Bundle Trust Board Public 13 January 2022

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates

1.2 10:10 - Staff Story

1.3 Welcome and Apologies

1.4 Declaration of Interests, Fit and Proper / Good Character

1.5 10:30 - Minutes of the previous meeting

Minutes attached from meeting held on 9th December 2021
For approval

1.5 Draft Public Board mins 4 November 2021.docx

1.6 10:35 - Matters Arising and Action Log

1.6 Trust Board Public Master Action Log.pdf

1.7 10:40 - Chairman's Business

Presented by Nick Marsden
For information

1.8 10:45 - Chief Executive Report

Presented by Stacey Hunter
For information

1.8a CEO Board Report - December for January (4).docx

1.8b Appendix 1 C1487_Omicron operational letter_131221.pdf

1.8c Appendix 1a C1488_Letter re Next steps for the NHS COVID-19 vaccine deployment_131221.pdf

1.8d Appendix 1b reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic 241221.pdf

1.8e Appendix 1c 2022-23 priorities and operational planning guidance_24 December 2021.pdf

2 ASSURANCE AND REPORTS OF COMMITTEES - NOTED BY EXCEPTION

2.1 10:55 - Clinical Governance Committee - 21 December

Presented by Eiri Jones
For assurance

2.1 Escalation report - from December 2021 CGC to January Board 2022.docx

2.2 11:00 - Finance and Performance Committee - 21 December

Presented by Paul Miller
For assurance

2.2 Board - Finance and Performance Committee escalation paper 21st December 2021.docx

2.3 11:05 - Trust Management Committee - 22 December

Presented by Stacey Hunter
For assurance

2.3 TMC Escalation Report for Board.docx

2.4 11:10 - Audit Committee - 16 December

Presented by Paul Miller
For assurance

2.4 Escalation report from Committee to Board - Audit Committee 16th December 2021.docx

2.5 11:15 - Charitable Funds Committee - 16 December

Presented by Nick Marsden
For assurance

2.5 charity escalation report.docx

2.6 11:20 - Integrated Performance Report to include exception reports

Presented by Lisa Thomas
For assurance

2.6a 130122 Trust Board cover sheet.docx

2.6b IPR January 2022 DRAFT TB.pdf

3 FINANCIAL AND OPERATIONAL PERFORMANCE

3.1 11:45 - The Trust Green Plan

Presented by Andy Hyett
For approval

3.1a Trust Board cover sheet - Green Plan January 2022.docx

3.1b Salisbury NHS Foundation Trust Green plan 2022 v10.docx

4 QUALITY AND RISK

4.1 12:00 - Q2 Patient Experience Report

Presented by Judy Dyos
For assurance

4.1 Patient Experience Report Q2 Nov 2021 final.docx

4.2 12:10 - Q2 Learning from Deaths Report

Presented by Peter Collins
For assurance

4.2a Quarterly Learning From Deaths Report - Q2.docx

4.2b Quarterly Learning From Deaths Report - Q2.pdf

4.3 12:20 - Director of Infection Prevention and Control Report

Presented by Judy Dyos
For assurance

4.3b DIPC Report 6 monthly Update 2021-22 (Final v.1).doc

4.3c ICC IPC BAF National V1.6 30.06.2021 SFT V4.0 (Q2 review 1.0).pdf

4.4 12:30 - LUNCH BREAK

5 PEOPLE AND CULTURE

5.1 Health and Safety Annual Report - deferred to March Public Board

5.2 13:00 - Education and Development Annual Report (deferred from November Trust Board)

Presented by Melanie Whitfield
For assurance

5.2a Education and Apprenticeships Annual report 2020-2021 cover sheet 2021 (1).docx

