the GMC register.

6.6 Medical Education Budgets

The department is supported by the following budgets:

Medical Education Director (Infrastructure)
Specialty Doctors' Training
Study Leave (since April 2018 held centrally by HE Wessex and reimbursed to SFT)
Southampton University - Service Increment for Teaching (SIFT)

These budgets have been the responsibility of the DME since July 2013.

The annual SIFT business plan, which outlines how the £550,000 of SIFT monies will be spent, is drawn up by the DME and then approved by the Chief Medical Officer. This year funds have been allocated for the purchase of the following items of equipment:

- Anaesthetics – BIS monitor, neuromuscular monitor, fibre-optic trainer, regional anaesthesia trainer
- Education – laptops, hardware and training for virtual learning
- Emergency medicine - video laryngoscope
- Haematology – teaching microscope
- Histology – text books
- ITU – intubating head, video laryngoscope
- Obstetrics – perineal repair simulator
- Paediatrics – projector and screen
- Pharmacy – videoconference screen
- Sexual health – teaching microscope
- Simulation – SMOTS equipment
- Surgery – laparoscopic instruments for simulation training
- Up-to-Date

6.7 Revalidation for Trainees

The GMC revalidation process for secondary care and doctors in training has been in place since 2012, which requires each doctor to revalidate on a 5 yearly cycle. Doctors

that were due to revalidate in the midst of the Covid pandemic were given a 12 month extension to their revalidation date.

The Postgraduate Dean of HE Wessex (Dr. Paul Sadler) is the Responsible Officer for all doctors in training.

The Trust reports on every trainee involved in an SII or Clinical Review or named in a Complaint. This information is collated by the DME and returned to the HE Wessex in the requested format known as an exception report (not to be confused with exception reports introduced as part of the new Junior Doctors' Contract). We continue to collate this information every 6 months, with the DME meeting formally with the Head of Risk Management, Patient Safety Facilitator, Clinical Governance Lead for Maternity and the Head of Customer Care to review the information required to generate the required reports.

All trainees about whom an exception report is completed are informed of this and sent a copy of the information submitted. These reports feed into the ARCP process, where information should triangulate with the self-reported incidents on the trainee's Form R.

7.0 Strengthen the Education Environment within the Health Community

The Salisbury Medical Education Department has been limited as to what support it can provide to the wider health community due to the Covid restrictions that are in place within the Education Centre itself – limits on numbers due to social distancing, inability to host visitors from outside SFT, lack of catering provision etc.

The mandatory training sessions required for the trainees have continued throughout the pandemic but normally in a hybrid format – some attending face-to-face and some attending virtually – although this has been exceedingly challenging.

It is hoped that there will be easing of these restrictions over the next 12 months, so that the Education Centre can re-establish this important function. This will be to the benefit of not only those in the health community, but also to their patients.

8.0 Inform Trust Management of National Policy

The Medical Education and Training Committee (METC) is a cohesive and useful group as it provides a forum for cascading information out to Departments and trainees within SFT via the Educational Leads. The DME sits on the People and Culture Committee in order to continue to highlight the impact of national directives regarding education and

training, and recruitment issues on service delivery and safe patient care. Finally, the DME meets every other month with the Chief Medical Officer to discuss issues that have arisen at Deanery, Trust and trainee level.

9.0 Clinical Governance Framework

The DME receives clinical review reports involving trainees and has regular communications with the Head of Risk Management. The Trust completes exception reports, which are forwarded to the HE Wessex, on all trainees involved in SIIs and Clinical reviews and named in Complaints (please see section on Revalidation for Trainees). This work has ensured close working with the Risk Departments for both maternity and the overall Trust.

Salisbury's inter-professional Healthcare Improvement Programme (HImP) is a well-established course to help Foundation Doctors learn basic improvement skills by undertaking service improvement projects. The programme is currently led by Dr. Christina Cox and Louise Arnett, Head of Service Improvement. It continues to be highly regarded both regionally and national, with several Foundation Doctors being invited to present their projects at national quality improvement meetings. The greatest challenge for HImP remains ensuring sustainability of the projects undertaken.

10.0 Careers Advice and Pastoral Care

Career support and pastoral care from the DME; FPD; College, Specialty, GP and Dental Tutors continues to ensure that trainees receive appropriate and timely assistance and guidance throughout the duration of their time in Salisbury.

Career guidance for Foundation Trainees takes place in both years of the Foundation Programme. There are 2 generic career guidance sessions, with additional specific sessions on interview preparation and applying for GPVTS in Foundation Year 2.

With the Covid pandemic, the need for pastoral care and well-being support has been in forefront of everyone's mind.

The DME and FPD continue to provide pastoral care for trainees who require additional support for reasons both within and outside the working environment. As a rule the FPD mainly supports the Foundation Doctors as issues regarding their welfare are usually escalated in that direction. The DME usually does the same for trainees above Foundation level, but not exclusively so. Both are supported in this regard by an excellent network of departmental educational leads.

Referrals from the Trust to the Wessex PSWU (Professional Support and Well-Being Unit) for the few trainees needing higher level of support, are usually made by the DME, and are always with her knowledge and support.

Most of the money that the BMA gave the Trust a couple of years' ago, to support trainee well-being has been spent. There is a new kitchen/relaxation facility in the Education Centre that the trainees can use out of hours, which has been popular (within the restrictions of social distancing). Unfortunately, a room for the promised rest area has yet to be found, after the need to reprioritise the use of space in light of the Covid pandemic. The trainees are very grateful to the orthopaedic department for being willing to share a quiet room, so that they have access to two (of the four) recliners out of hours. It is hoped that some concrete progress will be made to find a permanent space to house all four recliners will be made in the near future.

11.0 Trust and Departmental Inductions

As stated in the FPD's report, all Foundation Year 1 doctors were offered an extra, voluntary week of shadowing in acknowledgement of the fact that their training had been interrupted due to the Covid pandemic. The majority, but not all, availed themselves of this opportunity. This proved to be logistically tricky as two inductions had to be arranged – one for two week before the FY1s started work formally and one just one week before. Thanks goes to all those involved in this for their flexibility and understanding.

53 new doctors joined the Trust on Wednesday 4th August 2021, all receiving a mandatory induction followed by their departmental inductions. Due to the restraints of social distancing this proved to be a huge challenge to organise. The Education Centre and Medical Personnel staff are to be commended for all their hard work in ensuring that a blended approach of face-to-face and virtual induction worked so well in the circumstances.

Regular monthly inductions (of up to 20 doctors) follow a similar format but are often held in an alternative venue to the Education Centre.

Formal evaluation of the main August induction was undertaken and as stated in paragraph 6.3 is attached to this document in **Appendix B.**

12.0 Challenges for 2021/2022

- Working alongside the Trust and HE Wessex to support training recovery and to address the educational issues that have arisen, and will to continue to arise, as

a result of the Covid-19 pandemic, in order to ensure that our junior doctors continue to progress in their training in a safe and supervised manner.

- Introducing the new curricula across many specialties and embedding them into educational practice.
- Ensuring the emphasis on trainee well-being is maintained and initiatives to improve the lives of junior doctors completed in a timely manner.
- Continuing to ensure that all Named Clinical and Educational Supervisors who are GMC accredited trainers maintain this accreditation and comply with the updated requirements.
- Continuing to work with the Trust so that, even when vacancies in a rota are at the level that the viability of a rota is jeopardised, the impact on the quality of education provided and the time available by senior doctors to train is minimised.
- Ensuring full implementation of the self-development time for trainees at all levels, as required by the Junior Doctors' contract
- Working with trainees, supervisors, the GoSW and Trust management to ensure that issues raised by doctors in training through 'exception reports' are appropriately addressed and sustainable solutions put in place to resolve recurrent concerns.
- Supporting departments where there have been concerns about training and supervision raised by trainees at their ARCPs or via the GMC survey.
- Looking to continue to develop our SAS and Locally Employed Doctor cohort and, specifically, how we can support and develop these individuals.
- Training our new Physician Associate students whilst they are on placement.
- Developing support mechanisms for International Medical Graduates starting in the Trust

13.0 References

The following documentary evidence supporting this report is held in the Medical Education Department:

- Medical Education Strategic Plan: 2020-2021
- Evaluation of locally organised teaching
- Nationally analysed formal assessment of feedback from medical students on placement
- Feedback and analysis from the medical students of the local teaching sessions
- Evaluation forms received from shadowing week and induction August 2021
- Study leave database – Intrepid
- METC agenda and minutes
- Junior Doctors Induction and H@NT course programmes
- Website documentation
- Archives retained according to local policy

Appendix A

GMC Trainee Survey 2021

Background

The yearly, national GMC survey has taken place again in 2021 and the results were released in July. This year it was a ‘full’ survey after a truncated version had been undertaken in 2020 due to the Covid pandemic.

Caveats

Nationally

There was a lower response rate nationally than in more recent years (with the exception of 2020):

76% trainee response (95% 2019)

32% trainer response (45% 2019)

It is felt that is partly due to ‘survey fatigue’ as numerous surveys had been sent out over the pandemic and the NETS (multi-professional educational survey) had only just closed when the GMC survey opened.

Locally

Results are not reported if less than three responses to questions, so ability to look at individual departments/training programmes is more limited, especially when looking at the smaller departments. In addition, if only a few trainees in a department/programme respond the results can easily be skewed (positively or negatively) by an outlier. This means that the results for a hospital like Salisbury can potentially be less representative of the communal experience of all trainees within a particular area and more difficult to interpret.

Results

Results are benchmarked against other Trusts across the country. If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive but shares a confidence interval with the national average, the box is highlighted pink or light green.

The survey also asked questions about patient safety and undermining behaviour, allowing free text comments.

A trainer survey runs alongside the trainee survey.

Benchmarking results for SFT

There were insufficient responses for the results to be reported in the following programmes:

F1 – general medicine

F2 – genito-urinary medicine, intensive care, obstetrics and gynaecology, paediatrics, palliative care, psychiatry

GP VTS – emergency medicine, general medicine, obstetrics and gynaecology, paediatrics, palliative care,

Also – elderly care, gastroenterology, haematology/oncology, ophthalmology, radiology, respiratory medicine

Specialty	Programme	Green flags	Red flags
Anaesthetics	Core	0	Adequate experience
	Specialty	0	0
Emergency medicine	F2	Induction	Workload
	ACCS	0	0
Medicine	F2	0	Overall satisfaction Rota design
	IMT year 1	0	Rota design
Obstetrics and gynaecology	Specialty	0	0
Paediatrics	Specialty	0	0
Plastic surgery	Specialty	Handover Induction	0
Surgery	F1	Supportive environment	0
	F2	Induction	Clinical supervision out of hours
	CST	Feedback	Clinical supervision out of hours
	Specialty	0	Teamwork
Trauma and orthopaedics	Specialty	Induction Rota design	0
Total		**8**	**8**

The regional teaching domain has been excluded from these results as it is beyond the influence of the Trust.

These results are reported as by programme, rather than by specialty, as the former cover very small cohorts of trainees and therefore are more liable to be skewed.

Other aspects to note:

IMT year 1: Whilst only having one red flag, there were numerous ‘pink’ flags

Cardiology: When the results are interrogated by specialty, there were 6 red flags

Patient safety and undermining behaviour

There was on free text comment from one individual about potential patient safety concerns about the level of senior cover provided for oncology patients on Pembroke Ward.

There were no free text comments about undermining or bullying behaviour.

Trainer results

These results were only available for a small number of specialties, which is consistent with the last few years.

Specialty	Green flags	Red flags
Anaesthetics	Overall satisfaction Handover Time for training Rota design Support for trainers Trainer development	0
Emergency medicine	0	0
General surgery	Workload Time for training	Handover
Obstetrics and gynaecology	Educational governance	0
Plastic surgery	Workload	0
Total	**10**	**1**

Comments

The GMC survey continues to be regarded as the most valuable tool there is for assessing the quality of training of posts nationally. However, when there are only a small number of respondents in a programme it is relatively easy for the results to be affected by the responses of just one trainee. ‘Neutral’ or ‘average’ responses can also result in overall results for a department being particularly poor, especially if the particular programme

concerned is one of a limited number in the country, due to the manner in which results are analysed and compared. The falling response rate across the board is a concern as it threatens the robustness of the data and the ability to draw conclusions from it. Nationally and regionally there are discussions as to how this can improve for the 2022 survey.

However, many of us are aware that anecdotally there appears to be a pattern that trainees who are having difficulties or are unhappy will expose departments with issues (which may remain more hidden when the cohort of trainees are progressing well), as they tend to be more intolerant of deficiencies in their training and supervision. There also remains concern at local, regional and national level that some of the questions asked are ambiguous and would be better answered with a 'yes' or 'no' rather than a graded response.

Despite the fact that the GMC survey does not always give us the full picture, it does identify areas where there are significant concerns and also where training is clearly excellent. The results give a guide as to where work needs to be done to improve the quality of the posts and also where there is good practice that should be shared more widely.

Our results from the GMC survey this year have followed the mixed pattern that we saw back in 2019, when the last full survey was undertaken – 8 green flags 2021 v 14 in 2019; 8 red flags 2021 v 13 in 2019. 'Single year' reports do vary from year to year and the ability to assess trends over the last few years is probably of more use for corporate learning. The only consistent pattern of recurrent red or green flags over the last few years in Salisbury has been the red flag for 'Clinical Supervision Out of Hours' for CSTs and F2s in surgery. On further investigation, this reflects the current H@NT setup, whereby some surgical specialties have an overnight regional on call.

Looking at some specific areas, it was very pleasing to see the results for Plastic Surgery as the department has been through a challenging time which has been reflected in past surveys – 5 red flags in 2019, but 2 green flags 2021. These results highlight the large amount of work that has been put in by their Educational Lead, Miss Rebecca Exton, and I am very grateful for her expertise.

The cardiology results (when analysed by post) are concerning and disappointing. However, closer analysis shows that only three trainees responded and the majority of their responses fell into the 'neutral' area. As a result, where one trainee has marked a domain down, it has severely skewed the results in a negative direction.

The cardiology department has looked at the results in detail and acknowledged that work needs to be done around consistent handover and ensuring regular supervisor meetings, which had lapsed due to pressure of work over the Covid pandemic. They felt that other issues were difficult to address as they reflected understaffing of the department specifically and medicine in general, which then had a knock-on effect on the rota design, workload etc. Hopefully recent Trust initiatives to review the medical workforce may help to alleviate this pressure. In addition to this, I have arranged to meet the current cohort of cardiology trainees within the next month to see how they perceive their current training environment.

This is the first year that the IMTs have had an opportunity to participate in the survey since the medicine core curriculum changed. They were particularly impacted by this change happening over the last twelve months, as much of their training structure had not been embedded before the pandemic struck. Work is already underway in the Trust to improve their education e.g. implementation of a varied teaching programme, facilitated exam preparation etc., although we do appreciate that the experience of this cohort will need to be closely monitored as we go through the next year.

The patient safety issue that was reported about the level of senior oncology cover on Pembroke Ward was investigated in May 2021 when it was raised by HE Wessex. It reflected a staffing challenge with regards our external partner (University Hospital Southampton) providing oncology cover at SFT, although both parties were actively negotiating to try and resolve this. We agreed to work with/remind the juniors of who the accountable consultants are for in-patients on Pembroke Ward, namely the Haematology Consultants, and how they can access senior support as and when required.

These results have been discussed with educational leads for the various departments in order to facilitate further reflection and discussion.

Appendix B

EVALUATION OF INDUCTION DAY
Wednesday, 4th August 2021

	EXCELLEN T	GOO D	O K	POO R	COMMENTS
INTRODUCTION & WELCOME					
Dr Emma Halliwell Director of Medical Education	(5)	(5)	(1)		• **Good content but would have been handy to have slides for those who learn better visually than aurally.**
Dr Peter Collins Medical Director	(5)	(5)	(1)		• **No complaints; seemed nice.**
Freedom to Speak Up Guardian Elizabeth Swift	(5)	(5)	(1)		
Diversity and Inclusion Rex Webb	(5)	(4)	(2)		• **We have this every year in every hospital, whilst its important more**

					important for new doctors, and missed out much more important stuff i.e. how to bleep, hospital tour.
Dr Nicholas Hicks Mess Representative	**(4)**	**(5)**	**(2)**		• **Not encouraged or invited to mess events (even though there was one the next day!)**
			SESSIONS		
Blood Transfusion Sarah Salisbury	**(5)**	**(5)**	**(1)**		• **Covered the safety side but not practical elements ie when in the day can you get a cross match**
Documentatio n Judith Leach	**(6)**	**(4)**	**(1)**		• **Engaging and scary: love a good medical negligence anecdote or two.**
Resuscitation	**(5)**	**(5)**	**(1)**		• **Why did we then have another session a week or two later?** • **Useful to be advised of the local nuances in policy and resus.**
IT Training	**(4)**	**(4)**	**(1)**	**(2)**	• **Not enough time allocation, just given**

					passwords and not taught how to use systems. • **No education/opportunity to practise using the systems ie how to find the information you need for clinic, how the ED system works. I appreciate some of this is covered in e-learning, but not in enough detail and without practise using the actual system. Also no bighand login.** • **Really important aspect of induction, requires and deserves a larger proportion of the day, large amount of time wasted waiting for hand hygiene could have been better spent becoming more**

					familiar with software. • Good concise notes on quite complicated systems. • A bit of a marathon but it all worked in the end.
Medical HR	**(4)**	**(6)**	**(1)**		
Hand Hygiene	**(4)**	**(4)**	**(3)**		• **We have this every year in every hospital, whilst its important more important for new doctors, and missed out much more important stuff i.e. how to bleep, hospital tour.**
			APPOINTMENTS		
Occupational Health (if applicable)	**(1)**	**(2)**	**(1)**		• **Disappointing that I needed a blood test and told I couldn't work until the results were back, I felt this could have been done before I started at SDH.**

Fit testing	**(4)**	**(5)**	**(1)**		• **Very patient when none of the masks fit!**

Appendix C

EVALUATION TRUST REFRESHER COURSE
11th November 2020

Facilitators: Emma Halliwell and Adam Hughes

Attendees = 16

Content: poor / satisfactory / good / very good = 6xgood 8xvery good
Delivery: poor / satisfactory / good / very good = 3xgood, 11x very good

Any topics covered particularly well? Comments received
Trainee in difficulty
Trainees in difficulty and Covid
Trainees in difficulty
Trainee in difficulty
All topics covered fully
Trainees in difficulty. Feedback. Differential attainment
Resources open to the trainee in difficulty
Setting expectations at initial meeting. Documentation.
Managing trainee in difficulty
Trainee in difficulty
Good informal discussion amongst the group
Dealing with Drs in difficulty
Trainee in difficulty

Any topics that could have been covered better? Comments received
Divide in BAME trainees outcomes but appreciate evolving topic
E-Portfolio requirements
Trainee with dyslexia and failing the examination
Writing educational supervisor report
Importance of interdepartmental communication

Any topics that you feel should have been covered but weren't? Comments received
No because faculty were very open to questions

Was 4 hours for this Refresher: too short / about right / too long = 14x about right

Any other suggestions or comments? Comments received
Good to allow comments/experiences to be shared among delegates
Please update slides as can't read them, they are too busy, and contrast with colours poor. Thanks for allowing us to meet in a lecture theatre together.
Clearer slides please.
Slides projection need to be improved.
Thank you for organising this in house for us.
Update slides. Cure Covid.
Nice open forum for questions and input.
Couple of slides content – not visible when sitting in the back of the lecture theatre.
Good interaction with teams.
Great refresher course. Thank you!

EVALUATION TRUST REFRESHER COURSE
21st April 2021

Facilitators: Emma Halliwell, Adam Hughes and Aisling Coy

Attendees = 11

Content: poor / satisfactory / good / very good (11)
Delivery: poor / satisfactory / good (2)/ very good (9)

Any topics covered particularly well?

- All relevant
- SPA doctors in difficulty
- Structure of ES meetings
- Supervision meetings (I left early so missed trainees in difficulty)
- Roles of ES and meeting
- Roles and Responsibilities
- Trainee in difficulty
- Very good overall, Dr in difficulty
- Doctors in difficulty
- Self-development time, SPA changes, Revalidation and Trainee in difficulty
- Yes
- Excellent

Any topics that could have been covered better?

- All covered very well
- Very good update information on GMC and Deanery
- Support and governance for AHP
- None

Any topics that you feel should have been covered but weren't?

- Good opportunity for everyone to contribute to the contents of the meeting
- Flexible with good coverage of our choices which we gave at the start
- Governance structure for LED
- More about LEDs would be helpful
- Covered everything
- All topics were covered

Was 4 hours for this Refresher: too short / about right (13)/ too long =

Any other suggestions or comments?

- Very worthwhile
- Regular
- Thank you very much
- Very good
- Lovely
- Thanks, very helpful especially having the DME and FPD

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of Meeting:	07 April 2022		

Report Title:	2021 Staff Survey Results			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process				
Prepared by:	Melanie Whitfield, Chief People Officer			
Executive Sponsor (presenting):	Melanie Whitfield, Chief People Officer			
Appendices (list if applicable):	Appendix 1: Summary slides			

Recommendation:
The Committee is invited to note the final results and the action being taken.

Executive Summary:
The national NHS staff survey was carried out in autumn 2021. 1881 people from SFT took part. This paper provides some of the background information to the nationally-led survey, and highlights the initial results for the Trust. Final results were published 31st March at which comparisons are made with all trusts which took part in the survey. Like a number of others SFT's results are disappointing with some decreases in positive scores compared with last year, as well as in comparison with other trusts. The paper highlights actions which have been taken to date and planned next steps.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☐
Partnerships: Working through partnerships to transform and integrate our services	☐
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

2021 STAFF SURVEY RESULTS

1 Purpose of the paper

The purpose of the paper is to present the final 2021 staff survey results to the Public Board. The Board are invited to note the results and the action being taken.

2 Background and Context

A national staff survey is carried out across the NHS each year in the autumn. The questionnaire is developed nationally by the NHS staff survey co-ordination centre and is one of the largest workforce surveys in the world (600,000 people took part in 2020). The aggregated results were published as official statistics on 31st March.

The 2021 survey took place from September to November 2021. The initial results were received in December 2021 from our contractor, Picker Institute Europe, and compared SFT with 60 Acute and Acute Community Trusts which also use Picker as their survey contractor. It is important to note that there are several survey providers across the NHS, and the full comparator is made when the final official reports are shared and published.

There are 92 questions in the survey which uses the ‘positive score’ as the primary unit of measurement. Some changes were made in 2021 to align the survey with the NHS People Promise and to enable progress against that to be tracked. Other changes were to improve participation (from staff on long term sickness absence) and inclusivity (with a new question on gender identity) whilst maintaining historic comparability. 60 questions can be compared historically.

The results are presented by staff survey themes, (your job, your team, people in your organisation, your managers, health and wellbeing and safety, personal development and your organisation) and by the NHS People Promise themes. The People Promise themes are:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We work as a team.

The alignment to the People Promise will enable progress to be measured against this important aspect of the NHS People Plan both nationally and locally.

Results are also available by Division and by ‘locality’ (some teams within divisions). However, results only questions where the trust received at least 11 responses (the minimum required for reporting).

3 Summary headlines for SFT from the 2021 initial results

The initial picture is a disappointing one for SFT. The trust had a lower response rate than in previous years at 49% (compared with 54% in 2020). The 2021 SFT response rate was also below the average for Picker trusts (52%). Nevertheless, 1881 people at SFT have shared their views through the 2021 survey.

There have been widespread decreases across all staff survey themes with 34 out of 56 questions significantly worse than last year, and no areas significantly better. 46 out of 92 questions are significantly worse than our Picker comparators. SFT is now below average on 8 out of the 9 themes of the survey and average on staff engagement. The poorest results relate to the job (motivation and resources) and the personal development questions. The health, wellbeing and safety at work theme has the most favourable results when compared with other Picker trusts. There had been a big fall in the recommendation of the trust as a place to work (57% from 70%) and SFT is below average rather than above average on this.

There is notable variation between divisions and professional and demographic groups. Nursing colleagues for example report the least positive scores and BAME staff generally experience more harassment, bullying and abuse than white staff but score more highly on motivation. Those who prefer not to state their gender or sexual orientation report poorer experiences than others.

The slide deck at Appendix 1 show some examples of the results and potential areas of focus.

4 Action to date

Some analysis has been undertaken to understand the results better by survey theme, the People Promise and by division. Brief presentations have been made to private Board on 3rd February and a discussion has taken place with senior members of the OD and People team on 15 February. Discussions have focused on the potential areas for prioritisation, impact, hotspots and communications and engagement. Resource packs have been developed and circulated to each of the clinical to support colleagues in understanding their own results, engaging with teams, and with action planning. The Trust results have been communicated.

5 Next steps

Discussions to date have determined the next steps as follows:

- Plan and implement local (team) and large scale (division/organisation-wide) listening events across the working day/night/week
- Action plans to begin development – quick wins to be identified by end of April.
- Progress to be reported to People and Culture Committee on a regular basis for assurance.

Salisbury NHS Foundation Trust

NHS Staff Survey 2021: Final results for SFT

Melanie Whitfield, Chief People Officer

Trust Board

7 April 2022

Background to 2021 NHS national staff survey

NHS
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- Annual NHS staff survey: September to November 2021
- Questionnaire developed nationally by the NHS staff survey co-ordination centre
- One of the largest workforce surveys in the world (600,000 people took part in 2020)
- Aggregated results published as official statistics on Wednesday 30 March so the results are no longer embargoed following official publication
- Some changes made in 2021 to align with the NHS People Promise and to enable progress against that to be tracked as well as improve participation and inclusivity whilst maintaining historic comparability
- Initial results discussed previously compared SFT with 60 Acute and Acute Community Trusts, full official benchmark results compare SFT with 125 other Acute and Acute & Community trusts
- 92 questions use the ‘positive score’ as the primary unit of measurement
- 60 questions can be compared historically
- Results include every question where the trust received at least 11 responses (the minimum required for reporting)

NHS

2021 NHS Staff Survey

Alignment to the People Promise

- From this year the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of our NHS people, the things that would most improve our working experience – like health and wellbeing support, the opportunity to work flexibly, and to feel we all belong, whatever our background or our job. The People Promise is made up of seven elements:

- The people who work in the NHS are best placed to say when progress has been made towards achieving our People Promise. From this year, everyone's answers will be used to better understand what it's like at the moment and where more change is needed.

We each have a voice that counts
People Promise

Summary headlines for SFT

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- 48.5% response rate: a little above the national benchmarked median but lower than last year
- c.90% of people across our clinical divisions feel that their role makes a difference to patients or service users
- Divisional variation with some faring better than others
- Widespread decreases at Trust level across all themes: 34 out of 56 questions significantly worse than last year, no areas significantly better
- SFT is now below average on 8 out of the 9 themes of the survey and average on staff engagement
- Poorest results around the job (motivation, resources) and personal development questions
- A big fall in the recommendation of the trust as a place to work (57% from 70%) and now below average rather than above average on this
- Nursing colleagues report the least positive scores
- BAME staff experience more harassment, bullying and abuse than white staff but score more highly on motivation
- Those who prefer not to state their gender or sexual orientation report poorer experiences than others

Previous Private Board discussion

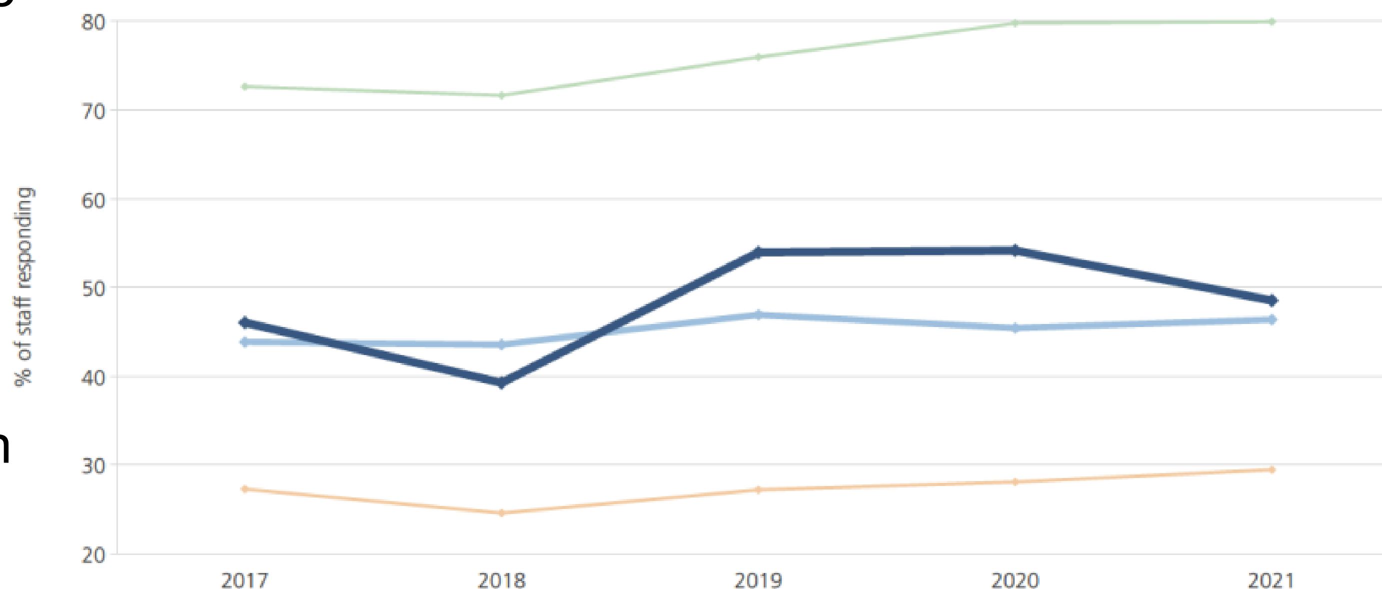
- Concerns about our people and for their wellbeing
- Concerns for our patients as patient experience and outcomes have been shown to link with staff engagement
- Staff experience is not what we would want, e.g., people are not getting their appraisals, and they are unable to take up learning and development opportunities
- More analysis needed based on the staff survey themes and the People Promise themes: **completed and shared with divisions and OD & P teams through February and March**
- The Divisions and professions will need to own and work with their data. It was recognised that they will already have made some improvements over the last few months: **Resource packs completed (see later slide) and OD&P teams briefed**
- More analysis is needed regarding the experience of those with protected characteristics: **completed and shared as part of above actions**

SFT 2021 staff survey response rate

48.5% (1881) of eligible staff completed the survey. This is above the national median response rate.

46.4% median response rate for similar organisations (125 other Acute and Acute & Community trusts)

SFT's response rate in 2020 was 54.2%, so has now fallen by 5.7% in 2021, when others' metrics (lowest, median and highest, have all increased slightly)



	2017	2018	2019	2020	2021
Highest	72.6%	71.6%	76.0%	79.8%	79.9%
Your org	46.0%	39.3%	54.0%	54.2%	48.5%
Median	43.9%	43.6%	46.9%	45.4%	46.4%
Lowest	27.3%	24.6%	27.2%	28.1%	29.5%

Top/bottom and most improved/declined scores

NHS
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NHS Foundation Trust

Top 5 scores vs Picker Average	Trust	Picker Avg
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	65%	61%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	77%	74%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	47%	45%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	71%	69%
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	69%	66%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
q8a. Teams within the organisation work well together to achieve objectives	46%	53%
q3g. Able to meet conflicting demands on my time at work	37%	44%
q19a. Received appraisal in the past 12 months	75%	82%
q3h. Have adequate materials, supplies and equipment to do my work	49%	56%
q6b. Organisation is committed to helping balance work and home life	37%	43%

Most improved scores	Trust 2021	Trust 2020
q13d. Last experience of physical violence reported	69%	66%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	88%	86%
q3c. Opportunities to show initiative frequently in my role	74.3%	73.7%
q14d. Last experience of harassment/bullying/abuse reported	45.3%	44.8%
q13b. Not experienced physical violence from managers	100%	99%

Most declined scores	Trust 2021	Trust 2020
q3i. Enough staff at organisation to do my job properly	20%	36%
q21c. Would recommend organisation as place to work	57%	70%
q4a. Satisfied with recognition for good work	47%	59%
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	69%	79%
q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work	72%	82%

Tables are based on absolute % differences, not statistical significance

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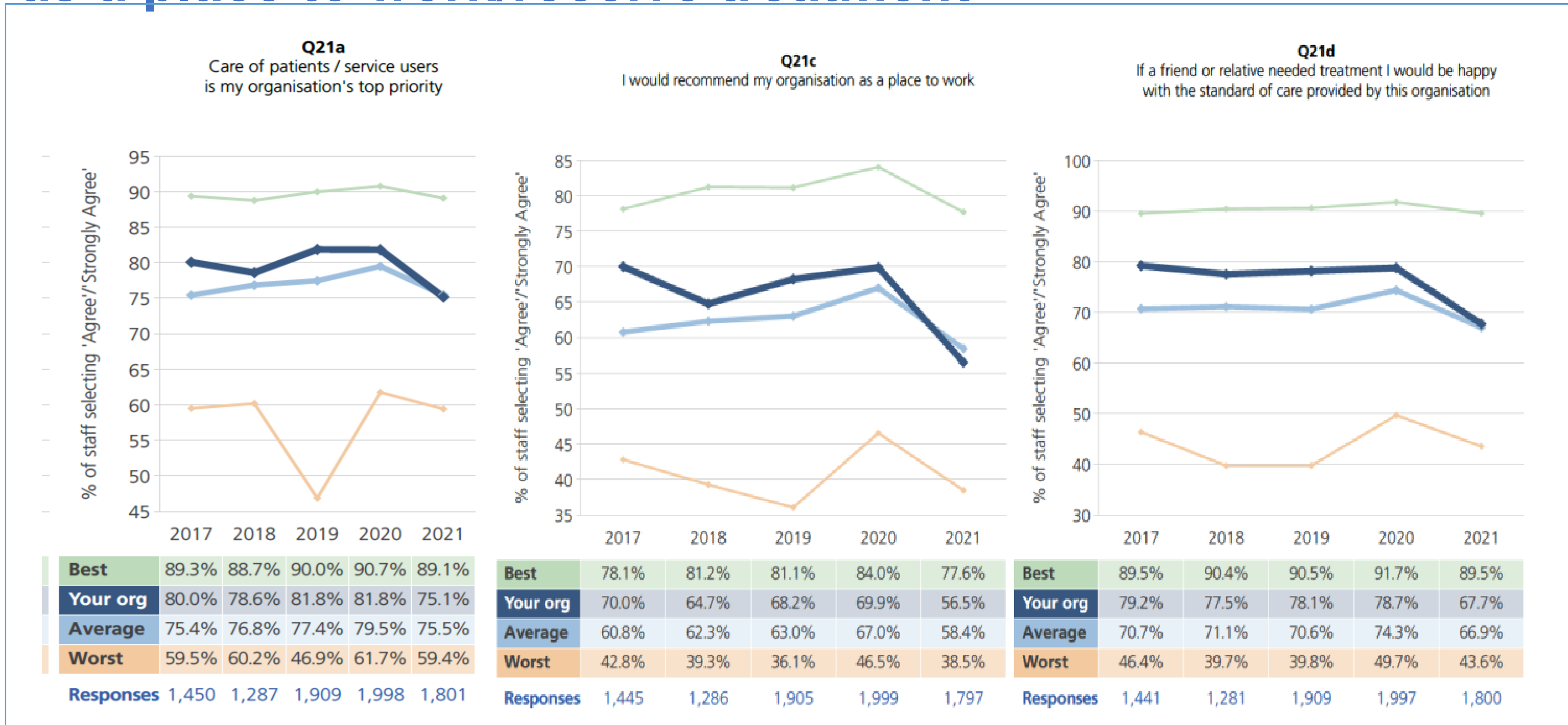
Staff engagement: recommendation of SFT as a place to work/receive treatment



Q21a

	2017	2018	2019	2020	2021
Best	89.3%	88.7%	90.0%	90.7%	89.1%
Your org	80.0%	78.6%	81.8%	81.8%	75.1%
Average	75.4%	76.8%	77.4%	79.5%	75.5%
Worst	59.5%	60.2%	46.9%	61.7%	59.4%
Responses	1,450	1,287	1,909	1,998	1,801

Q21c

	2017	2018	2019	2020	2021
Best	78.1%	81.2%	81.1%	84.0%	77.6%
Your org	70.0%	64.7%	68.2%	69.9%	56.5%
Average	60.8%	62.3%	63.0%	67.0%	58.4%
Worst	42.8%	39.3%	36.1%	46.5%	38.5%
Responses	1,445	1,286	1,905	1,999	1,797