5.2b Annual Education and Training Report 20_21_v5.docx

5.3 Nursing Skill Mix - deferred to March

5.4 13:10 - Equality and Diversity Annual Report

Presented by Melanie Whitfield
For assurance

5.4a Trust Board cover sheet_Annual EDI Report 2021.docx

5.4b SFTEqualityreport2021_v2.pdf

5.5 Medical Education Performance Report - deferred to March Public Board

6 GOVERNANCE

6.1 13:20 - Emergency preparedness Annual Report and Compliance Statement

Presented by Andy Hyett
For assurance

6.1a EPRR Annual Report 2021 Version 1.0.docx

6.1b BSW ICS EPRR Assurance submission 2021.docx

6.2 13:30 - Register of Seals

Presented by Fiona McNeight
For information

6.2 Register of seals.docx

6.3 13:35 - Annual Review of the Constitution

Presented by Stacey Hunter
For approval

6.3a Trust Board Constitution Cover Sheet.docx

6.3b Constitution V 2.2 Draft Jan 2022.docx

7 CLOSING BUSINESS

7.1 13:45 - Agreement of Principle Actions and Items for Escalation

7.2 13:50 - Any Other Business

7.3 13:55 - Public Questions

7.4 Date next meeting

10th March 2022

8 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 4th November 2021, Salisbury Rugby Club/MS Teams
Salisbury NHS Foundation Trust

Present:

Nick Marsden (NM)	Chairman
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
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
Esther Provins (EP)	Director of Improvement and Partnerships

In Attendance:

Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Helen Rynne (HR)	Patient Engagement Lead (via Teams)
Lucinda Herklots (LH)	Lead Governor Observer
Peter Kosminsky (PK)	Governor Observer (via Teams)
Mark Wareham (MW)	Staff Side Union Representative (via Teams)

ACTION

TB1 4/11/1 **OPENING BUSINESS**

TB1 4/11/1.1 **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:

- Leigh Blake, Sarum Ward
- Ginette Phippen, Sandra Treslove, Mehdi Belbahi, Jo Revell, Tracey Gibson, SaLT, Spinal and Therapies

NM and the Board congratulated the members of staff who had received a SOX award and the Board noted the continued effort from staff who provide a great level of care to patients even during extremely challenging times.

TB1 4/11/1.2 **Patient Story**

This patient story was revisited from the previous Public Board meeting so everyone had the opportunity to hear the story. The story was told by the sister of a patient who had been quite severely injured and sadly passed away. The story focused on the sister's experience of being a

visiting relative during the height of Covid-19 visiting restrictions in the hospital.

Discussion:

- PM reflected that this story had really highlighted the importance of the whole patient journey, including the relatives experience too.
- TB thanked the relative for sharing their story and noted that this story had highlighted the importance of the Trust ensuring and enabling a good death.
- JD noted that the outcome and learning points from this story had been escalated to nursing teams. JD reflected that this was at a time when visiting was limited due to Covid-19. The relative was initially given more visiting rights than the agreed guidelines due to the circumstances, however it was noted that there had been a failure to communicate properly regarding the use of a side room.
- EJ referred to the compassionate leadership training which had recently been introduced and how impactful it would be if everyone were to complete it. EJ noted that what she took from the story was the variation of experience based on who is around.
- PC noted that whilst we strive to deliver a good patient experience there are going to be times when things do not go right and it is how we recognise this and improve the delivery of the patient journey.
- SH noted that this had been a distressing story in terms of the impact on this relative and what was stark was the variation in communication and interpersonal skills. At the time the Trust had to make difficult decisions about who could visit due to Covid-19 and the nurses on the ward were carrying out the rules that had been put in place. There is a balance to strike between minimising the risks and what this means when patients cannot visit their loved ones. More needs to be done to support and maintain effective and consistent communication.
- NM noted the story had given the Board a lot to consider and noted that some of the messages from the story would be pertinent throughout the meeting. NM noted the challenging times ahead and encouraged the Board to think about how the Trust moves forward during winter and beyond and how difficult choices in terms of delivering health care are explained to the population.

TB1 4/11/1.3 **Welcome and Apologies**

NM welcomed everyone to the meeting and noted that the following apologies were received:

- Rakhee Aggarwal – Non Executive Director

TB1 4/11/1.4 **Declarations of Conflicts of Interest**

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

TB1 4/11/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 9th September 2021.**

NM presented the minutes from 9th September:

It was noted that as part of the patient story NM thanked the relative, not the patient for sharing the story. It was further noted that the Health and Safety Annual Report would actually be reporting to January's meeting.

Further to these amendments the minutes were agreed as a correct record of the meeting.

TB1 4/11/1.6 **Matters Arising and Action Log**

NM presented the action log and it was agreed that all matters arising were either on the agenda, a future agenda or closed.