Q21d

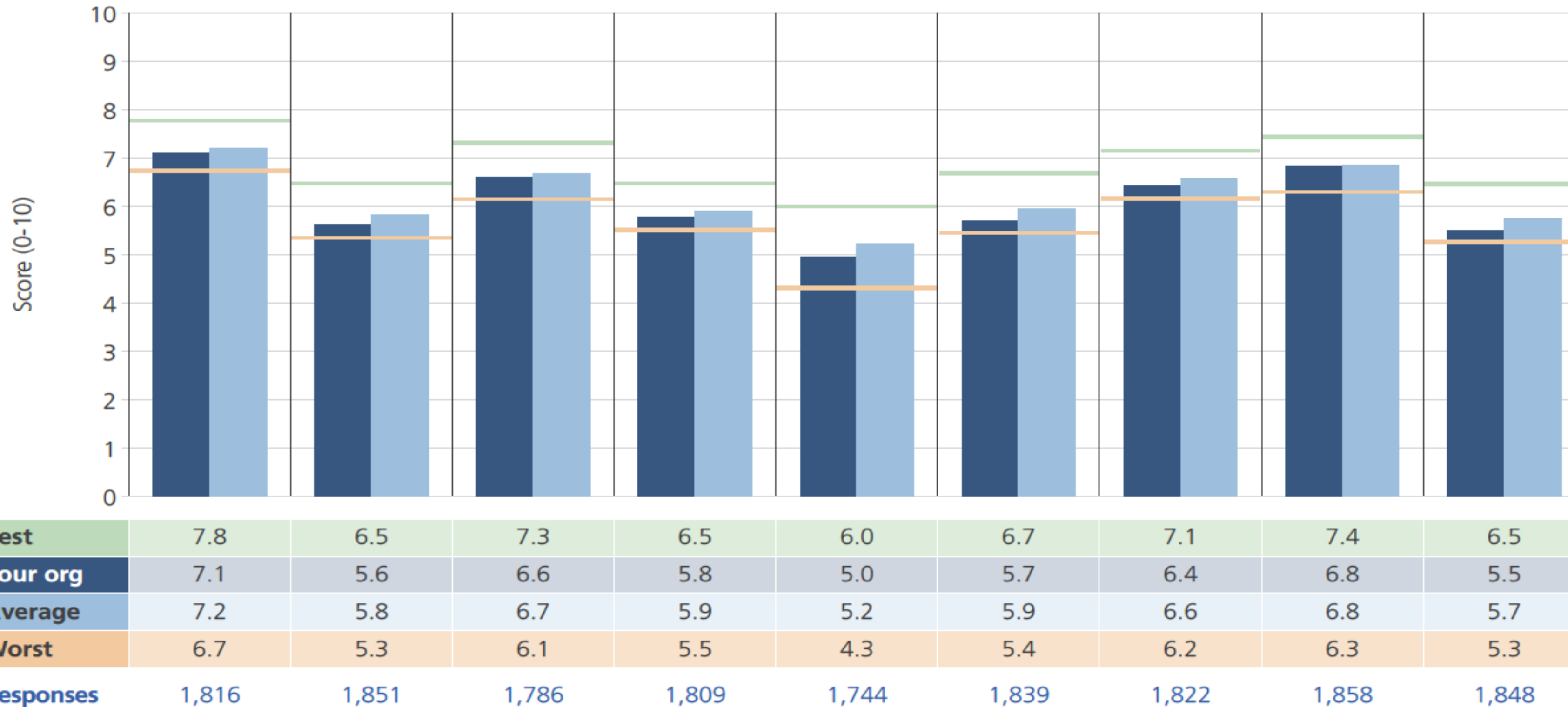
	2017	2018	2019	2020	2021
Best	89.5%	90.4%	90.5%	91.7%	89.5%
Your org	79.2%	77.5%	78.1%	78.7%	67.7%
Average	70.7%	71.1%	70.6%	74.3%	66.9%
Worst	46.4%	39.7%	39.8%	49.7%	43.6%
Responses	1,441	1,281	1,909	1,997	1,800

Source: NHS_staff_survey_2021_RNZ_full

Overview of full benchmark results

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > **Overview**

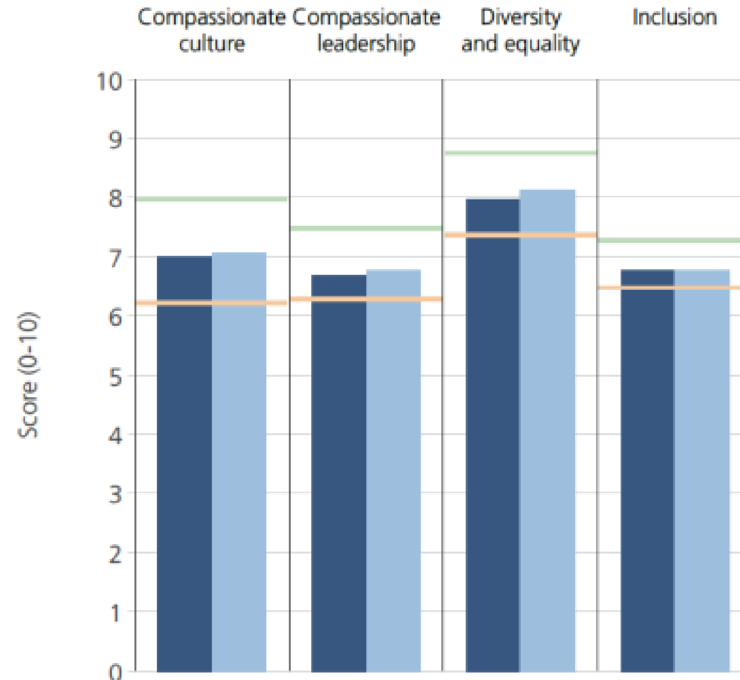


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.6	6.6	5.8	5.0	5.7	6.4	6.8	5.5
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,816	1,851	1,786	1,809	1,744	1,839	1,822	1,858	1,848

Source: NHS_staff_survey_2021_RNZ_full

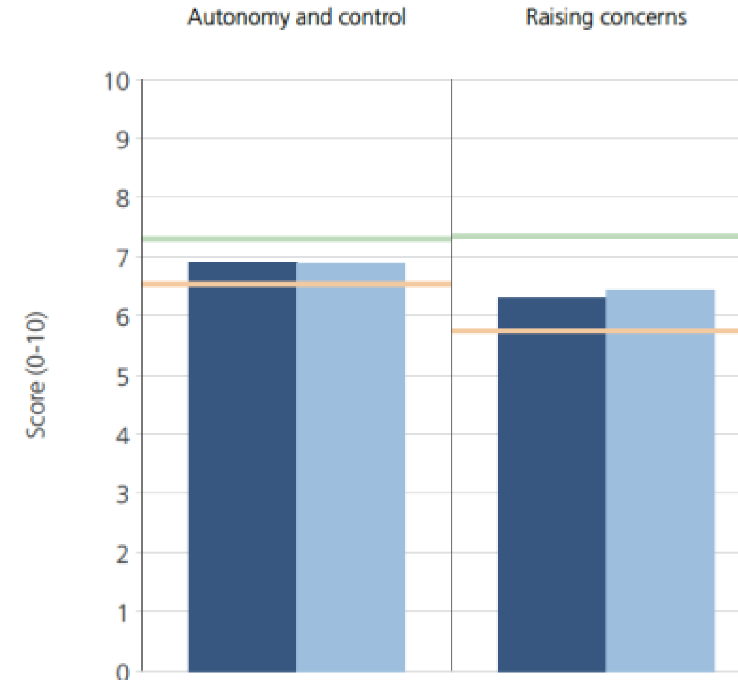
People Promise elements 1 & 3

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	7.0	6.7	8.0	6.8
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5
Responses	1,800	1,820	1,817	1,824

Promise element 3: We each have a voice that counts



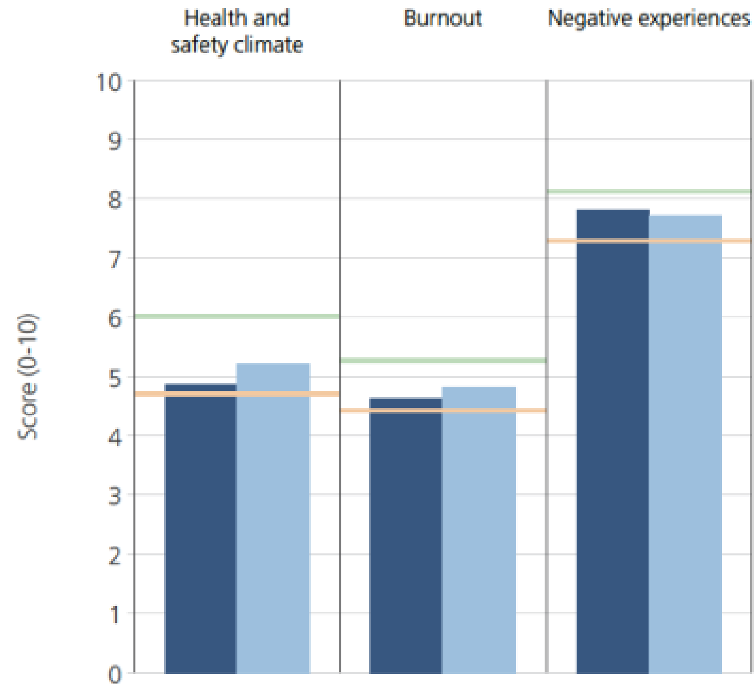
	Autonomy and control	Raising concerns
Best	7.3	7.3
Your org	6.9	6.3
Average	6.9	6.4
Worst	6.5	5.7
Responses	1,856	1,788

* Promise element 2 features no sub-scores and so is not included in this section of the benchmarking report

Source: NHS_staff_survey_2021_RNZ_full

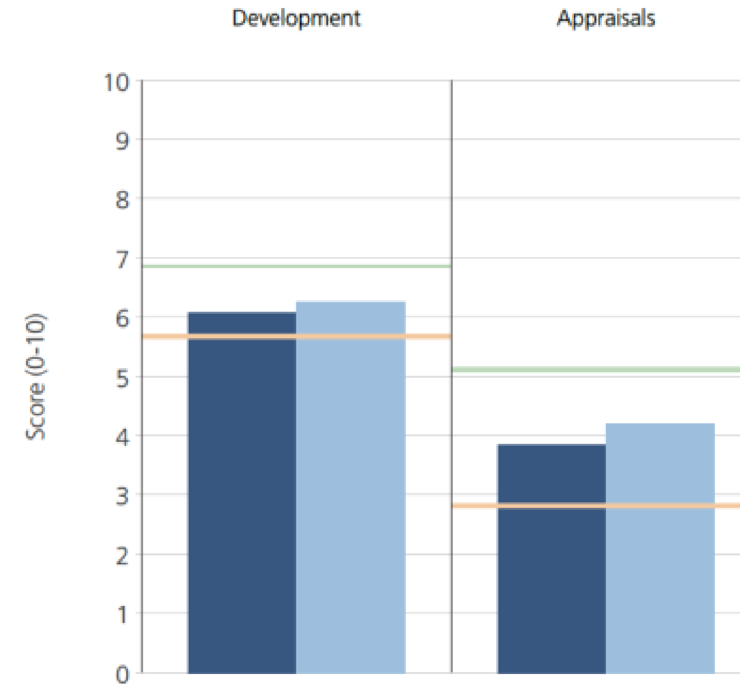
People Promise elements 4 & 5

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	4.9	4.6	7.8
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	1,855	1,819	1,812

Promise element 5: We are always learning

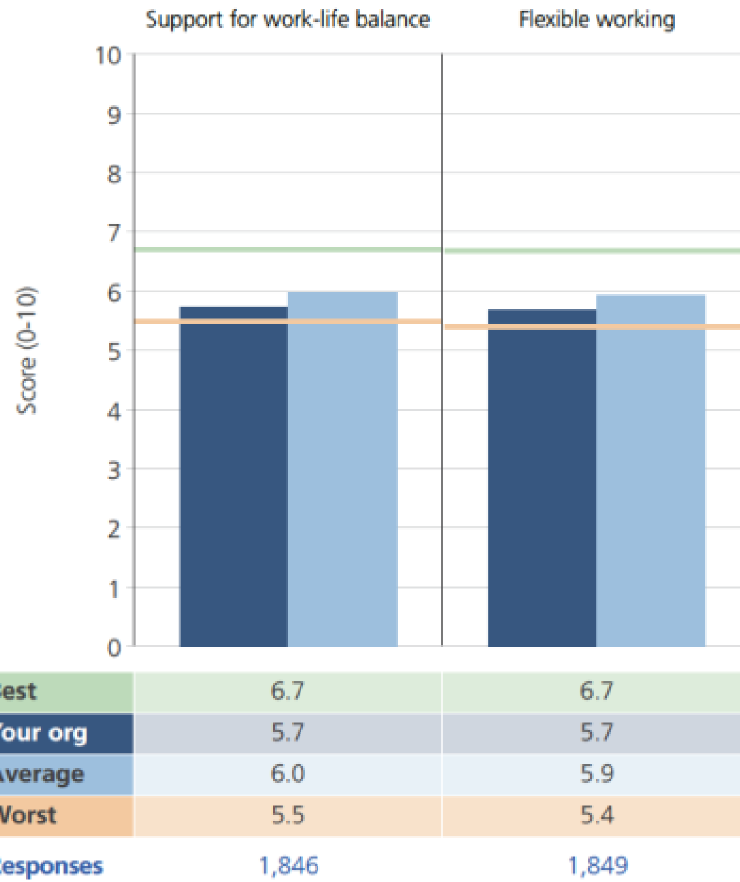


	Development	Appraisals
Best	6.9	5.1
Your org	6.1	3.8
Average	6.3	4.2
Worst	5.7	2.8
Responses	1,804	1,753

Source: NHS_staff_survey_2021_RNZ_full

People Promise elements 6 & 7

2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Sub-score results page 3 of 4**



	Support for work-life balance	Flexible working
Best	6.7	6.7
Your org	5.7	5.7
Average	6.0	5.9
Worst	5.5	5.4
Responses	1,846	1,849

	Team working	Line management
Best	7.0	7.3
Your org	6.3	6.5
Average	6.5	6.6
Worst	6.2	6.2
Responses	1,834	1,823

Source: NHS_staff_survey_2021_RNZ_full

Responding to the survey

- Prior to the embargo being lifted, we were able to share the initial results internally so discussions have taken place in the Executive team, with the divisions, and with the OD & People team who will support the divisions in their response
- Communications to staff, thanking them for their feedback and inviting them to participate in listening events
- We have started work with our people to develop action plans together which will have some 'quick wins' with impact in the first 3 months, and some longer term solutions
- For the first time, we have developed 'resource packs' for use in divisions/teams. The packs contain the data for each division/team, some analysis against the people promise themes and a suggested approach to having a facilitated conversation
- Conversations/listening events are expected to take place:
  - Organisationally
  - Divisionally/ as teams
  - By professional group
  - In network groups

People promise themes & areas of focus

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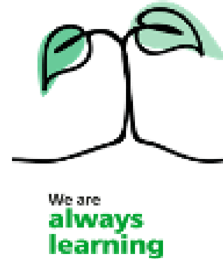
SFT as a place to work, careers, management skills, dealing with concerns raised

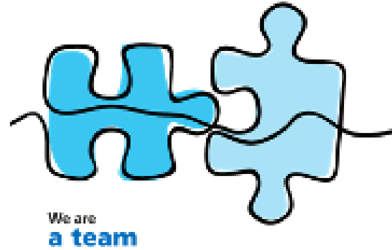
Appraisals, career development, learning and development opportunities



Work-life balance and flexible working

Recognition valuing people

Team working, empowerment, team meetings



Resources, time management, positive action on health & wellbeing

Raising concerns and addressing concerns raised

Next steps

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- HR Business Partners working closely with the divisions on the results, using the Resource Packs as a framework to support facilitation of local discussions.
- Plan and implement large scale listening events/approaches
- Prioritise actions at corporate, divisional, team and professional group level
- Assurance via People and Culture Committee

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Report to:	Trust Board (Public)	**Agenda item:**	7.1
Date of Meeting:	07 April 2022		

Report Title:	2022 Annual Review of Directors Interests/Annual Review Fit and Proper Persons Test			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Approval Process (where has this paper been reviewed and approved)	Board Approval required. Annual Register of Interests published on website			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Annual Register of Interests			

Recommendation:
To review and note the annual Register of Interests and the outcome of the annual Fit and Proper Person Review as at March 2022.

Executive Summary:

There is a requirement as part of the Trust's licence agreement to publish the annual Register of Directors' interests to the Board. In 2020 it was agreed that the annual requirement would extend to all decision-making staff, described as those at band 8d and above or equivalent.

In 2021, after changing the process to include these staff, compliance was reported as 20%. The counter fraud team highlighted several areas of improvement and an action plan was produced to improve the annual process and staff's awareness of their responsibilities. These actions included amending the policy and form with suggested changes; commencing a focused communications campaign to encourage all staff to declare; and improve awareness and targeted emails to those staff who had been identified by counter fraud as having a potential conflict.

Progress on these actions went to the Audit Committee in March, confirming that compliance had increased from 20% in 2021 to 60% in 2022. This high increase in returns and the number of queries to the corporate governance team further indicate that staff's awareness of the declaration of interests' process has improved. To ensure this progress is maintained and subsequently improved upon, the communications messages in the Daily Bulletin and Line-Manager Round-up will continue throughout the year.

The corporate governance team have reviewed any positive declaration and any agreed action is documented on the register. The Senior Independent Director has also had sight of the register of interests. No concerns have been raised as part of this process.

There is also a requirement for all Executive and Non-Executive Directors to complete an annual form of declaration confirming that they continue to be a fit and proper person. This has been completed and no concerns have been raised.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☐
Partnerships: Working through partnerships to transform and integrate our services	☐
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

Salisbury NHS Foundation Trust Register of Interests 2021/22

Includes: All decision making staff, agenda for change band 8D and above or equivalent.

Name	Job Title	Company	Position	Action / Notes
Roger Humphry	Consultant Ophthalmologist	Care Quality Commission	Ad Hoc work <20 hours a year	No action – secondary employment
		Self-employed private clinical practice	Consultant Ophthalmologist 1992 –present	
Nicholas James Carty	Consultant General Surgeon	New Hall Hospital	Consultant General Surgeon 1994 – present	No action
Ian Downie	Consultant Surgeon	Salisbury Hospice Charity	Trustee	No action
		New Hall Hospital	Private Clinical Practice since 2003	
		Bond Dental	Private Clinical Practice since Nov 2020	
Caroline McGuiness	Consultant Plastic Surgeon	New Hall Hospitall	Private Clinical Practice	No action
		Orthopaedics Plastics and Spinal Specialists LLP and Carol	Private Clinical Practice	No action
Uma Thakur	Consultant Ophthalmologist	New Hall Hospital	Private Clinical Practice	No action
		Caprihealthcare	Husband's Private Limited Company	
Aisling Coy	Consultant Rhematologist	Purple Medical Ltd	Own limited company	No action
		New Hall Hospitall	Private Clinical Practice	
		Abbvie	Advsiory Boared for AbbVie in June 2021	
Melissa Davies	Consultant Urologist	Wessex Urology	Director	no action
Stuart Verdin	Consultant Gynaecologist	S.M.Verdin	Private Clinical Practice since 2004	No action
Simon Williams	Consultant Anaethetist	SPW Medical Ltd	Director/ Wife also a director	no action
		New Hall Hospital	Private Clinical Practice via SPW Medical Ltd	
Kush Duggal	Consultant Anaethetist	New Hall Hospital	Private Clinical Practice	no action
Ben Siggars	Consultant Anaethetist	Siggars Medical Ltd	Director	no action
		New Hall Hospital	Private Clinical Practice via Siggars Medical Ltd since 2008	
		South Central Ambulance Service Trust	Medical Incident Advisor since 2016	
		Hampshire and Isle of Wight Air Ambulance	Consultant in Prehospital Emergency Medicine since 2013	for addditional duties only. The majority of this work is contracted via service level agreement with SFT.
James Brewin	Consultant Urologist	Salisbury Urology Ltd	Director	no action
		New Hall Hospital	Private Clinical Practice via Salisbury Urology Ltd	no action
Christina Cox	Consultant Anaethetist	CRC Anaesthesia ltd	Director	no action
		New Hall Hospital	Private Clinical Practice CRC Anaesthesia ltd since 2000	
		West Dean Village Hall Committee	Treasurer	
		Salisbury Hospital Foundation	Trustee	
Mark Ellis	Deputy Director of Finance	Odstock Medical Limited	Director	no action
Tim Wells	Consultant Cardiologist	T.A.N.T Medical Ltd	Director	no action
		New Hall Hospital	Private Clinical Practice	
		Spire Hospital Southampton	Private Clinical Practice	
		Bournemouth Nuffield Hospital	Private Clinical Practice	
Laurence Arnold	Campus Project Lead	Nil Return	Nil Return	no action
Naginda Dhanoa	Chief Digital Officer	Nil Return	Nil Return	no action
William Garrett	Consultant Anaethetist	New Hall Hospital	Private Clinical Practice	no action
Martin Smith	Consultant Endocrinologist	Salisbury Endocrinology Partnership Ltd	Director	no action
		New Hall	Private Clinical Practice	
G R Smith	Consultant Rhematologist	Dr G R Smith Ltd	Co-Director / Wife is also co-director	No action
		INSPIRE	Member of the Board of Trustees	
		KEMH Falklands Islands	Consultant Rhematologist	
		OPL	Private Clinical Practice	
		New Hall	Private Clinical Practice (no clinics in 12 months)	
		SIMP (Southern Independent Medical Practice)	Private Clinical Practice	
Jonathan Linton	Consultant Anaethetist	J&f Linton Ltd	Director	no action
		New Hall Hospital	Private Clinical Practice since 2014	
Graham Branagan	Consultant Surgeon, GI Surgery	G & PB Ltd	Director (Wife is also a director)	No action
		Bishops Wordsworth School	Governor	No action
		New Hall	Private Clinical Practice via G &PB Ltd since Jan 2006	no action
Alistair Campbell	Consultant Urologist	RALP Ltd	Director	no action
		New Hall	Private Clinical Practice	
Dr J Onslow	Consultant Anaethetist	Charity for Childhealth	Wife is on the Board	no action

		New Hall	Private Clinical Practice	no action
Kate Jenkins	Consultant Psychologist	Self employed - since 2007	Psychologist	no action
Duncan Wood	Consultant Clinical Scientist	Odstock Medical Ltd	Shareholder	Does not receive a dividend or any other benefits. No conflict of interest. No action
Neal Jacobs	Consultant Trauma and Orthopaedic Surgeon	OPSS LLP (Orthopaedic and Plastic surgery specialists)	Partner	No action
		Salisbury Medical Solutions Ltd	Director	No action
James Haslam	Consultant Anaethetist	Critical Care Medicine Ltd	Director (Wife is also a director)	no action
		Ramsey HealthcareNew Hall Hospital	Private Clinical Practice	no action
Rob Webb	Director of Procurement and Commercial Services	Nil Return	Nil Return	no action
Harshad V Dabke	Trauma and Orthopaedic Consultant	Orthopaedics Plastics and Spinal Specialists LLP	Director	No action
		Ramsay New Hall Hospital	Consultant Orthopaedic Surgeon since Jan 2009	no action
Julia Bowditch	Consultant Anaethetist	Bowditch Medical Ltd	Director since Oct 2019	no action
		Ramsey HealthcareNew Hall Hospital	Private Clinical Practice	no action
Quentin Lillis	Deputy Chief People Officer	Avalon HR Consulting Ltd	Director / Shareholder	No action
Abi Kingston	Consultant Obstetrician and Gynaecologist	New Hall Hospital	Director of a Ltd company providing private medical practice in	No action
Rakhee Aggarwal	Non-Executive Director	Nil return	Nil Return	No action
Tania Baker	Non-Executive Director	Nil Return	Nil Return	No action
Michael von Bertele	Non-Executive Director	Grenadenburg Consulting	Owner / Director	No action
		Rutherford Health	Non-Executive Director	
		Rutherford Innovations	Non-Executive Director	
		Rutherford Estates	Non-Executive Director	
		Rutherford Diagnostics	Non-Executive Director	
		Rutherford Infrastructure	Non-Executive Director	
		Trayned Insight	Director	
		Aspen Medical	Non-Executive Director	
		Ultra-Genetics Ltd	Director	
		Ministry of Defence: Army HQ	Chairman of Appeal Body for employment related complaints.	
David Buckle	Non-Executive Director	Society for Assistance of Medical Families	President	No action
		East and North Hertfordshire NHS Hospital Trust	Non-Executive Director	
		Stroke Association	Vice President	
		Berkshire Healthcare NHS Foundation Trust	Non-Executive Director	
Peter Collins	Chief Medical Officer	Nil Return	Nil Return	No action
Jane Dickinson	Deputy COO	Nil Return	Nil Return	No action
Naginder Dhanoa	Chief Digital Officer	Nil Return	Nil Return	No action
Judy Dyos	Chief Nursing Officer	Nil Return	Nil Return	No action
Kieran Humphrey	Associate Director of Strategy	Nil Return	Nil Return	No action
Stacey Hunter	Chief Executive	Nil Return	Nil Return	No action
Andy Hyett	Chief Operating Officer	N/A	Spouse is Fiona Hyett, Operations Director for Salisbury City H	No action
Fiona Hyett	Operations Director for Salisbury City Hall Vaccination Centre	N/A	Spouse is Andy Hyett, Chief Operating Officer	No action
Eiri Jones	Non-Executive Director	EJP ltd.	Director	No action
		Borough Welsh Chapel London	Trustee	
		London Welsh School	Governor	
		Dorset County Hospital	Clinical Non-Executive Director	
Paul Kemp	Non-Executive Director	Magistrates Association	Honorary Treasurer	No Action
Denise Major	Deputy Director of Nursing	Nil Return	Nil Return	No action
Nick Marsden	Chairman	Nil Return	Nil Return	No action
Fiona McNeight	Director of Integrated Governance	Nil Return	Nil Return	No action
Paul Miller	Non-Executive Director	Sparrow Healthcare Consulting Limited	Director and Employee/ 50% ownership	Provides training, coaching consulting and audit services to a wide variety of NHS clients. Does not undertake work in Salisbury NHS FT.
		Hampshire Hospitals NHS FT	Spouse is a volunteer	No action
Esther Provins	Director of Improvement and Partnerships	Salisbury Plain Academies Multi-Academy Trust	Member of the Board	No action
		N/A	Partner is executive Director at Dorset healthcare NHS Founda	No action
Lisa Thomas	Chief Finance Officer	Sterile Services Ltd (SSL)	Director	No action
		Salisbury Linen Services (STL)	Director	no action
		Bed Storage Solutions	Director	no action
		Dauntsey Academy Primary School	Vice Chair	no action
Melanie Whitfield	Chief People Officer	Nil Return	Nil Return	No action
Henry Wilding	Deputy Director of Nursing	Nil Return	Nil Return	No action

Duncan Murray	Deputy Chief Medical Officer	DM Clinical and Professional Services	Director / Part Owner	No action
		DM Clinical and Professional Services	Spouse is a Director and part owner	No action
		New Hall Hospital	clinical anaesthesia services	no action
Laszlo Zavori	Consultant Emegency Medicine	Nil Return	Nil Return	no action
Lynn Fenner	Consultant Anaesthetist	Nil Return	Nil Return	no action
Jonathan Quayle	Consultant Orthopaedics	Nil Return	Nil Return	no action
James Lawrence	Consultant Diabetes and Endocrinology	Nil Return	Nil Return	no action
Micahel Clynes	consultant rheumatologist	Nil Return	Nil Return	no action
Clare Hennerby	Consultant Anaesthetist	Nil Return	Nil Return	no action
Nicola Bell	Consultant/ Lead Clinician Radiology	New Hall	Private Clinical Practice	no action
Elisa Porretta	Consultant in Stroke Medicine	Nil Return	Nil Return	no action
Stephen Davies	Consultant Emegency Medicine	Nil Return	Nil Return	no action
Emily Gosse	Locum Consultant Ophthalmologist	Nil Return	Nil Return	no action
Pippa Caygill	Consultant Urologist	Nil Return	Nil Return	no action
Rob Ritchie	Consultant Urological Surgeon	Nil Return	Nil Return	no action
Russell Mellor	Consultant Elderly Medicine	Nil Return	Nil Return	no action
Richard Cole	Consultant	Nil Return	Nil Return	no action
Catherine Thompson	Consultant Respiratory Medicine	Nil Return	Nil Return	no action
Laura Spooner	Consultant Elderly Medicine	Nil Return	Nil Return	no action
Andy Agombar	Consultant General Surgeon	Nil Return	Nil Return	no action
Mansoor Khan	Consultant Plastic Surgeon	Nil Return	Nil Return	no action
Abdul Sajith	Consultant Anaesthetist	Nil Return	Nil Return	no action
Danielle Bagg	Consultant Acute Physician	Nil Return	Nil Return	no action
Anisa Nazeer	Associate Specialist - Medicine	Nil Return	Nil Return	no action
Nola Lloyd	Consultant Surgeon	Nil Return	Nil Return	no action
Damian Mayo	Consultant Surgeon	Nil Return	Nil Return	no action
Anna Barton	Respiratory Consultant	Nil Return	Nil Return	no action
Timothy Burge	Consultant Plastic Surgeon	Clifton Plastic Surgery - provider of medico legal reports	Sole proprietor	no action
Saumitra Banerjee	Consultant Histopathologist	Nil Return	Nil Return	no action
Belinda Cornforth	Consultant Anaesthetist	Hartley Orthopaedics, a Ltd company. Since circa 2005.	Director (other directors are family members)	no action
Paul Flanagan	Consultant Microbiologist	Aneurin Bevan University Health Board (NHS)	Locum Consultant Microbiologist - since nov 2020	no action
Annalise McNair	Orthodontic Consultant	Inspire Orthodontics	Owner from May 2013	no action
Gurdip Shergill	Orthopaedic Consultant	Shergill Orthopaedics Ltd	Director	no action
Toby Black	Consultant Physician Geriatric and Stroke Medicine	Nil Return	Nil Return	no action
Karinya Lewis	Consultant Ophthalmologist	Nil Return	Nil Return	no action
James Milnthorpe	Consultant Haematology	Nil Return	Nil Return	no action
Claire Page	Consultant Elderly Medicine	Health Education England – Wessex	Accredited facilitator on Educational Supervisor courses	not run since 2018 but remains on their list of facilitators - no action
Johnathan Cullis	Consultant Haematologist	Cress UK	Trustee	no action
		Salisbury Hospital NHS Foundation Trust	Private Clinical Practice	no action
Paul Stephens	Clinical Director Division Surgery	Nil Return	Nil Return	no action
Anna Aertssen	Consultant in Breast & Endocrine Surgery	Nil Return	Nil Return	no action
Hannah Boyd	Divisional Director of Operations for Women	Nil Return	Nil Return	no action
Emma Halliwell	Director of Medical Education and Consultant Anaethetist	Nil Return	Nil Return	no action
Michael Hughes	Consultant Radiologist	Nil Return	Nil Return	no action
Alistair Raynes	Chief Pharmacist	Nil Return	Nil Return	no action
Samuel Leach	Consultant Radiologist	New Hall	Private Clinical Practice	no action
Tracey Farnon	Consultant Paediatrician	23rd Salisbury Scount Group	Treasurer	no action
Christopher Pandya	Consultant Acute Medicine	Nil Return	Nil Return	no action
Joanne Hayward	Director of Maternity Services	Nil Return	Nil Return	no action
Anne Goggin	Consultant in Palliative Medicine	Nil Return	Nil Return	no action
Alison Vandyken	Divisional Director of Operations - Surgery	NHS Supply Chain	Spouse is a Category Tower Director for NHS Supply Chain with specific responsibility for Orthopaedic and Ophthalmic Consumables. SFT has contractual arrangements in place with a variety of suppliers, via the NHS Supply Chain Framework Agreements that spouse is responsible for.	Contract renewal will be managed by the Procurement Team @ SFT, with input from the relevant clinical and operational teams. Any recommendation reports relating to either of these framework agreements are approved by other members of the Surgery DMT to avoid any direct involvement by myself that could be construed as a conflict of interest
Rashi Arora	Consultant Ophthalmologist	Nil Return	Nil Return	no action
Sian Evans	Respiratory Consultant	Nil Return	Nil Return	no action
John O'Keefe	Head of Estates	Claymoor Estates Residents Limited	Director	no action
Georgina Morris	Consultant in Sexual Health and HIV	Nil Return	Nil Return	no action
Ross Cruickshank	Consultant Anaethetist	Ramsay Healthcare	Private Clinical Practice	no action
Effie Grand	Consultant Haematologist	Nil Return	Nil Return	no action
Stuart Henderson	Clinical Director Medicine	Nil Return	Nil Return	no action
Susan Hegarty	Consultant Radiologist	Nil Return	Nil Return	no action
Matthew Wakefield	Consultant Ophthalmologist	Matthew Wakefield Eye Surgery Limited	Director (spouse also a director)	no action
		MWNH Limited	Director	no action
		HBSUK	Practising privileges and Clinical Lead for Ophthalmology	no action
		IHG	Practising privileges	no action
		New Hall Hospital/Ramsay Healthcare	Practising privileges	no action

		Medcentres Plus	Practising privileges	no action
Andy James	Finance Controller/ Senior Manager	League of Friends of Salisbury Hospital	Treasurer	no action
Rayyan Pervez	Consultant Radiologist	New Hall Hospital	Private Clinical Practice	no action
Marcel Geyer	Consultant ENT Surgeon	Practice Plus Group	Consultant surgeon since 2015	no action
		New Hall	Consultant surgeon since 2013	no action
Peter Ellis	Consultant ED	Nil Return	Nil Return	no action
Bushra Aslam Awan	Consultant Radiologist	Nil Return	Nil Return	no action
Aarti Umranikar	Consultant in Reproductive Medicine	Spring banks Medical Limited company.	Co-Director	no action
Christine Waterman	Consultant Clinical Scientist / Head of Service	Nil Return	Nil Return	no action
Syed Abbas	Consultant Anaethetist	Property Rental Business	Manager	no action
		Member of the Anaesthetic Consortium	Self Employed/ Consultant Anaethetist	no action
Jonny Drayson	Consultant Geriatrician	Nil Return	Nil Return	no action
Nigel Horlock	Consultant Plastic and Reconstructive Surgery	Nigel Horlock Partnership	Director / Private Clinical Practice	no action
Ahmed Elmorsy	Trauma & Orthopaedic Consultant	Nil Return	Nil return	no action
Victoria Brown	Consultant Surgeon	Nil Return	Nil return	no action
Victoria Smith	Consultant Dermatologist	Nil Return	Nil return	no action
Susan Lewis	Consultant Cardiologist	Private Clinical Practice/ no employer	Consultant Cardiologist since 1995	no action
Mark Wills	Consultant Radiologist	New Hall	Consultant Radiologist - 4 hr per week	no action
Ian Cook	Consultant Histopathologist	New Hall	Consultant Pathologist (since Feb 2005)	no action
Sarah Cook	Consultant Radiologist	Nil Return	Nil return	no action
Mohammed Elsaghir	Consultant Urology	New Hall	Private Clinical Practice	no action
Martin Cook	Consultant anaethetist	Ramsey Hospital/ New Hall	Private Clinical Practice - Consultant anaethetist (Dec 2007)	no action
Lynda Steer	Associate Director , Special Projects OD & Learning	People Progression Ltd	Director	no action
Amy Pearce	Consultant in Sexual Health and HIV	G&S	Sexual Offences Examiner (since Nov 2018)	no action
Alex Crick	Consultant Plastic and Reconstructive Surgery	Nil Return	Nil return	no action
Sridhar Rao Sampalli	Associate Specialist - Trauma and Orthopaedics	OPSLLP	Director	no action
		New Hall	Orthopaedic Surgeon (since April 2021)	no action
		SRS Orthopaedics	Owner	no action
Katharine Johnson	Consultant Radiologist	Southampton University Hospitals Trust	Consultant Thoracic Radiologist	no action
Carmen Carroll	Consultant Elderly Medicine	Nil Return	Nil return	no action
Jonnthan Arnott	Consultant Radiologist	New Hall Hospital	Private Practice (since 2019)	no action
Alice Veitch	Consultant Radiologist	Shareholder	SW Veitch Orthopaedics Ltd (spouse is also a shareholder)	no action
		SFT radiology	Private Clinical Practice at SFT site only.	no action
		OPSS LLP	Spouse is a shareholder	no action
Helen Iveson	Clinical Lead for Sexual Health and HIV	Nil Return	Nil return	no action
Susana Bull	Acute Oncology Doctor	Nil Return	Nil Return	no action
Katharine Backhouse	Consultant Gynaecologist	Nil Return	Nil return	no action

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Report to:	Trust Board (Public)	**Agenda item:**	7.2
Date of Meeting:	07 April 2022		

Report Title:	Integrated Governance Framework 2022			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				✓
Approval Process (where has this paper been reviewed and approved)	Board Committees ToR approved at Committee Trust Board 7th April			
Prepared by:	Fiona McNeight, Director of Integrated Governance Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	IGF March 2022			

Recommendation:

The Trust Board is asked to approve the amendments to the Trust's Integrated Governance Framework as part of the annual review.

Executive Summary:

The Integrated Governance Framework has been reviewed and the following amendments have been made:

- Section 1 and 2 have been updated to reflect the Trust's new vision and strategic priorities.
- Sections 2 and 4.4 have been updated to reflect the Trust's Improving Together programme.
- Section 5 - The integrated governance framework structure has been updated to provide additional clarity.
- Section 6.10 – the Director of Integrated Governance is in the process of updating the Divisional Governance Committee agendas. This section now states that these meetings cover the three key elements of quality i.e., safety, patient experience and clinical effectiveness and outcomes. Further detail will be added once the standing agendas have been agreed.
- Section 8, Collaborative working and partnerships has been updated to reflect the Trust's current position.

- Appendix 2 – accountability of direct reports to the chief executive have been updated to reflect director's responsibilities.
- Appendix 3 - the most recent organisational committee assurance map has been added.
- Appendix 5 – Updated TMC Terms of Reference added for Board approval. These Terms of Reference will be updated in-year once the structure of the meeting has been reviewed and finalised.
- Appendix 6 – Updated Board Committee Terms of Reference added for Board approval. To note the People and Culture Committee Terms of Reference were approved at Committee subject to further alignment to the People Plan which is in progress.

Other small amendments relating to wording and job titles have also been made.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

INTEGRATED GOVERNANCE FRAMEWORK

March 2022

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1. INTRODUCTION

Integrated Governance is how the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to support the delivery of our vision to "provide an outstanding experience for our patients, their families and the people who work for and with us" by an organisation that is well managed, cost effective and has a skilled and motivated workforce.

Salisbury NHS Foundation Trust is committed to operating by the principles of good governance. This framework sets out to describe the system of integrated governance used within the Trust with reference to the provision of quality services.

This document is supported by the Accountability Framework which specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focussing across the breadth of quality, operations, finance and workforce.