TB1 4/11/1.7 **Chairman's Business**

NM highlighted the following key points

- Whilst there has been a small increase in Covid-19 inpatients in the Trust, internal modelling has indicated this could reach between 30-40 inpatients at one time which will add further challenges to an already pressured system.
- Additionally, there have been a lot of patients presenting in the Emergency Department (ED) and patient flow out of the hospital is extremely challenging.
- There is a focus on what can be done to relieve the pressure, particularly on front line staff.
- There is an Integrated Care System (ICS) bill going through parliament currently which will see ICS's as statutory bodies from 1st April 2022. There should be a focus of the Board on external challenges to help minimise the effect that these have on staff and treating patients.

TB1 4/11/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- The government have now tabled the legislation changes which will formalise the arrangements for Integrated Care Systems (ICS). There is a significant amount of work to undertake in relation to the new arrangements which is being led by BSW Executive. SH noted that from an executive perspective the Board is well represented in these discussions. FMc has had sight of and reviewed alongside peers from the other organisation the draft governance documents.
- The Trust have recently received a letter in relation to NHSE/I System Oversight Framework which provides focused assistance to organisations and systems. Segmentation. The letter indicates that we are placed in segment 3 on the basis of financial legal undertakings, CQC issues in the recent maternity and spinal unit inspections and accuracy in the reporting and delivery of cancer wait times. Whilst the first two reasons are accepted, the Trust has not aligned with the view that has been taken in relation to cancer waiting times having explored the rationale for this with the regional

cancer lead. This has been escalated to the regional team.

- The Trust continues to face increased and significant pressure in this period resulting in consistently high escalation levels of Operating Pressure Escalation Levels (OPEL) 3 or 4. Given the level of pressure this continues to be a priority for executives and senior leaders and is detracting from the time to progress other priorities.
- The recently published CQC inpatient survey continued to show a positive performance and the Trust benchmarks in the Top 5 South West providers for several of the key questions patients responded to.
- Thank you to the colleagues who managed the major incident on Sunday in relation to the train collision. In total 13 people attended ED on Sunday evening of which 9 were discharged home the same day. All other patients have now been discharged.
- Maternity services have been working really hard to respond to the improvements required as part of the Care Quality Commission (CQC) inspection. The CQC came back on 8th November and the draft report is expected in mid-November. This will be shared with Board colleagues when it becomes available.
- Thank you to the communications team who helped organise a number of celebratory events in September included the staff awards ceremony. The event received great feedback and was greatly needed after what has been a really challenging few years.

Discussion:

- PM referred back to the patient story which had referenced the small things staff can do to improve patient care and the patient journey. PM asked what small things Trust could do above and beyond what is already being done to help people manage the pressures currently faced. SH explained that she had asked JD at their weekly executive meeting to take a step back and think about all the things being done and what of those things being done doing has the most impact for those colleagues on wards. Additionally, there has been feedback from the all staff briefings that have recently been held and there is another one planned this week.
- NM noted that he had a meeting with Jane Podkolinski, governor representing volunteers and the Trust have 700 volunteers who are eager to support the organisation in any way they can.
- JD noted that she and MW have written to letter to those staff who are feeling the most pressure and noting all the actions that have been taken and also detailing all health and wellbeing offers available. It is clear that colleagues across BSW are all having a very challenging time and we have invited them to share any information that would be helpful in managing these pressures.
- EJ reflected on the broader workforce and noted the importance of also ensuring those in supporting roles, i.e. non clinical are happy in their roles as everyone contributes to excellent patient care.
- TB asked how the Trust is managing the communications and subsequent process of which is coming out centrally and how it is landing with senior leaders across the organisation, alongside the additional pressures. SH noted the huge amount of work required as a result of the changing arrangements for the way ICS's work. A

judgement has been taken on the level of burden placed on colleagues who have operational pressures to contend with. Colleagues have taken an interest on new integrated ways of care but there is the balance to be struck. MW and EP are giving lots of thought to big ticket items in response to the external environment of integration and collaboration. The focus should be looking at how we deploy the Trust Strategy and engage staff in the cultural changes required as part of the Improving Together programme, whilst keeping it relevant to people's day to day jobs.

TB1 4/11/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 4/11/2.1 **Clinical Governance Committee- 26th October**

EJ presented the report, providing a summary of escalation points from the meeting held on 26th October:

- A presentation on Stroke services was provided outlining the areas of performance which have been impacted by the pandemic. Assurance was provided by CMO that the Trust is not an outlier in relation to mortality for stroke patients. The Executive team will provide support to the Stroke service to address current challenges.
- A hot topic presentation on child and adolescent mental health services (CAMHS) was provided by the link Consultant and whilst this continues to be a challenge, partnership working continues to improve. Further work was required in relation to training of general paediatric staff and this was underway. The Trust continues to escalate concerns to both the CCG and the regional team.
- The Committee received the quarterly maternity report was presented which updated the committee on recruitment. It was positive to note that all senior posts will have commenced by the beginning of November.
- The committee have requested that the Chief Information team (CIO, CNIO and CCIO) present a hot topic to a future committee to outline the clinical digital plan.

Discussion:

- EJ noted that what was clear in the meeting was the enthusiasm on improvement and sustaining a good position in terms from a quality, patient experience and outcome perspective which is extremely difficult in the current context.
- It was noted that the presentation from the paediatric consultant about CAMHS and clinical leadership was excellent and highlighted how the team have organically learnt how to manage to the best of their ability and PM noted that this learning should be shared.
- The digital challenges from a clinical perspective were discussed. JD explained that the Trust is still using hand held notes for maternity whilst a number of other regions have transitioned to an electronic system. SH noted that the policy position in relation to the ICS is at odds with the way in which clinical networks are managed. Efforts are being focused on the capital requirements for the shared Electronic Patient Record (EPR) in the context of

ICS. However, a further complexity is that some Trust partners are outside of this system.

TB1 4/11/2.2 **Finance and Performance Committee – 26th October**

PM provided a summary of escalation points from the Finance and Performance Committee held on 26th October.

Discussion:

- PM noted the high bed occupancy and the challenge of discharging patients which has meant an increase of patients in the hospital with "no criteria or right to reside". The Committee had felt this was a pertinent discussion to escalate to Board due to the key risks associated. SH noted that these discussions have been had internally with AH and operational colleagues and at the Urgent Care Board to discuss how the challenges in the community and social care can be addressed differently and what can be achieved to influence better outcomes for patients.
- PM referred to the H2 planning guidance that had been received and it was agreed that the key priority is delivering safe, urgent and emergency services as we go through second half of the year and therefore we need to be realistic about other targets.
- SH noted that she understood from feedback relating to the regional check in for the H2 plan that it was well received and consistent with what they had heard from other ICSs. Concerns have been raised about organisational ability to deliver the elective plan unless further support is provided to manage patient flow. The Trust will always prioritise P1 and P2 patients but the balance around the elective plan has a level of risk going into winter.
- PM referred to the winter plan and asked if the Trust is clear at what point we make decisions and escalate and communicate them. AH explained that the Trust will use the same process it has done for the last few years in relation to the levels of escalation via Operating Pressure Escalation Levels (OPEL).

TB1 4/11/2.3 **Trust Management Committee – 27th October**

SH provided a summary of escalation points from the Trust Management Committee (TMC) held on 27th October.

- The Committee approved three business cases as detailed in the report. SH noted that there is a robust process that business cases now go through as they are reviewed and scrutinised at Trust Investment Group (TIG) and TMC. The standard of business cases has improved and learning points are taken from the process.
- The Committee approved the Serious Incident Policy and Adverse Events Policy.
- TMC asked colleagues to review the Board Assurance Framework which had been aligned to the Trust Strategy and strategic objectives of Population, People and Partnerships and feedback any comments to FMc.

Discussion

- PK referred to the business case process and noted that the process could be further strengthened by considering these cases on a broader scale. For example, it is easy to see the benefits of additional staff to a small department however; it is sometimes necessary to zoom out and consider the longer term implications and the issues around base workforce efficiency. In short, the overall position should not be lost with the desire to fix specific problems
- SH acknowledged that this is sometimes the case but explained that this is getting better and a broader view is now being taken; particularly now business cases are reviewed at a divisional level. LT explained that every business case is compelling and what is needed is a business planning process that stops individual cases coming in year. It is acknowledged that the planning process was somewhat lost during Covid and the focus in H2 and going into 2022/23 should be productivity.
- EJ referred to the ratification of the Serious Incident and Adverse Event Policy and asked if this will be updated to reflect the new Patient safety Framework in 2022. SH noted that these two policies will need a rewrite and that no significant changes had been made in this instance.