2. STRATEGIC PRIORITIES

The Trust's strategic priorities are set out in its 2022-26 strategy. Underpinning delivery of these objectives, there is a business planning process. The strategic aims are:

In 2022, the Trust launched the Improving Together Programme, which is one of the four strategic priorities that underpin the delivery of the updated Trust Strategy. These priorities, supported by annual breakthrough objectives, will be focusing and guiding how we work within our hospital and as part of an Integrated Care System (ICS).

3. SCOPE OF THE FRAMEWORK FOR INTEGRATED GOVERNANCE

Integrated Governance is based on the understanding that all elements of governance are important and they should not be managed in silos. To achieve focused decision-

making and deliver strategic objectives, the Board considers all aspects of accountability in the round. This framework sets out the principal strands of governance and describes how Salisbury FT arrangements bring these together.

4 ELEMENTS OF GOVERNANCE

4.1 Corporate Governance

The term is used in the NHS to mean the system by which an organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet the necessary standards of accountability, probity and openness. Corporate governance, led by the Trust Board, is about achieving objectives, providing quality services and delivering value for money.

The Constitution sets out the workings of the Foundation Trust – the membership, Council and Board. Appendices to the Constitution include formal procedures for the conduct of meetings and membership elections.

As a Foundation Trust, the organisation is asked to certify annually that it is compliant with the NHS Provider license conditions. The Trust completes an annual self-certification that confirms eligibility to hold an NHS Provider licence and submits this to NHS Improvement/England.

4.2 Financial Governance

Financial governance will be the responsibility of the Board supported by the Audit Committee, (governance, risk management and internal control, internal audit; external audit, other assurance functions, counter fraud, financial reporting and raising concerns) and the Finance & Performance Committee (financial strategy and policies, effective and efficient use of resources, appraise annual budgets, cost improvement plans, financial issue management, performance reporting and management).

4.2.1. Standing Orders and Standing Financial Instructions

The Trust Standing Orders and Standing Financial Instructions provide the regulatory framework for the financial conduct of the Trust. This includes guidance on delegation limits and procurement rules.

4.3 Clinical Governance

This is a responsibility of the Trust Board, supported by the Clinical Governance Committee for continuously improving the quality of the services and safeguarding high standards of care by creating an environment in which excellence in clinical care will

flourish.

Clinical governance is the mechanism for understanding and learning, to promote the components that facilitate the delivery of quality care: candour, learning, questioning, a just culture, and excellent leadership.

4.3.1. Demonstrating Quality

The Integrated Governance Framework will provide evidence to the Trust Board through demonstrating its compliance with the quality and safety standards relevant to an NHS provider organisation. This will include: Quality Accounts, Data Security and Protection Toolkit, CQC standards and the Trust's performance monitoring framework.

4.4 Continuous Quality Improvement

Trust Board are responsible for ensuring that a continuous quality improvement approach is adopted and embedded throughout the organisation. This should be evidenced at all levels across the organisation. This approach should be evident at Trust Board and all Board Committees and at Executive Committees.

The Improving Together Programme is focused on continuous improvement and is supported by the development of a coaching culture. This programme will support staff in undertaking tasks that really add value and empower them to make process changes at a local level. The approach is intended to ensure that everyone has the time, space and responsibility to be curious about processes, consider how priorities can be achieved and have freedom to test new ways of working. As part of this programme all Trust colleagues will be invited to a modular training programme, which will be rolled out in a phased approach.

4.5 Risk Management Strategy & Board Assurance Framework

The Risk Management Strategy and Board Assurance Framework enable the Trust to manage risk at all levels in the organisation.

The key objectives of the risk framework are to:

- Ensure that the Board Assurance Framework is a dynamic Board assurance tool, underpinned by the Corporate and Divisional Risk Registers
- Clearly evidence the control and management of risk to achieve the Trust's strategic aims and objectives.
- Provide assurance that the Trust has an appropriate Assurance Framework in place and adheres to guidance on the Annual Governance Statement.
- Ensure that principal risks to meeting corporate objectives are identified and

mitigated to an acceptable level.

The Board will be responsible for the Board Assurance framework, but the Audit Committee will undertake scrutiny and review of the process, to provide assurance to the Board, supported by the three assuring committees: Clinical Governance Committee, Finance & Performance Committee, People and Culture Committee together with the Trust Management Committee.

The Board Assurance Framework is reported to the Trust Board quarterly with a detailed review undertaken in advance by the assurance committees.

4.6 The Role of the Trust Board

Comprising executive and non-executive directors, the Trust Board will work actively to promote and demonstrate the values and behaviours which underpin integrated governance.

It will ensure a balanced focus on all aspects of its business.
Further to this:

- The Integrated Governance Framework ensures the Board and its committees are structured effectively and properly constituted.
- The Board will ensure it promotes a culture where patients are at the centre; staff learn from experience; and the Trust engages with patients, the public and partners to develop services in the future.
- Board business cycles will be clearly set out with actions implemented.
- The Board will ensure codes of conduct are upheld and the public service values of accountability, probity and openness in the conduct of business are maintained.
- Board members will receive appropriate induction and ongoing training and development to ensure they can undertake their responsibilities effectively and appropriately.

4.6.1. Charitable Trustees

The Trust Board is the corporate trustee of the Salisbury District Hospital Charitable Fund, known as the STARS appeal. Members of the Board meet quarterly as the Charitable Funds Committee to oversee the work of the charity, decide how charitable money should be used to support the hospital, manage its investments and the reporting requirements to the Charity Commission. The Terms of Reference can be found in Appendix 6.

4.7 Annual Governance Statement

The Annual Governance Statement (AGS) is produced and signed off by the Accounting Officer having regard to the model template and following discussion at the Audit Committee and comment from the auditors on the effectiveness of the Trust's internal controls. This is supported by the Board Assurance Framework and the underpinning Trust risk management arrangements.

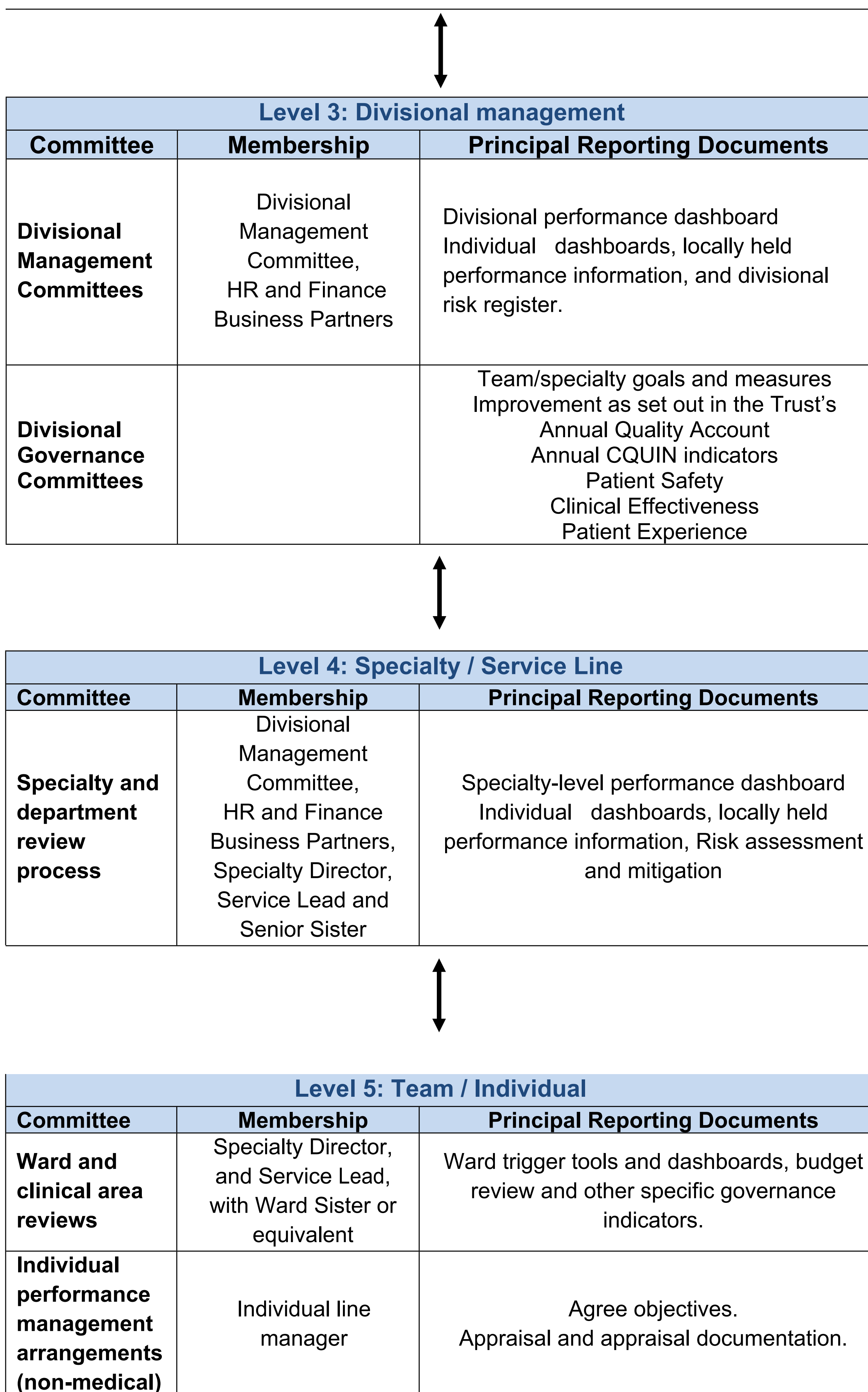
Any significant weaknesses identified in the Trust's internal control mechanisms are highlighted in the AGS, together with the actions necessary to address the issues reported on.

5. INTEGRATED GOVERNANCE FRAMEWORK

The following describes the Trust's Integrated Performance Management Framework.

Level 1: SFT Trust Board		
Committee	**Membership**	**Principal Reporting Documents**
Trust Board	All directors	Corporate Strategy. Other principal strategies – e.g. People, Quality, I.T, & Estates. Budget & Capital Programme Annual reports on Health & safety, Information Governance, Risk Management. Performance Reports – quality, workforce, operations, finance. Board Committee supporting information. Customer Care and Legal Reports.
Board Committees	Non-Executive Directors, CEO Lead Executives	Presentation on key performance information, including detailed information and actions on any key business targets currently being failed. Scrutiny of the Trust's commercial holdings. Scrutiny and assurance regarding risks and adequacy of actions. Escalation actions from Divisional Performance Reviews (by exception).

Level 2: Review of Divisional Management		
Committee	**Membership**	**Principal Reporting Documents**
Executive Performance Review Meetings	Lead Executives Divisional Management Team HR and Finance Business Partners	Detailed performance dashboard for Division Division commentary Risk Registers Other issues by exception



Level 3: Divisional management		
Committee	**Membership**	**Principal Reporting Documents**
Divisional Management Committees	Divisional Management Committee, HR and Finance Business Partners	Divisional performance dashboard Individual dashboards, locally held performance information, and divisional risk register.
Divisional Governance Committees		Team/specialty goals and measures Improvement as set out in the Trust's Annual Quality Account Annual CQUIN indicators Patient Safety Clinical Effectiveness Patient Experience

Level 4: Specialty / Service Line		
Committee	**Membership**	**Principal Reporting Documents**
Specialty and department review process	Divisional Management Committee, HR and Finance Business Partners, Specialty Director, Service Lead and Senior Sister	Specialty-level performance dashboard Individual dashboards, locally held performance information, Risk assessment and mitigation

Level 5: Team / Individual		
Committee	**Membership**	**Principal Reporting Documents**
Ward and clinical area reviews	Specialty Director, and Service Lead, with Ward Sister or equivalent	Ward trigger tools and dashboards, budget review and other specific governance indicators.
Individual performance management arrangements (non-medical)	Individual line manager	Agree objectives. Appraisal and appraisal documentation.

6. COMMITTEES

The Board's purpose is to govern effectively and in doing so build patient, public and stakeholder confidence that sustained, quality services are delivered. Several meetings and processes support the Board in its role.

Level 1: Assurance Committees of the Board

6.1 Audit Committee

The Audit Committee's terms of reference detail its role in providing assurance by independently and objectively monitoring and reviewing the Trust's processes of integrated governance, risk management, assurance and internal control and, where appropriate, to require the Executive to instigate actions necessary to mitigate gaps.

The Committee fulfils its governance and accounting responsibilities by consideration of the integrity, completeness and clarity of annual accounts and the risks and controls around its management.

The Committee adopts a risk-based approach, but this does not, however, preclude the Committee from investigating, any specific matter relevant to their purpose.

Principal functions:

To oversee the governance and management of risk and internal control including the provision of the following:

- Governance
- Risk Management
- Internal Audit
- External Audit
- Other Assurance Functions
- Counter Fraud
- Financial Reporting
- Raising Concerns

6.2 Clinical Governance Committee

The Clinical Governance Committee's terms of reference detail its responsibility in delivering clinical governance and the quality agenda i.e. patient safety, clinical effectiveness and patient experience.

The Committee reviews the Quality Account and agrees priorities for the forthcoming year and monitoring of the current year.

The Committee provides assurance to the Board, through ensuring the supporting processes are embedded and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties.

Principal functions:

To provide assurance to the Board on:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Service Improvement and Change Management
- Continuous Quality Improvement

6.3 Finance & Performance Committee

The Finance & Performance Committee provides assurance to the Board that the finance and performance of the Trust is meeting its targets and proposes mitigating strategies as required. It will do this through continual review of financial, risk and performance issues. The Committee has delegated powers to scrutinise, on behalf of the Board, all high-level operational matters and finance related matters, providing assurance regarding reported results and compliance with NHS Improvement requirements.

Principal functions:

To provide assurance on and scrutinise high level operational and finance related matters, providing assurance to the Board regarding reported results and compliance with NHSI requirements and in particular:

- Financial strategy, policy, management and reporting
- Management and reporting Performance
- Monitoring Cost Improvement Programmes
- Operational performance

6.4 People and Culture Committee

The People and Culture Committee has responsibility for the delivery and assurance of the People Strategy. In addition, it has responsibility for:

- ensuring the mechanisms are in place to support the development of leadership capacity and capability within the Trust
- the development and design of the workforce, to ensure that the Trust has productive staff, with the skills, competencies and information to meet the required contractual obligations
- the mechanisms of improving how the Trust engages with its workforce so that they are motivated to do the best they can for the organisation and for the communities the Trust serves.
- Organisational Development and Change Management.
- Continuous Quality Improvement

Principal functions:

To provide assurance on:

- Workforce Effectiveness Programme
- HR Strategy
- Scrutiny of Workforce Performance
- Organisational Development
- Policies and Procedures
- Key workforce KPIs
- Compliance with employment legislation
- Educational and professional development
- Recruitment and retention
- Staff engagement
- Change Management
- Occupational therapy and counselling services
- Service Improvement and Change Management

6.5 Subsidiary Governance Committee

The Subsidiary Governance Committee was established late 2018 to provide assurance to the Board of Directors on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company. Meetings commenced in early 2019.

Principal Functions:

- Oversight of the subsidiary level risk profile and exposure
- Ensuring a governance framework and structure for oversight of any related company/entity

6.6 Remuneration and Nominations Committee

The purpose of the Remuneration Committee is to ensure there is a fair and transparent procedure for developing and maintaining policy on executive remuneration and for setting the remuneration packages of individual Directors.

Specifically, the Committee will make decisions, on behalf of the Board, on the appropriate remuneration and terms of service for the Chief Executive, Executive Directors within the remit of the Remuneration Committee, including:

- all aspects of salary, including any performance related/bonus elements.
- arrangements for termination of employment and other contractual terms.
- monitor and evaluate the performance of the Chief Executive and Executive Directors.
- succession planning.

6.7 Level 2 – Review of Divisional Management

Executive Performance Review Meetings are held monthly with the clinical Divisions, consisting of the executive directors and each Divisional Management Team to review performance across quality, finance, operations, and workforce. Further detail is given in the Accountability Framework.

Level 3: Divisional Arrangements

6.8 Divisional Clinical Governance Arrangements

The Trust manages the delivery of its services through a divisional structure with each accountable for its contribution to the Trust's strategic objectives and integrated business plan. Authority to act is set out in the Trust's Scheme of Delegation and Accountability Framework as appropriate to each individual post or generic staff group.

There are also specific corporate functions in place to support the Divisions to achieve their objectives and to provide assurance to the Trust Board in its performance management role. These include finance; human resources; quality; operations, and informatics.

6.9 Divisional Management Committees

Each division is led and managed by a Divisional Management Team (DMT), made up of the Clinical Director, Divisional Director of Operations and Divisional Head of Nursing.

This Divisional Management Committee (DMC) is supported by Lead Clinicians, operational managers, and the corporate functions such as Organisational Development and People and Finance. For the Facilities Directorate, this is the Head

of Service and General Managers.

The Divisional Management Committee is responsible for providing leadership within the clinical divisions. They ensure the Trust delivers an outstanding experience for every patient, which represents best value and includes working with partner organisations to deliver innovative models of care.

Divisional Management Committees, together with Specialty Leads, have specific roles and responsibilities to ensure that the care and treatment provided to patients meets with the Care Quality Commission's standards.

Each Division will have governance arrangements appropriate to their services as set out in the Accountability Framework.

6.10 Level 4: Quality Assurance within Divisions

The Divisions have in place arrangements for quality governance that is accountable, through the Divisional Management Team and Divisional Governance Committee and escalation via the Executive Performance Meetings to the executive team.

Divisional Governance Committees are held monthly. Standard Terms of Reference can be found in the Accountability Framework.

The Director of Integrated Governance ensures regular review of the standard agenda in consultation with the Divisions and the Heads of Patient Safety, Experience and Effectiveness. These meetings include the agreed core standard items and the three key elements of quality: patient safety, patient experience and clinical effectiveness and outcomes.

All of the elements include:

- The monitoring of progress against associated action plans.
- Monitor progress with current quality initiatives.
- Provide a forum for continuous improvement and development.
- The DMC will ensure that clinical specialties have relevant supporting/ parallel working arrangements.

Executive and Committees

6.12 Accounting Officer – Chief Executive

Under the Accounting Officer Memorandum, the Chief Executive is responsible for the stewardship of all the resources entrusted to the Trust. This role also carries

extensive delegated authority from the Trust Board for the delivery of the Trust's services.

6.13 Trust Management Committee

The Trust Management Committee (TMC) comprises the Executive Directors, Clinical Directors, and Divisional Managers and is the senior Executive committee. The purpose of TMC is to support the Chief Executive in ensuring the delivery of Trust services, meeting required financial, organisational and governance requirements.

The quality governance arrangements underpinning TMC were revised in 2021.

Public accountability

6.14 Council of Governors

The Council of Governors comprises Public, Staff and Appointed governors and has a number of responsibilities to hold the Trust Board to account through the Non-executive directors, to appoint and remunerate the Non-executives, to appoint the Trust's auditor (in conjunction with the Audit Committee). It has an essential role in representing the views of the membership to the Trust Board.