TB1 4/11/2.4 **People and Culture Committee – 29th October**

MvB provided a summary of escalation points from the People and Culture Committee held on 29th October.

- The Committee discussed the overwhelming positive feedback from the staff events that had been held in September which had given a number of staff a positive boost and emphasised the great work undertaken in the last two years.
- The Committee discussed feedback on the all staff briefings that had recently taken place. These had been set up to acknowledge the pressure that staff are currently experiencing and listening to useful feedback on how to manage these challenges.
- The Committee discussed the four strands of work that feed into winter planning. A tremendous effort is being made in supporting the health and wellbeing of staff. The work undertaken by the psychology team is making a positive difference and there is progress in training people to understand how to manage the psychological wellbeing of staff.
- There is a focus on how the Trust can improve flexible working and a pilot scheme is under development to test this.
- Progress is being made in developing a refreshed Equality, Diversity and Inclusion (EDI) strategy and an external expert has been brought in to assist the Head of Diversity and Exclusion, for 6 months.

Discussion

- PM referred to the EDI strategy and asked that whilst the Board is assured there is a strategy, is there the staff and resource and structure required to drive forward the work. MW noted that

there will be investment required to ensure there is the capability or capacity to deliver the agenda. This will come forward as part of the business planning process.
- SH extended her thanks to MW for the work she had undertaken so far as this is an area of the hospital and team that requires strengthening. MW noted that there is a sense of momentum but it is appreciated this is the start of a process and further work is required to see how we take those steps forward.

TB1 4/11/2.5 **Integrated Performance Report (M6)**

JD presented the Integrated Performance Report and noted that this report provided a summary of August's performance. The following key points were noted:

- A continued improvement in the 6 week diagnostic standard saw achievement of standard for the first time since February 20. Achievement of this important standard really helps to support recovery of the cancer and RTT standards.
- Cancer performance has also improved as detailed in the report. .
- There is a fairly stable picture relating to the data around quality of care which is positive to note amongst the complex challenges facing the Trust.
- There were 2 Never Events in September and the Trust have subsequently had a third. These are all unrelated but will be investigated thoroughly as per the standard process.
- In terms of workforce data the Trust continues to experience higher than normal turnover and a reduced appraisal rate which is linked to the ongoing significant pressures.
- Positively the Trust's mortality is sitting within the expected range.

Discussion:

- PK noted that he understood the focus on the patient flow and discharge issues in the report; however, when reviewing the stranded and super stranded it is clear there is a length of stay problem. PK therefore asked the Board to be mindful of not losing sight of the secondary effect of some of these issues. AH explained that average length of stay (LoS) is increasing which is partly attributed to high acuity and staffing issues. AH reassured the Board that this is being worked through with the appropriate teams. It was acknowledged that there have been changes to way LoS is now measured and it is difficult to benchmark pre-Covid.
- PK noted that he was interested in understanding trajectories and going forward would like to see what the Trust is doing to impact those trajectories.
- EJ noted that as part of the Trust's quality improvement (QI) aspirations, the best practice in terms of LoS would also have benefits for the workforce.
- PM noted the changes to discharge processes during Covid and asked about the current arrangements. SH explained that the policy is still in situ and funded. However, the issue is one of

workforce. The Trust is looking at how it can support in the recruitment of these vital workers in the community.

- DB referred to the high turnover rate and highlighted the impact a lack of administrative staff can have and the implications outside of the organisation e.g. discharge letters. DB asked if the Trust is on top of this or is there a delay in letters being sent out. AH explained that some letters are automated via Lorenzo but assured the Board that he was not concerned about reporting and letters and if there is an issue this would be highlighted at F&P.
- SH explained that work is ongoing in relation to providing more support to administrative and support colleagues to ensure they have the opportunity for career development and progression.

TB1 4/11/3 **FINANCIAL AND OPEATIONAL GOVERNANCE**

TB1 4/11/3.1 **Trust Strategy 2022/26**

SH presented the report which asked the Board to approve the Trust Strategy 2022-26 for publication and wider engagement internally and externally.

SH extended her thanks to K Humphrey, Associate Director of Strategy, and other colleagues for completing the strategy which will allow the Trust to enter an annual planning phase with a clear 5 year ambition.

Discussion

- The Board discussed the importance of exercising pragmatism to support staff to work towards this strategy.
- PK noted that 31 pages was slightly too long and asked if a more digestible version was due to be published.
- The Board further discussed what other items of work are called so as not to confuse ‘strategies’ and ‘plans’ and to create a consistent approach to work that sits underneath the Trust Strategy. SH noted that in relation to some items of wok the regulators dictate the sort of document required e.g. Equality, Diversity and Inclusion Strategy is required.

TB1 4/11/3.2 **Corporate Priorities 2021/22 and quarterly review**

LT presented the report which asked the Board to note the progress and updates against the corporate objectives agreed in May.

Discussion:

- PK suggested that some of the numbers in the report need to be checked. AH agreed that this had been picked up and there is a need to standardise some of the data in the report.

The report was noted.

TB1 4/11/4 **QUALITY AND RISK**

TB1 4/11/4.1 **Board Assurance Framework and Corporate Risk Register**

FMc presented the report providing an update on the newly revised Board Assurance Framework (BAF) . The following key points were noted:

- The BAF has been completely revised to align to the recently approved Trust Strategy and Strategic Objectives of Population, People and Partnerships. The format has been amended to strengthen the presentation and alignment of corporate risks to the corporate priorities, making the link more explicit.
- This is a live document and the Board Committees have reviewed and pulled out some key points for revision. There is some further alignment to do as risks have been mapped across to fit into the strategic objectives and this will be done in the next round of updates to the Committees. .
- In terms of risks it has been acknowledged that risks around workforce require further review and this will be picked up with MW.
- There will be a Board seminar to consider strategic risks and risk appetite.
- In relation to the Corporate Risk Register (CRR) there were points made on updating this to focus on current actions and mitigations and FMc will work with the risk team on this.

Discussion

- NM thanked FMc for her work in updating the BAF and noted that the Board Committees had discussed and analysed the new report in detail.
- AH referred to risk 6905 in relation to potential striking action by nurses. He noted this risk could potentially relate to all staff across winter and he has picked this up with JD.
- EJ noted that further to a presentation from Stroke services at CGC there should be further reflection to revisit risks relating to stroke in light of these conversations. **ACTION: AH/FMc**

AH/ FMc

TB1 4/11/4.2 **Patient Experience Report**

JD presented the report which provided the Board with of activity for Q1 2021/22 in relation to complaints and the opportunities for learning and service change.

- New National Complaint Standards have been published by the Ombudsmen and will be rolled out across the NHS in 2022. The Trust will be early adopters of this programme and are currently in a self-assessment stage.
- Complaint response times were challenging in Q1 with a slight decrease in response times reflected in the report.
- Generally, the same themes from complaints and concerns have been highlighted, the main theme being attitude of medical staff.
- A positive report from the Patient Experience Platform (PEP Health) have recently published their latest findings which places the Trust in the Top 5 non-specialist acute Trusts in the country.

- It is important to note that the Trust's Head of Patient Experience, Kat Glaister, is leaving the Trust. JD extended her thanks to Kat who has been a great asset to the patient experience team.

Discussion

- The Board discussed the compliant response times and SH noted that there is an increased focus on improving timeliness of complaint responses. There is a balance to be struck between ensuring timely responses and providing a full and appropriate response. There is a lot of work that does go into complaint responses and ensuring divisional teams, PALS and SH are all satisfied with the response prior to sending out.
- EJ noted that CGC had a discussion regarding the timeliness of complaint responses and there will be a continued focus on this over time. DB noted that as this is now a negotiated timescale with the patient it is even more important to get it right. FMc noted that this is incorporated into the Improving Together work.
- The position of Head of Patient Experience was discussed and JD confirmed that there has been a positive response to the job advert and there has been internal and external interest.