Board Appointments

6.15 Nominations Committees

The non-executive directors are appointed by the Council of Governors and a Nominations Committee that is run jointly with the Board, oversees the appointments process. Executive Directors are appointed by a committee of the non-executive directors and the Chief Executive. The Chief Executive is appointed by the non-executive directors, and the appointment is subject to approval by the Council of Governors.

7. GOVERNANCE SUPPORT ARRANGEMENTS

Quality Directorate

The Quality Directorate provides trust-wide guidance, facilitation & support for the following elements of the integrated governance agenda, linked to Divisions:

- Collecting and storing evidence to support external assessments and preparing submissions to the CQC and NHS Resolve.
- Monitoring compliance with NICE guidelines and standards, alerts and other

national frameworks.

- Producing the Trust's annual Quality Account
- Practice development associated with Patient Safety.
- CQUINs and clinical audit element of the annual contract.
- Risk management, including operational and corporate risk registers.
- Serious, critical and other Incident investigation and reporting.
- Aggregating learning from Incidents, Complaints, PALs, Claims, Mortality Review, Inquests and Regulation 28 letters.
- Monitoring and reporting with National Institute of Health Research and clinical Research Network high level objectives'
- Customer Care: Complaints and PALs
- Clinical audit programme
- Mortality review processes
- Administering the CAS process

The Trust's CQC registration is overseen by the Director of Integrated Governance supported by the Head of Compliance.

8. COLLABORATIVE WORKING AND PARTNERSHIPS

The Trust is part of the Bath & North East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS). This allows partners to take collective responsibility for the health and wellbeing of the population across the region. The agencies that comprise the partnership are working to address five priorities:

- Create locality-based integrated teams supporting primary care
- Shift the focus of care from treatment to prevention and proactive care
- We will develop an efficient infrastructure to support new care models
- Establish a flexible and collaborative approach to workforce
- Enable better collaboration between acute providers

Statutory component parts of an ICS are an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). The ICB is a statutory NHS body that will bring partner organisations together in a new collaborative way with common purpose; and will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place. The governance around these new bodies is under review with the aim to have the ICB established by July 2022. The Trust Board receives a monthly update on system working, outlining the activities at system level in BSW and the impact and involvement of the Trust. Whilst governance arrangements are still under review, the

Trust's 2022/23 planning process is focused on the development of the BSW system plan, which is submitted to NHS England/ Improvement in April 2022.

As part of the move towards more collaborative working the Trust is also part of the Acute Hospital Alliance (AHA) with Great Western Hospital and Royal United Hospitals (RUH) Bath NHS Foundation Trusts. The AHA is focused on improving clinical services and closing the gaps in relation to health and care inequalities and finance to benefit the population of BSW. The local place-based Wiltshire Integrated Care Alliance will also be a priority for the executive team and clinical leaders over the coming year.

9. MONITORING AND REPORTING PROCESS

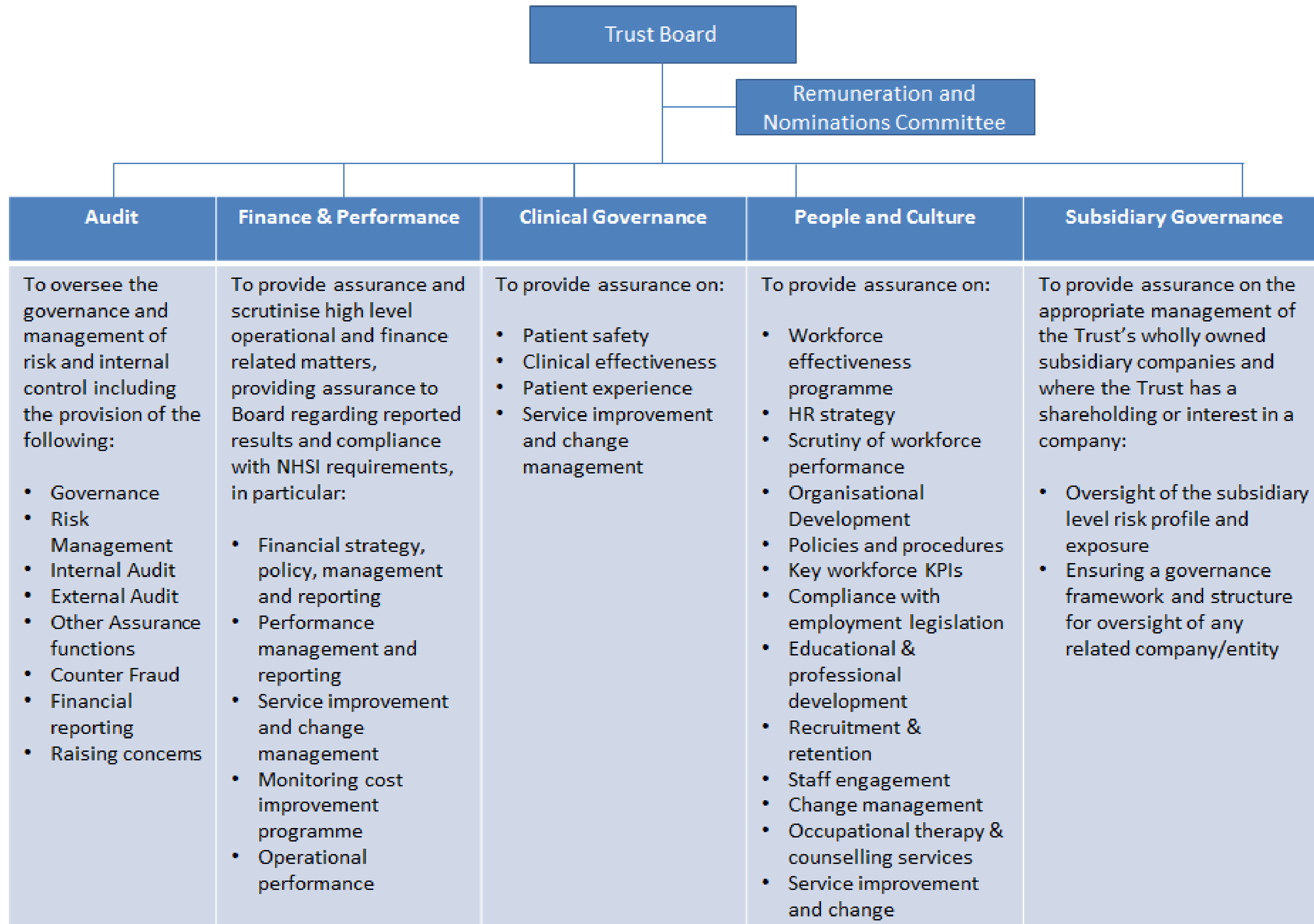
The Trust Board monitors the delivery of this framework primarily through reports to the Board from the following committees:

- Audit
- Finance & Performance
- Clinical Governance
- People and Culture
- Subsidiary Governance
- Trust Management Committee

In addition, reports will be received from internal and external audit, Counter Fraud and other regulatory bodies to provide independent assurance to the Board.

All committees receive reports and regular monitoring information as set out in each committee's work plan. This covers all principal strands of governance as part of the Trust-wide assurance framework

Appendix 1: Overview of Assurance Committees that report to Trust Board



NB: Committee reporting comprises an Escalation Report prepared by the Chairman of the committee and Lead Executive, and is supported by the minutes presented to the Trust Board.

APPENDIX 2: ACCOUNTABILITY OF DIRECT REPORTS TO THE CHIEF EXECUTIVE

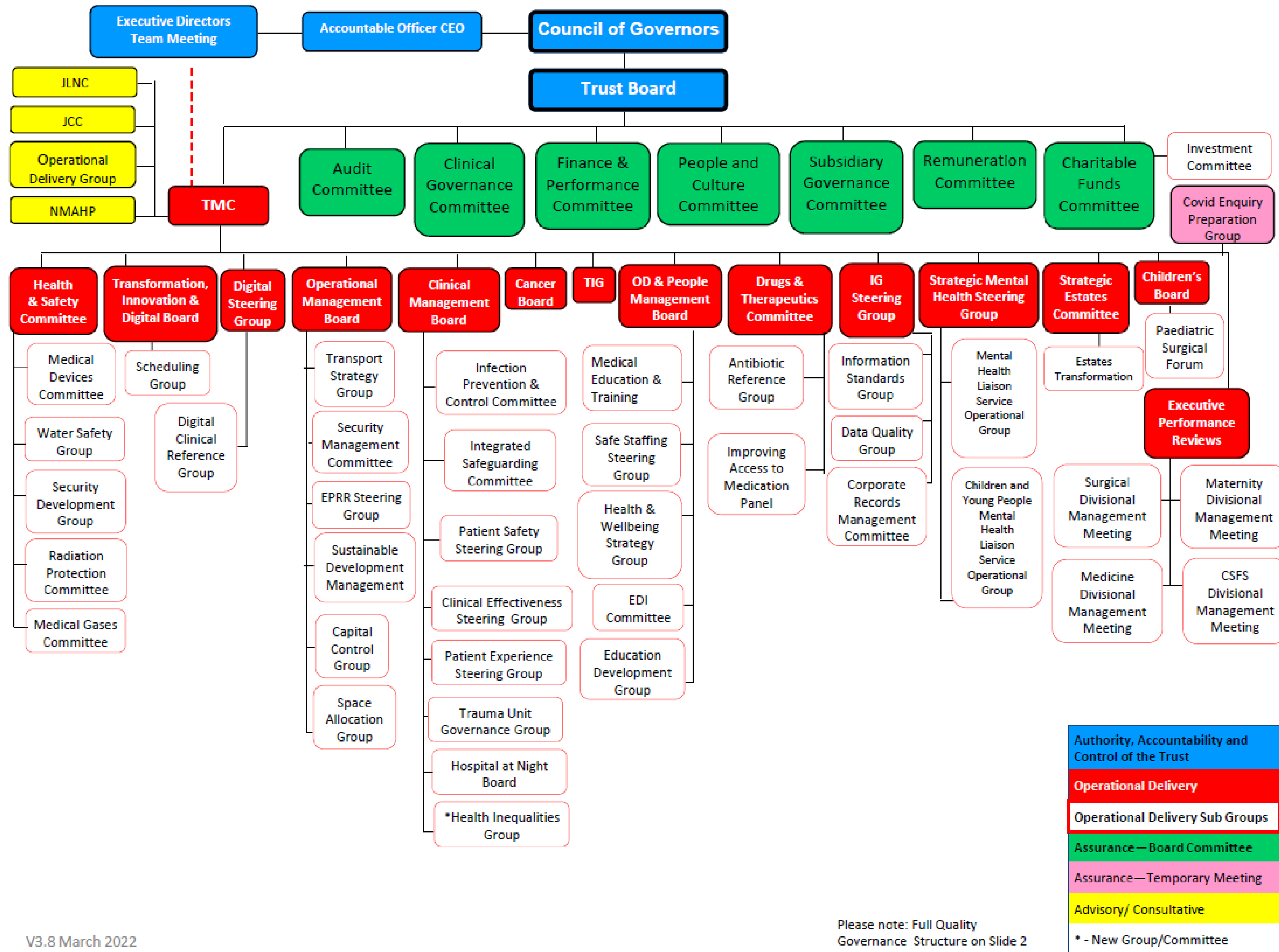
Note: Executive Directors are Board level positions

Lead for Board Objective	
Chief Executive Officer	• Delivery of strategic and corporate objectives • Working across the wider health and social care system • Financial Recovery Plan • Accounting Officer for Annual Governance Statement • Executive governance arrangements • Corporate governance – policies and compliance • Board Assurance Framework
Chief Operating Officer (Executive Director)	• Clinical Divisions and Facilities • Service delivery • Performance delivery of divisions • Accountable Officer for emergency planning and business continuity • Medical Equipment • Security Management • Estates • Hard Facilities Management
Chief Medical Officer (Executive Director)	• Professional leadership – medical • Responsible Officer (Medical Appraisal) • Clinical Effectiveness • Quality Account (joint with Chief Nursing Officer) • Caldicott Guardian • Mortality reviews • Clinical audit and effectiveness • Medical-legal matters • Research and Development Medical Education • QIA approval (joint with Chief Nursing Officer) • Medicines Management • Joint management of the Quality Directorate (with Chief Nursing Officer) • Chief Knowledge Officer

Chief Nursing Officer (Executive Director)	• Professional lead – nursing, midwifery, therapists • Patient Safety • Patient Experience • Quality Account (joint with MD) • Joint management of the Quality Directorate with Chief Medical Officer • Risk management • Infection, prevention and control (DIPC) • Safeguarding adults and children • Legal Services • CQC lead (liaison and reporting) • QIA approval (joint with Chief Medical Officer) • CQUIN and Quality Schedule negotiation
Chief Finance Officer (Executive Director)	• Financial Recovery Plan • Financial planning and performance • Financial management and accounting • Audit and counter fraud • Performance management Oversight • Capital planning and management • Commissioning and Contracting • Payroll • Procurement • Charitable Trustees • Trust-owned companies and Wholly Owned Subsidiary project • Wiltshire Health & Care Estate strategy and management • Trust Strategy and business planning • GP relationships • Commercial – tenders co-ordination
Chief People Officer (Executive Director)	• Human resources • Health & Safety • Learning, Training and development • Equality and diversity (staff, patient and public) • Corporate Communications • Volunteers • Chaplaincy • Fire Safety • Occupational Health • Employment law • Staff involvement • Radiological Protection lead

Director of Improvement and Partnerships	• Improving Together Programme • Change management/CIP programme • Transformation and improvement • Innovation • Quality Improvement/ continuous improvement
Director of Integrated Governance	• Corporate and Clinical Governance systems and processes • CQC Well-Led Framework • Board Assurance Framework • Board and Committee business and standards • Integrated Governance Framework • Foundation Trust Governors and member's function • Provider Licence • HTA Licence Holder Contact
Chief Digital Officer (GWH/SFT)	• Chief Information Officer • Chief Clinical Information Officer • Information Governance and records management • Informatics / Digital • Senior information risk owner (SIRO)

APPENDIX 3 – Salisbury Hospital NHS Foundation Trust Organisation Committee Assurance Map



APPENDIX 4 – ANNUAL REVIEW OF COMMITTEES

In devising their annual reviews, committees are requested to follow the template set out here

1. Conduct of business throughout the year

- Committee membership and any changes
- Frequency of meetings and register of attendances
- Administration arrangements
- Reports to Board

2. Terms of Reference

- Delivery against terms of reference and work programme
- Key decisions or recommendations
- Key risks identified and mitigations
- Key issues managed or escalated to board
- Any changes made or requested to the Terms of Reference

3. Future plans

- Areas of focus for the coming year

4. Timings of reviews

- Committees to review their effectiveness in Quarter 1 each year.

A report providing an overview of the outcomes of this process will be presented to the Board at their meeting in public in August each year.

APPENDIX 5 – TRUST MANAGEMENT COMMITTEE TERMS OF REFERENCE

Trust Management Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
March 2020	1.1	Major Revision	All sections revised	Corporate Governance Manager
March 2021	1.2	Minor - Annual Review	All sections reviewed	Corporate Governance Manager
March 2022	1.3	Minor – Annual Review	All Sections Reviewed	Director of Integrated Governance

Date Adopted	7 April 2022 (tbc)
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	Trust Management Committee
Adoption and ratification	Board of Directors

1) Purpose

1.1. The Committee is established by the Chief Executive as the senior executive committee of Salisbury NHS Foundation Trust.

1.2. The Trust Management Committee is responsible for the coordination and operational management of the system of internal control and for the management of the achievement of the Trust's objectives as agreed by the Board of Directors.

1.3. It is the formal route to support the Chief Executive in effectively discharging their responsibilities as Accounting Officer.

2. **Authority**

2.1. The Chief Executive has established an executive committee to be known as the Trust Management Committee (TMC).

2.2. The Trust Management Committee is accountable to the Board of Directors through the Chief Executive for the operational management of the Trust and delivery of objectives agreed by the Board.

3. **Membership and Attendance**

Membership

3.1. The Committee shall be appointed by the Chief Executive and shall consist of:

- Chief Executive
- Chief Medical Officer
- Chief Operating Officer
- Chief Finance Officer
- Chief People Officer
- Chief Nursing Officer
- Director of Improvement and Partnerships
- Director of Integrated Governance
- Divisional Directors of Operations
- Clinical Directors
- Chief Information Officer

3.2. Each Clinical Director or Executive Director may nominate a deputy to attend in their place if they are unable to attend. Other attendees may attend at the discretion of the Chair in support of specific agenda items.

Quorum

3.3. The quorum necessary for the transaction of business shall be half of members including at least two Executive Directors and at least one representative from the Divisional Management Teams.

4. Roles and Responsibilities

Strategy and Business Planning

4.1. Support the development of the Trust Annual Plan, including policy direction, revenue and capital finance and play a key role in developing and implementing the overall strategy of the Trust.

4.2. Clear recommendations to the Trust Board on key strategic and operational decisions which are retained by the Board.

4.3. To ensure effective arrangements are in place to manage key partnerships and stakeholder engagement.

4.4. Maintain the Board Assurance Framework, reviewing and mitigating gaps in evidence and assurance to align with and support the Trust's objectives.

4.5. To determine business cases for approval which require investment of £20k - £250k and ensure that approved business cases are reviewed within the agreed timeframe.

Operational, Quality and Performance

4.6. Ensuring collective and individual responsibility and accountability for delivering operations, required performance and addressing current and emerging risk to maintaining successful delivery.

4.7. Develop and monitor the implementation of plans to improve the efficiency, effectiveness, quality and safety of services.

4.8. Clear decision making in accordance with the decision-making framework on a timely basis and subsequent communication as appropriate.

4.9. The monthly Integrated Performance Report will be circulated for information.

4.10. Receive assurance and have oversight of Care Quality Commission (CQC) preparedness and to ensure subsequent actions are effectively embedded.

Governance and Risk

4.11. Monitor the management of Organisational risk.

4.12. Receive and review the Corporate Risk Register and manage actions to effectively mitigate risks.

4.13. Receive assurance that both the clinical and non-clinical Register of External Visits and Accreditations is maintained and that the outcome of these visits has been appropriately actioned.

4.14. Monitor the Register of Gifts, Interests and Hospitality.

Procedural Documents in line with the Policy for Policies

4.15. Review and approve procedural documents, including strategies, policies, protocols and procedures.

4.16. Monitor and provide updates for the schedule of Matters Arising and ensure agreed actions are appropriately and promptly completed.

Receive Reports from the following sub-groups*

4.17. Clinical Management Board (CMB)
Operational Management Board (OMB)
Trust Investment Group (TIG)
Transformation, Innovation and Digital Board

Strategic Estates Committee
Health and Safety Committee
Executive Performance Reviews
Information Governance Steering Group (IGSG)
Organisational Development and People Management Board
Patient Experience and Patient Safety Steering Group
Drugs and Therapeutics Committee
Strategic Mental Health Steering Group

*Frequency of reporting to be dictated by the Committee's annual business cycle.

5. Conduct of Business

Administration

5.1. The Committee shall be supported administratively by the Executive Services Manager, whose duties in this respect will include:

- Agreement of agendas with Chair and attendees and collation of papers;
- Taking the minutes.
- Maintain a record of matters arising and track the progress of actions delegated for action by the committee.
- Provision of an escalation report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

5.2. It is the responsibility of the author to produce the paper and any supporting documents in the correct format. Papers not in the correct format will be sent back to the author for amendment.

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. Meetings will be held once a month.

Notice of meetings

5.4. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Agenda template attached as Appendix A. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

5.5. Late papers are unacceptable and will only be added to the meeting papers after the deadline if permission has been given by the Chair of that meeting.

5.6. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.7. Formal minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The Committee shall also raise any significant

concerns in relation to the business undertaken directly with the Board in a timely manner.

5.9. The Committee will report to the Board of Directors annually on the performance of its duties as reflected within its Terms of Reference.

5.10. The Committee will report to the Board of Directors after six months on its effectiveness in meeting responsibilities as reflected within this Terms of Reference.

5.11. The Committee will receive minutes for information from the sub-groups listed under point 4.13 and from the following advisory groups:
Joint Local Negotiating Committee (JLNC)
Joint Consultative Committee (JCC) Nursing, Midwifery and Allied Health Professionals Forum (NMAHP)

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable

APPENDIX 6 – BOARD COMMITTEE TERMS OF REFERENCE

Finance & Performance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
Nov 2019	3	Minor	Added delegated authority limits	Corporate Governance Manager
May 2020	4	Minor	Annual Review	Corporate Governance Manager
March 2021	4.1	Minor	Annual Review	Corporate Governance Manager
March 2022	4.2	Minor	Annual Review	Head of Corporate Governance

Date Adopted	**7th April 2022 (tbc)**
Review Frequency	**Annual**
Terms of Reference Drafting	**Director of Corporate Governance**
Review and Approval	**Finance & Performance Committee**
Adoption and ratification	**Trust Board**

1. Purpose

1.1. The Committee is established to provide the Board of Directors with assurance on the trust's financial and operational performance. The Committee also supports the Board's strategic direction and stewardship of the Trust's finances, investments and sustainability.

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Finance & Performance Committee (the Committee).
2.2. The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
2.3. The Committee may take any legal or other professional advice with regard to the financial performance of the Trust as necessary.
2.4. The Committee is authorized by the Board to review, monitor, and where appropriate, investigate any financial matter within its terms of reference, and seek such information as it requires facilitating this activity.

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:
- Three non-Executive Directors
- Chief Finance Officer (Lead executive)
- Director of Improvement and Partnerships
- Chief Executive
- Chief Operating Officer
- Chief People Officer

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.
3.3. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.
3.4. Each member may nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members.
3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:
- Core members defined in para 3.1 above
  - Deputy Director of Finance
  - Other directors and other staff by invitation
  - Governor observer(s)

The Director of Integrated Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4. Roles and responsibilities

4.1. The aim of the Finance and Performance committee is to provide an objective view of the financial and operational performance, and financial strategy of the Trust, together with an understanding of the risks and assumptions within the Trust plans and projections.

4.2. The Committee will routinely consider four key reports in detail:

- The monthly performance report
- The monthly finance report,(including forecast outturn report quarterly)
- The monthly contracting monitoring report
- The monthly savings/transformation report

4.3. The duties of the committee can be categorised as follows:

4.3.1. **Reporting**

- To oversee the ongoing development of the Integrated Performance Report.
- To seek assurance that the measures incorporated in the Board report meet the requirements of external stakeholders.
- To seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support operational management of the organisation.
- Monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review in detail via a deep dive any major performance variation, to obtain assurance on behalf of the Board as to the effectiveness of corrective actions and associated governance arrangements.
- To consider changes to the Trust reporting requirements under any new regulatory arrangements.

4.3.2. **Financial and Operational performance management**

- To undertake high-level, exception-based monitoring of the delivery of operational and financial performance to ensure that the Trust is operating in line with its annual business plan objectives and, where not, satisfy itself that appropriate action is being taken by Executive Directors.

- To take an overview of the Trust's performance against financial and performance objectives (including delivery of recovery and transformation plans) ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

- Review forecast performance against operational targets and improvement trajectories, escalating issues of non-delivery to the Board, and monitoring against achievement of any national funding (e.g. Provider sustainability funding).

- Monitor identification of schemes within the Cost Improvement Programme and overall forecast delivery, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

- Review operational performance in relation to information technology, information governance, data quality and estates and facilities.

4.3.3. **Income and Contracts management**

- Review the Trust contracting approach with key commissioners

- Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.

- Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.

- Consider material opportunities to grow new commercial income streams and market share of existing services.

4.3.4. **Annual Trust planning cycle**

- To consider the Trust's medium and long-term financial strategy, in relation to both revenue and capital.

- To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of directorate business plans, including workforce plans, linked to the Trust's Corporate Objectives.

- To ensure that the Trust has an appropriate Recovery and Transformation Programme in place and provide Board level oversight of its delivery

- Consider proposals for Commercial and Business Development activities in accordance with Standing Financial instructions. The Finance and Performance Committee has delegated authority to approve revenue business cases from £250k - £750k. The Committee has delegated authority to approve capital business cases from £300k - £750k.

- Review the process for developing the transformation plan and for the oversight and delivery of the programme within the Trust. Consider and recommend any major transformation programmes that the Trust should undertake.

- Review the annual CIP and transformation plan to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable.

- Receive benchmarking and other information (for example from GIRFT and Model Hospital) to assess Trust productivity and ensure targeting or efficiency programmes.

- Review the Trust procurement strategy, systems and arrangements for obtaining best value. Monitor progress against the NHS standards of Procurement within the Trust.

- To consider the implications of wider changes in NHS policy and governance within the committee's remit including (but not limited to) the development of Integrated Care Boards (ICB), NHSE regulatory oversight and developments of provider collaboratives including BSW Acute Alliance.

4.3.5. **Capital management**

- Review the strategic five-year capital programme and the annual capital budgets and recommend as appropriate to the Board of Directors;

- To consider the financial proposals for investment in the estate and technology to ensure alignment with Trust strategy.

- Approve capital business cases in accordance with the Trust's Detailed Scheme of Delegation (DSoD).

4.3.6. **Treasury management**

- To review the cash position of the Trust and the related treasury management policies of the Trust.

- Review Trust finance applications including loan applications.

4.3.7. **Risk Management**

- The Committee shall ensure the Trust has robust financial and operational risk management systems and processes in place.

4.3.8. **Other**

- To review any matter referred to this committee by the Board of Directors.

- To make arrangements as necessary to ensure that all Board members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.

- To notify the Audit Committee of any statutory reporting concerns or system weaknesses identified.

5. Conduct of Business

Administration

5.1. The Committee shall be supported administratively by the Corporate Governance Manager, whose duties in this respect will include:
- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- Provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible in conjunction with the Committee Chair.

Frequency

5.2. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.3. Meetings will be held at least twelve times per year, with additional meetings where necessary.

Notice of meetings

5.4. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.5. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.6. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.8. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.
6.2. As part of this assessment, the Committee shall consider whether it receives adequate and appropriate support in fulfilment of its role and whether its current workload is manageable.
6.3. These terms of reference were reviewed and approved by Trust Board INSERT DATE

Clinical Governance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
March 2019	2	Major	All sections revised	Director of Corporate Governance
May 2020	3	Minor	Annual review	Corporate Governance Manager
March 2021	3.1	Minor	Annual Review	Corporate Governance Manager
March 2022	3.2	Minor	Annual Review	Director of Integrated Governance – updates made by PA

Date Adopted	7th April 2022 (tbc)
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	CGC/ Trust Board
Adoption and ratification	Trust Board

1. Purpose

1.1. The Committee has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board and the Chief Executive that high quality care is provided to patients throughout the Trust.

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Clinical Governance Committee (the Committee).

2.2. The Committee is a standing committee of the Board of Directors (the Board).

2.3. A non-executive Committee of the Trust Board of Directors has no executive powers, other than those specifically delegated in these Terms of Reference

2.4. The Committee is authorized to monitor, scrutinize and where appropriate, investigate any quality activity considered to be within its terms of reference

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Three Non-Executive Directors
- Chief Medical Officer, Chief Nursing Officer (joint Lead executive)
- Chief Operating Officer

3.2. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.3. A Non-Executive Director shall be appointed as Chair of the Committee.

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members or nominated deputy.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- Any nominated deputy attending in place of a designated Committee member.

- Other Non-Executive Directors and Executive Directors are invited to contact the Chairman in advance if they wish to attend a CGC meeting.
- The PA to the Chief Nursing Officer and Chief Medical Officer will act as Secretary to the Committee.
- Governor observer(s)
- The Director of Integrated Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.
- Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1. The function of the Committee is to ensure:

4.1.1. That the Board establishes and maintains compliance with health care standards including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission and statutory regulators of health care professionals (including NHS Improvement).

4.1.2. Provision of assurance that high quality care is provided to patients throughout the Trust, actively engaging with patients, staff and other key stakeholders as appropriate.

4.1.3. There is clear accountability for quality of care throughout the Trust including but not restricted to, systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate

4.1.4. Support for the Trust's objective to strive for continuous quality improvement and outcomes, through the Care and Innovation objectives.

4.1.5. Consideration of the clinical risks to the Trust's ability to achieve high quality care and continuous quality improvement through review of the Care and Innovation sections of the Board Assurance Framework

4.1.6. To consider the implications of wider changes in NHS policy and governance within the committee's remit including (but not limited to) the development of Integrated Care Boards (ICB), NHSE regulatory oversight and developments of provider collaboratives including BSW Acute Alliance.

4.1.7.

4.2. The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

4.2.1. Development and Review

- Agree the annual quality plan (quality account priorities) and monitor progress**.**
- Extend the Boards monitoring and scrutiny of the standards of quality, compliance and performance of Trust services
- Make recommendations to the Board on opportunities for improvement in the quality of services
- Support and encourage quality improvement where opportunities are identified

- Working in conjunction with the Audit Committee, People and Committee and Finance and Performance Committee, cross-referencing data and ensuring alignment of the Board assurances derived from the activities of each committee
- Review the Trust's Annual Quality Report and Account prior to submission to the Trust's Board of Directors for approval
- Monitor the status of the Trust's quality objectives as set out in the Annual Plan
- Review the Integrated Performance Report Quality and Care section prior to inclusion in the Board Integrated Performance Report Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust
- Receive Quality Impact Assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience, and patient safety
- Provide oversight of relevant Internal Audit recommendations as directed by the Audit Committee
- Quarterly Strategic focus to include population health.

4.2.2. Review of Trust activity in assigned area

Patient Safety:

- Agree the annual safety plan and monitor progress.
- Ensure risks to patients are minimised through application of a comprehensive risk management system in accordance with the risk management strategy. Identify areas of significant risk, set priorities and agree actions using the Assurance Framework and Corporate Risk Register process.
- Monitor and review the clinical risks in the Assurance Framework and corporate risk register as per the risk management strategy and policy.
- Assure that there are processes in place that safeguard adults and children within the trust and review the annual safeguarding adult and children's reports prior to submission to Trust Board
- Receive and review bi-annual reports from the Director of Infection Prevention and Control

Clinical Effectiveness / Clinical Outcomes:

- Ensure that care is based on evidence of best practice and national guidance.
- Assure the implementation of all new procedures and technologies according to Trust policies
- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.
- Review the Annual Clinical Audit plan and receive a bi-annual report on progress with the plan.

Patient Experience:

Assure that the Trust has reliable, real time, up to date information about what it is like to be a patient experiencing care in this hospital, to identify areas for improvement and ensure that these improvements are made. This will be provided through a comprehensive patient engagement programme. This will be achieved through:

- Review of the patient experience quarterly report
- Agree the annual patient experience/engagement plan and monitor progress.
- Receipt of reports regarding patient experience and engagement and review the results and outcomes of local and national patient surveys

Learning:

- Commitment to strengthen learning across the organization aligned with continuous improvement and improve patient safety, experience and outcomes.
- Ensure the Trust is outward looking and incorporates learning and recommendations from external bodies into practice with mechanisms to monitor their delivery.
- Request reports to monitor against action plans arising from Serious Incidents, complaints and Never Events to ensure Trust-wide learning.

4.2.3. Policy monitoring and review

Ensure the research programme and governance framework is implemented and monitored.

5. Conduct of Business

Administration

5.1. The Committee shall be supported administratively by the PA to the Chief Nursing Officer and Chief Medical Officer whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

The Committee chair will provide an escalation report to the Board of Directors following each meeting, in the public session where possible; agreed with the Committee Chair.

Frequency

5.2. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.3. Meetings will be held 12 times per year, with additional meetings where necessary.

Notice of meetings

5.4. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.5. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.6. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner through the Board escalation report template.

5.8. Reporting arrangements into the Committee from Sub-Committees

5.9. The Clinical Management Board will continue to report to the Trust Management Committee, and its Escalation Report (Minutes) will be submitted to the Clinical Governance Committee for assurance.

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

3. These terms of reference were approved by the Clinical Governance Committee with amendments and these terms of reference were reviewed and approved by Trust Board on 1st April 2021

People and Culture Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
May 2020	3		Annual Revision	Corporate Governance Manager
March 2021	3.1	Minor	Annual Revision	Corporate Governance Manager
January 2022	3.2	Minor	Annual Revision	PA to Chief People Officer

Date Adopted	7th April 2022 (tbc)
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	People and Culture Committee
Adoption and ratification	Trust Board

1) Purpose and Function

1.1 The purpose of the Committee is to ensure that the Trust has a workforce strategy in place that recognises the importance of all of the people who work within the Trust, and that will enable it to recruit and retain sufficient numbers of people with the necessary skills, training and motivation to deliver its clinical objectives. Specifically:

- That the Trust has a clear understanding of its strategic workforce needs and that plans are in place to deliver these;
- That the Board receive assurance that all legislative and regulatory requirements relating to the workforce are met;
- That workforce risks are understood by the Board and that appropriate mitigating actions have been identified and are being implemented.

1.2 To achieve this, the Committee shall:

- Support the development and monitoring of a workforce strategy
- Champion workforce issues ensuring adequate oversight of all workforce areas by the Board.

1.3 The Committee shall discharge this function on behalf of the Board of Directors by:

- Monitoring key workforce metrics to ensure that the expected standards are being delivered
- Receiving reports to provide assurance around compliance with legislation and regulations
- Considering workforce plans and improvement plans on behalf of the Board

2) Authority

1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the People and Culture Committee (the Committee).
2. The Committee is a standing committee of the Board of Directors (the Board).
3. The Committee is a Non-Executive Committee and has no Executive powers.

3) Membership and Attendance

Membership

1. The Committee shall be appointed by the Board of Directors and shall consist of:
    - Two Non-Executive Directors
    - Chief People Officer (Lead Executive)
    - Chief Medical Officer
    - Chief Nursing Officer
    - Executive Director of Improvement & Partnerships
2. A Non-Executive Director shall be appointed as Chair of the Committee.

3. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.
4. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members or nominated deputy.
6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

7. Meetings of the Committee shall normally be attended by:

- Chief People Officer
- Chief Nursing Officer
- Deputy Chief People Officer
- Associate Director of Education & Learning
- and others by invitation

The Director of Integrated Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

Executive and Non-Executive Directors can attend any Board Committee to exercise their functions.

4) Roles and Responsibilities (not delegated unless otherwise stated)

1. Oversee progress on the development and delivery of workforce, OD and cultural change strategies, taking into account relevant best practice and ensuring alignment with the Trust's strategic priorities and objectives.
2. Review and provide assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance. The detail of this review will be upwardly reported to the Board to provide oversight.
3. Oversight of the delivery of the HR operating plan and associated policy management.
4. Maintaining oversight of the business of the Organisational Development and People Management Board and associated sub-structure. Escalation reports will come to the People and Culture Committee summarising the themes and providing assurance on

operational decisions affecting workforce performance, organisational change and the implementation of initiatives.

5. Oversight of the development and delivery of the People Strategy and the people aspect of the Clinical Strategy
6. Monitor effectiveness of compliance with local and National staff surveys and the implementation of action plans to deliver against identified areas of concern.
7. Receipt and review of the Workforce Report prior to submission to Trust Board as part of the Integrated Performance Report. This includes a review of the Trust's workforce performance indicators to provide assurance that mitigating actions are in place where appropriate.
8. Oversee the implementation of Internal Audit recommendations as directed by the Audit Committee
9. To receive and review quarterly and annual reports of the Guardian of Safe Working on the Board's behalf.
10. To receive and review quarterly reports of the Freedom to Speak up Guardian, including an annual report.
11. To receive and review Safe Staffing reports to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the needs of patients and service users.
12. Maintaining oversight of the Trust's employment related equality, diversity and inclusion agenda. To receive and review the minutes of the Equality and Diversity Committee.

5) Conduct of Business

Administration

1. The PA to the Chief People Officer & Chief Finance Officer shall be Secretary to the Committee
2. The Committee shall be supported administratively by the PA to the Chief People Officer & Chief Finance Officer whose duties in this respect will include:
    - agreement of agendas with Chair and attendees and collation of papers
    - taking the minutes
    - keeping a record of actions, matters arising and issues to be carried forward
    - advising the Committee on pertinent issues/areas
    - provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

4. Meetings will be held at least nine times per year, with additional meetings where necessary.

Notice of meetings

5. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

6. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

7. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board through use of the Board Escalation Report template. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

9. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

10. The Committee will receive, for oversight and information, the minutes of the following committees:
    - Organisational Development and People Management Board

6) Review

1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

2. As part of this assessment, the Committee shall consider whether it receives adequate and appropriate support in fulfilment of its role and whether its current workload is manageable.

3. These terms of reference were approved by the People and Culture Committee with amendments on and ratified by the Board of Directors on **INSERT DATE**

Audit Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
March 2020	2.1	Minor	Annual Revision	Director of Corporate Governance
March 2021	2.2	Nil changes	Annual Revision	Director of Corporate Governance
Dec 2021	2.3	Nil changes	Annual Revision	Director of Integrated Governance

Date Adopted	7th April 2022TBC
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	Audit Committee
Adoption and ratification of changes	Board of Directors

1) Purpose and function

The purpose and function of the Committee is to:

1.1. Monitor the integrity of the financial statements of the Trust, any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them

1.2. Assist the Board of Directors with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management, and where appropriate, facilitate and support through its independence, the attainment of effective processes

1.3. Review the effectiveness of the Trust's internal audit and external audit function; and in discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards.

1.4. Report to the Board as to how it is discharging its responsibilities as a Committee

2) Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee.

2.2. The Committee is a standing committee of the Board of Directors (the Board).

2.3. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and any such employee will be directed to co-operate with any request made by the Committee.

2.4. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise. Should the projected cost of any such external advice exceed £50k, consent of the CEO and Director of Finance should be sought in advance of engagement.

2.5. A Non-Executive Committee of the Trust Board of Directors has no executive powers, other than those specifically delegated in these Terms of Reference

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of four Non-Executive Directors, with at least one of whom shall have recent and relevant financial experience.