TB1 4/11/4.3 **Learning from Deaths Report**

PC presented the report which provided assurance to the Board that the Trust is learning from deaths and making improvements where possible.

- HSMR has become statistically significantly higher than expected for the last 4 rolling 12 month periods. If COVID activity is removed from HSMR then it remains within the expected range.
- The lack of external data experienced over the last few months has been rectified and this is included in IPR.
- PC noted that this data is Q1 and it is felt this is too retrospective. PC has asked the new Head of Clinical Effectiveness to bring two reports together so the report will only be one quarter in arrears.

Discussion:

- PM asked if it is possible to get down to speciality level in the report to get greater detail in terms of outcomes. PC explained that there are regulatory requirements in relation to the report format. However, as part of Improving Together the Trust is focusing on mortality as a metric of safety within the organisation and how people experience death and dying, which includes not just the patient but relatives too.
  In terms of outcomes for patients, as part of the Trust Strategy and organisation has agreed a strategic ambition to impact on the health of the population and therefore it will be increasingly important to measure outcome.
- The Board discussed the impact of COVID on mortality and PC reiterated that because there were different waves of COVID which did not affect everyone at the same time in the same

place, the Trust will look like an outlier compared to other organisations in other areas.

- DB noted that the report provided assurance that mortality is within the expected range and there are comparisons that can be made regionally. DB noted that the Board should not lose sight of how important mortality is as a metric and welcomed further work in terms of patient outcomes.
- TB reflected that structured judgement reviews were introduced in 2017 to review deaths in hospitals prior to medical examiners being in place. TB asked if the medical examiners now undertake that role. PC confirmed that the medical examiners are now involved in that screening process. TB noted that there are a number of people undertaking this role and asked if the Trust is content with this process and that the appropriate cases are being reviewed. PC assured the Board that there is a national training process for medical examiners.
- TB suggested that the explanation in relation to mortality during COVID should be included in the report to provide transparency and context.

TB1 4/11/5 PEOPLE AND CULTURE

TB1 4/11/5.1 Medical Revalidation and Appraisal Annual Report to include Statement of Compliance

PC presented the report which asked to approve the annual Board Report for Medical Appraisals and Revalidation and support the completion of the Statement of Compliance to NHS England. PC highlighted the following key points:

- The Trust is required to provide assurance to NHS England that there is a robust and sufficiently resourced system to ensure the provision of safe and effective care by the medical workforce. Therefore the report asks the Board to approve the annual report and Statement of Compliance for submission.
- It is important to note that whilst in 2020/21 it was not mandatory for clinicians to have appraisals the Trust has processes to ensure the appraisal and revalidation for the doctors it employs and there are adequate policies and procedures for the management of concerns raised about doctors.
- Areas for development for 2021/22 are included in the report.

Discussion:

- EJ referred to the Paterson Report and asked how, with the pause of revalidation during COVID, the Trust is ensuring its medical workforce are properly supported and fit for purpose. PC explained that appraisal and revalidation is only one method of employee/ employer feedback. It is understood that the appraisal process is flawed and there needs to be a focus on trying to get people to understand importance of governance and feedback.
- MW noted that in her new role as CPO she is satisfied with the report from workforce perspective.

Decision:

- The Board approved the report for submission to NHS England.

TB1 4/11/6 **GOVERNANCE**

TB1 4/11/6.1 **Board Effectiveness Internal Well-Led Review**

KN presented the report which asked to note the process and consider the outcome for the annual review of Board Effectiveness in relation to the CQC Well-Led Framework. The Board is also asked to discuss any areas of development to focus on prior to the external CQC Well Led Assessment scheduled for Summer 2022. The following key points were noted:

- The Board were due to undertake an external well led assessment but this was deferred to 2022 so the Board were asked to complete a self-assessment of 46 statements based on the CQC Well Led framework.
- The outcome of this is summarised in the report and you can see responses in Appendix A and B with the themes from the report highlighted in section 5.1.
- The Board is asked to consider any areas of development to focus on, identify if the concerns are already being addressed as part of established work streams and agree any specific actions prior to the external CQC Well Led scheduled for summer 2022.