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.

3.3. The Chairman of the Board of Directors shall not be a member of the Committee.

3.4. The Chair of the Committee shall not be the Senior Independent Director of the Board of Directors.

Quorum

3.5. The quorum necessary for the transaction of business shall be two members of the Committee

3.6. In the absence of the Chair of the Committee, the Secretary will invite one of the other Committee members to chair the meeting.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- The Chief Executive
- The Chief Finance Officer, or a nominated Deputy
- Representatives from the External (Appointed) Auditors, Internal Auditors and Counter Fraud advisors
- The Director of Corporate Governance, or nominated deputy, will act as Secretary to the Committee and will therefore attend all meetings
- Financial Controller
- Others by invitation – this may include executive sponsors in the case of audit reports Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1 Financial reporting

The Committee shall:

a) Ensure the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain
b) Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement, focusing in particular on:
    - Any changes in accounting policies and practices
    - Major judgmental areas
    - Value for Money considerations
    - Significant adjustments arising from the audit
    - The going concern basis
    - Compliance with accounting standards
    - Major risks to the Trust
c) Review the consistency of, and changes to, accounting policies both on a year-on-year basis and across the Trust.
d) Review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements)
e) Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of both the Trust Executive and the External Auditor
f) Review the clarity of disclosure in the Trust's financial reports and the context within which statements are made
g) The Committee Chair shall report formally to the Board on its proceedings after each meeting on all escalation matters
h) The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

4.2 Governance, Risk Management and Internal Control

The Committee shall:

a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives
b) Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board
c) Review the Trust's processes to establish and maintain an effective Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements
d) Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security as required by the NHS Counter Fraud Authority
e) Receive assurance from Internal Audit, External Audit, Directors and managers, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.3 Internal Audit and Counter Fraud

The Committee shall:

a) Ensure that there is an effective Internal Audit function that meets the aspirations of the Trust's Executive, *Government Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors
b) Consider and approve the Internal Audit Strategy and annual plan recommended by the Chief Finance Officer and ensure there are adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management or other restrictions
c) Review promptly all reports on the Trust from the Internal and External Auditors, review and monitor the Executive Management's responsiveness to the findings and recommendations of reports, and ensure coordination between Internal and External Auditors to assist the Executive to optimise use of audit resource
d) Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee
e) Conduct a review of the Executive's use of internal audit and counter fraud consultancy resources, including an assessment of the effectiveness of these services.

4.4 External Audit

The Committee shall:

a) In conjunction with the Chief Finance Officer, consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor
b) Work with the Chief Finance Officer and the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors
c) Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts
d) Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted
e) Review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work
f) Meet the external auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audit
g) Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, and the impact on the audit fee
h) Review all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

4.5 Other Board Assurance Functions

a) The Committee will initiate investigations or reviews of any matters within its scope of authority in response to any indicators or matters of concern arising at the Committee or raised elsewhere and referred to the Committee.
b) The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators and professional bodies with responsibility for the performance of staff or functions
c) The Committee shall review the work of other Committees within the organization, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Clinical Governance Committee and the Finance and Performance Committee. In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will satisfy itself on the assurance that can be gained from the clinical audit function.

5). Reporting and Accountability

a) The Committee Chair shall report formally to the Trust Board of Directors through the template escalation report, and make recommendations the Committee deems appropriate on any area within its remit where action or improvement is needed

b) The Committee shall report to the Trust Board annually on its work in support of the Annual Governance Statement and Accounts
c) The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement as it deems appropriate
d) The Chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances
e) Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee shall write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation
f) The Committee shall produce a statement to be included in the Trust's Annual Report which describes how the Committee has fulfilled its terms of reference and discharged its responsibilities throughout the previous year
g) The Committee shall review its own terms of reference annually.

6) Conduct of Business

Administration

a) The Director of Corporate Governance shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

b) The Committee shall be supported administratively by the Director of Corporate Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- minute the proceedings of all Committee meetings, and draft minutes of Committee meetings shall be made available promptly to all members of the Committee
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

Enabling the development and training of Committee members

c) The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

d) Meetings will be held at least quarterly, an additional meeting to review the draft annual report and accounts, with additional meetings where necessary.

Notice of meetings

e) An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

f) In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Subsidiary Governance Committee
Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
August 2018	1.0	Major	Drafted	Director of Corporate Governance
Jan 2019	1.0	Minor	Minor amendments agreed at the first meeting	Director of Corporate Governance
May 2020	1.1	Minor	Annual Revision	Director of Corporate Governance
March 2020	1.2	Minor	Annual Revision	Corporate Governance Manager
March 2021	1.3	Minor	Annual Revision	Corporate Governance Manager
March 2022	1.4	Minor	Annual Revision	Director of Corporate Governance

Date Adopted	7th April 2022 (tbc)
Review Frequency	Annual
Terms of Reference Drafting	Chief Finance Officer
Review and Approval	Subsidiary Governance Committee
Adoption and ratification	Trust Board

1. Purpose

The Committee is established to provide the Board of Directors with assurance on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company (known as related company/entity).

2. The committee is established to:

- Ensure that where the Trust has an interest, or shareholding, the Trust has appropriate oversight and governance.

3. Authority

3.1. The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Subsidiary Governance Committee (the Committee). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3.2. The Committee is a standing committee of the Board of Directors (the Board).

3.3. The Committee is authorised to:

- Perform any of the activities within its terms of reference;
- Obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- Consider and make recommendations to the Board of Directors any and all items of which they should be aware to fulfil their responsibility

4. Membership and Attendance

Membership

4.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Two Non-Executive Directors
- Independent Chairman of OML and STL
- Chief Financial Officer
- Chief People Officer
- A Non-Executive Director shall be appointed as Chair of the Committee. In the absence of the Chair, a Non-Executive Committee member will perform this role.

4.2. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

4.3. Three voting members of the Board of Directors (at least one Executive Director and one Non-Executive Director). A nominated Deputy for the Chief Finance Officer must be in attendance if the Chief Finance Officer is absent.

Attendance (non-voting members)

4.4. Meetings of the Committee shall be attended by:

- Director of Procurement and commercial services
- Director of Corporate Governance
- Specialist expertise as required

Attendance by Other Trustees

4.5. Any member of the Board of Directors can attend.

4.6. Note: All Board of Directors will be sent copies of the agenda for each meeting and may attend the meeting should they wish to do so.

5. Roles and Responsibilities

The duties of the Committee can be categorised as follows:

5.1. Ensuring the Trust has a clear strategy for the use and development of subsidiary and related companies/entities.

5.2. Maintaining a clear view of the subsidiary level risk profile and exposure (operational, reputational and financial) across the group profile.

5.3. Ensuring the Trust has a clear governance framework and structure for oversight of any related company/entity. This framework will ensure:

- That any related company/entity identifies and evaluates all potential commercial opportunities in line with its agreed strategy.
- That any related company/entity complies with its relevant industry regulatory framework.
- That the related company/entity achieves the planned financial and operational performance levels.
- That the related company/entity has due regard for the issue of public accountability in the context of ethical responsibilities, corporate and social responsibility, statutes and other regulations e.g. tax.
- That the related company/entity has appropriate governance mechanisms in place (including SFI's, business planning process).
- The process for appointing the senior leadership team (Managing Director, Non-Executive Directors).

6. Conduct of Business

Administration

The Director of Corporate Governance is a member of the committee and has corporate responsibility for:

6.1. Liaising with the chair on all aspects of the work of the committee, including providing advice.

6.2. Ensuring the committee acts in accordance with standing orders and scheme of reservation and delegation.

6.3. Identifying an officer to undertake the role of secretary.

Frequency

6.4. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

6.5. Meetings will be held no less than four times per year, with additional meetings where necessary.

Notice of meetings

6.6. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than three working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

6.7. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

6.8. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

6.9. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

6.10. The Committee will report annually to the Board of Directors on the performance of its duties as reflected within its Terms of Reference.

6.11. Any items of specific concern or which require the Board of Directors approval will be subject to a separate report.

7. Review

7.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

7.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

Charitable Funds Committee Terms of Reference

The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), operating under the working name of Stars Appeal, and is responsible for the management of funds it holds on trust.

In line with the registration to the charity commission the Board of Directors of Salisbury NHS Foundation Trust collective is the Corporate Trustee. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately.

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
August 2018	1	Approved version	Approved by the Trust Board of Directors	
March 2019	2	Minor	Added role of secretary to the Committee	Director of Corporate Governance
December 2020	2.1	Minor	Membership and Administration	Investment Planning and Policy Manager
March 2022	2.2	Minor	Review of TOR addition of Head of PALS to attend.	Executive Services Manager

Date Adopted	1st January 2021/ Approved at Board 7th April 2021 tbc
Review Frequency	Annual
Terms of Reference Drafting	Investment Planning and Policy Manager
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1. Purpose

The Committee is established to provide the Board of Directors with assurance on the appropriate management and use of charitable funds it holds on trust.

2. The committee is established to:

2.1. Ensuring the stewardship and effective management of funds which have been donated, bequeathed and given to Salisbury District Hospital Charitable Fund for charitable fund purposes.

2.2. Determining an investment strategy and arrangements for the investment of funds which are no immediately required for use.

2.3. Coordinating the provision of assurance to the Board of Directors, acting as trustee of the funds, that the funds are accounted for, deployed and invested in line with legal and statutory requirements.

2.4. Considering and approving the annual accounts for charitable funds for submission to the Board of Directors, acting as trustee of the funds.

3. Authority

3.1. The Board of Directors, acting as the Trustee for the Salisbury Hospital Charitable Fund Charity, hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds Committee (the Committee). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3.2. The Committee is a standing committee of the Board of Directors (the Board).

3.3. The Committee is authorised to:

- Perform any of the activities within its terms of reference;
- To approve or ratify as appropriate those policies and procedures for which it has responsibility (including SFI and SO's).
- Obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- Consider and make recommendations to the Board of Directors any and all items of which they should be aware to fulfil their responsibility as corporate trustee.
- Approve use of charitable funds in line with the SFI's.

4. Membership and Attendance

Membership

4.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Non-Executive Directors
- Executive Directors, of which one is the Chief Finance Officer (lead Executive)

4.2. A Non-Executive Director shall be appointed as Chair of the Committee. In the absence of the Chair, a Non-Executive Committee member will perform this role

4.3. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

4.4. Three voting members of the Board of Directors (at least one Executive Director and one Non-Executive Director). A nominated Deputy for the Chief Finance Officer must be in attendance if the Chief Finance Officer is absent.

Attendance (non-voting members)

4.5. Meetings of the Committee shall be attended by:

- Senior Responsible Officer for the Charity
- Financial Controller or Financial Accountant
- Director of Integrated Governance
- Representative from the Fundraising Team
- Staff representation – in the form of representatives from the Charity Ambassador board
- Community representation – in the form of the Chairman for the Fundraising Committee which is external to the Trust
- Head of Patient Advice and Liaison Service (PALS) Department

Attendance by Other Trustees

4.6. Any member of the Board of Directors (Trustee) can attend.

4.7. Note: All Board of Directors will be sent copies of the agenda for each meeting and may attend the meeting should they wish to do so.

5. Roles and Responsibilities

5.1. The duties of the Committee can be categorised as follows:

Assurance

5.2. Manage the affairs of the Salisbury District Hospital Charitable Fund within the terms of its declaration of trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations.

5.3. Scrutinise requests for the use of charitable funds to ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.

5.4. Review the Charitable Funds annual accounts and comment/ recommend approval to the Trustee as appropriate.

5.5. Ensure that the NHS Foundation Trust's Constitution, Standing Financial Instructions and the Scheme of Reservation and Delegation are appropriately interpreted for charitable funds.

5.6. Receive and discuss all audit reports on charitable funds and recommend action to the Trustee.

Investments

5.7. Recommend an investment advisor to the Trustees following appropriate tendering procedures and regularly monitor and review their performance.

5.8. Ensure that the investment policy for Charitable Funds set by the Trustees is implemented and that sufficient funds are kept readily available to meet planned requirements.

5.9. Review the performance of investments on a regular basis with the external investment advisors to ensure the optimum return from surplus funds.

Fundraising

5.10. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commissioner guidance and legislation.

5.11. Ensure the sources of income and the terms on which donations are received are acceptable to the Trustee.

5.12. Ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law.

5.13. Ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments

5.14. Ensure effective communication regarding whistle blowing relating to fundraising, donations or subsequent use of funds.

6. Conduct of Business

Administration

6.1. The Chief Finance Officer is a member of the committee and has corporate responsibility for:

6.2. Liaising with the chair on all aspects of the work of the committee, including providing advice.

6.3. Ensuring the committee acts in accordance with standing orders and scheme of reservation and delegation.

6.4. The Executive Services Manager will act as the role of secretary to the Committee.

Frequency

6.5. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

6.6. Meetings will be held no less than four times per year, with additional meetings where necessary.

Notice of meetings

6.7. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than three working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

6.8. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

6.9. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

6.10. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

6.11. The Committee will report annually to the Board of Directors on the performance of its duties as reflected within its Terms of Reference.

6.12. Any items of specific concern or which require the Board of Directors approval will be subject to a separate report.

7. Review

7.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

7.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

Remuneration, Nominations and Appointments Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
September 2019	1	New ToR		Director of Corporate Governance
November 2020	1.1	Minor	Updates to membership and attendance sections and minor formatting	Director of Corporate Governance
March 2022	1.2	Minor	Update to job titles	Head of Corporate Governance

Date Adopted	7th April Board TBC
Review Frequency	Annual
Terms of Reference Drafting	Head of Corporate Governance
Review and Approval	
Adoption and ratification	Trust Board

1. Purpose

1.1. To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

2. Authority

2.1. The Remuneration, Nominations and Appointments Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

2.2. The committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the committee.

2.3. The committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Membership and Attendance

Membership

3.1. The membership of the Committee shall consist of:

- The Trust Chair
- The other Non-Executive Directors
- When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act). When appointing or removing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act (that is, the Chairman, Chief Executive and the Non-Executive Directors).

3.2. The Trust Chair shall chair the Committee.

Attendance

3.3. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair. At the invitation of the Committee, meetings shall normally be attended by the Chief People Officer.

3.4. Any non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Quorum

3.5. The quorum necessary for the transaction of business shall be the Chair of the Committee and three other Non-Executive Directors

Secretary

3.6. The Director of Integrated Governance shall be secretary to the Committee.

4. Duties

4.1. Appointments

The Committee will:

4.1.1. Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Nomination Committee of the Council of Governors, as applicable, with regard to any changes. The Constitution sets out the requirements of the Board composition.

4.1.2. Consider and make plans for succession planning for the Chief Executive and other Executive Directors considering the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

4.1.3. Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.1.4. Be responsible for identifying and appointing Executive Director candidates to fill posts within its remit as and when they arise.

4.1.5. When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the appointment. In identifying suitable candidates, the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.1.6. Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

4.1.7. Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.1.8. Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

4.2 Remuneration

The Committee will:

4.2.1. Establish and keep under review a remuneration policy in respect of Executive Board Directors.

4.2.2. Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

4.2.3. In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's Executive Directors, including:

- Salary, including any performance-related pay or bonus.
- Provisions for other benefits, including pensions and cars.
- Allowances.
- Payable expenses.
- Compensation payments.

4.2.4. In adhering to all relevant laws, regulations and trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

4.2.5. Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify them.

4.2.6. Be sensitive to pay and employment conditions elsewhere in the Trust.

4.2.7. Monitor and assess the output of the evaluation of the performance of individual Executive Directors and consider this output when reviewing changes to remuneration levels.

4.2.8. Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

5. Conduct of Business

Administration

5.1 The Director of Integrated Governance shall be Secretary to the Committee.

Frequency

5.2 The Committee will be held bi-annually and at such other times as the Chair of the Committee shall require.

Notice of meetings

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting,

Reporting

5.4 Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

6 Review

6.1 These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

APPENDIX 7: Version control

Document Title	Integrated Governance Framework			
Date Issued/Approved:				
Date Valid From:	1ST April 2022			
Date Valid To:	31st March 2023			
Division / Department responsible (author/owner):	Director of Integrated Governance			
Brief summary of contents	Description of the integrated governance operated within the Trust. It is designed to ensure the delivery of high-quality patient focussed care from an organisation that is well managed, cost effective and has a well-trained and motivated work force.			
Executive Director responsible for Policy:	Chief Executive			
Date revised:	March 2022			
Approval route (names of committees)/consultation:	Trust Board			
Name and Post Title of additional signatories	Not Required			
Publication Location (refer to Policy on Policies – Approvals	Internet & Intranet		Intranet Only	x

and Ratification):	
Document Library Folder/ Folder	Constitution
Links to key external standards	Well-Led Framework
Related Documents:	Accountability Framework Constitution Standing Orders Standing Financial Instructions Scheme of Delegation
Training Need Identified?	No

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
1 March 2017	V1.0	Initial Issue	David Seabrooke Head of Corporate Governance
1 April 2017	V2.0	Completed version	David Seabrooke Head of Corporate Governance
8 August 2017	V 3.0-	Amended Exec responsibilities from away awayday – appendix 4	David Seabrooke Head of Corporate Governance
16 November 2017	V v4.0	Minor amendments to exec responsibilities and introduction of OETB	David Seabrooke Head of Corporate Governance
22 January 2018	V 5.0	Introduction of Trust Management Committee and Strategy Committee	David Seabrooke Head of Corporate Governance
20 February	V 5.1	Minor updates and clarifications; addition of Charitable Trustees	David Seabrooke Head of Corporate

			Governance
19 March 2018	V5.2	Comments by CEO and DoN Attendance at Strategy C'ttee Removed Exec Oversight of Directorates (previously extracted from Accountability Framework) and individual extract of Terms of Reference of Trust Management Team Proposed removal of committee memberships Added review of committees Added Nominations Committees	David Seabrooke Head of Corporate Governance
26 March 2019	V6.0	Document updated to reflect changes to Board Committees including introduction of a Subsidiary Governance Committee, update to accountabilities of direct reports to the chief executive and condensing of content to remove duplication	Fiona McNeight Director of Corporate Governance
2 July 2020	V6.1	Document updated to reflect the changes as a result of the Internal Audit of Board Compliance and Reporting in November 2019. The Strategy Committee has been removed. The Workforce Committee's name has been changed to People and Culture Committee. Charitable Funds Committee and Remuneration Committee Terms of Reference added. Directorates are now called Divisions. The Divisional Governance Committee remit has been strengthened.	Fiona McNeight Director of Corporate Governance
15 March 2021	V6.2	The executive directors titles have been updated to reflect changes from 1st April 2021 Board Committee Assurance Map updated to reflect changes that have occurred in reporting and committee structure. Section 8 – updated title 'Collaborative	Fiona McNeight Director of Corporate Governance

		Working and Partnerships' to reflect the developing ICS work.	
March 2022	V6.3	Annual Review Sections 1,2, 4.4, 5, 6.10 and 8 have been amended. Appendices 2, 3, 5 and 6 have also been updated. Titles and responsibilities updated.	Fiona McNeight, Director of Integrated Governance. Kylie Nye Head of Corporate Governance

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