Discussion:

- SH noted that there are definitely areas to pay attention to as a result of the assessment. It was agreed that more time was needed to go through the assessment and have a further discussion about Board Effectiveness from a well-led perspective but also about the Board's role in light of the emerging context in relation to system working. (*post meeting note: Board seminar scheduled for February 2022 to discuss)*
- Members of the Board fed back that they did find the questionnaire fairly time consuming and difficult to complete. It was also pointed out that there are limitations to the data but the qualitative comments are useful to analyse.

TB1 4/11/6.2 **Annual Report 2020/21**

FMc presented the Annual Report which was to note. The document was laid before parliament in September 2021 and was available to the public on the Trust website.

The report was noted.

TB1 4/11/6.3 **Register of Seals**

FMc presented the report which asked the Board to note the entries to the Trust's Register of Seals since the last report in July 2021.

It was noted that none of the signatories who witnesses the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

The report was noted.

TB1 4/11/7 **CLOSING BUSINESS**

TB1 4/11/7.1 **Agreement of Principle Actions and Items for Escalation**

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

Additional work to do that supporting operational work and we need to make sure we have a plan that addresses some of the issues. Productivity of staff and will be a significant challenge.

Actions are balance providing what is required for patients and population and also setting organisation from population in the strongest position possible.

TB1 4/11/7.2 **Any Other Business**

AH reported that the Trust declared a major incident on Sunday 31st October as a response to the railway collision that took place in Salisbury.

AH further noted that from an annual assurance perspective the Trust's Emergency Preparedness, Resilience and Response (EPRR) status had been confirmed as fully compliant. The ICS chief executive noted that the Trust's assessment was exemplary. Thanks were extended to the EPRR team and AH for their continued hard work.

TB1 4/11/7.3 **Public Questions**

There were no public questions.

TB1 4/11/7.4 **Date of Next Public Meeting**

Thursday 13th January 2022, Board Room, Salisbury NHS Foundation Trust

TB1 4/11/8 **RESOLUTION**

TB1 4/11/8.1 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 04/11/4.1 - Board Assurance Framework and Corporate Risk Register	03/02/2022	Andy Hyett, AH / Fiona McNeight, FMc	EJ noted that further to a presentation from Stroke services at CGC there should be further reflection to revisit risks relating to stroke in light of these conversations	Update included in BAF which will come to Board in Feb 2022.	Y	3

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	13 January 2022		

Report Title:	Chief Executive Officer 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):	Appendix 1a - Omicron operational letter Appendix 1b- Letter re Next steps for the NHS COVID-19 vaccine deployment Appendix 1c - reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic Appendix 1d – Operational planning Guidance			

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 Board of Directors needs to be aware of. This report covers the period since the last public board meeting on the 4th November 2021.

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. National and ICS Updates

It has been an exceptionally busy period dominated by the requirement the NHS had to increase the pandemic incident response back to Level 4 because of the COVID Omicron variant and the potential to overwhelm NHS services.
I am able to assure the board that from an organisational perspective we have stepped back up the internal incident response structures and are supporting the BSW system response too. This inevitably detracts from our collective leadership capacity to prioritise other areas of less immediate work.
We have received multiple letters in relation to the change in incident status from NHSE/I and I attach 3 in the appendices (1a, 1b, 1c) covering operational readiness, vaccination and reducing the burden that I think it is relevant to share with Board colleagues.

The operational planning guidance was shared by NHS E/I on the 24th December 2021(Appendix 1d) which confirmed that whilst Integrated Care Systems are still expected to be operational by April 2022 the move to put them on a statutory footing will be delayed by 3 months to July 2022.

The planning guidance is comprehensive and I have asked Lisa Thomas to lead a conversation with the Board about the priorities for SFT in our private session on the 13th January 2022

The Board will be aware that the NHS is required to progress the work needed to support the COVID vaccination as a condition of deployment. The deadline for this April 1st 2022 which requires people to have received their first vaccination by February 3rd 2022. Our Chief People Officer is leading this work and will provide a verbal update to the Board in the private session.

2. Operational Context

At the time of writing this report the organisation is in our highest level of escalation OPEL 4 driven by staff absence, demand and an increased number of patients with No Criteria to reside in hospital.

The overall BSW system is in significant distress with the other 2 acute hospitals declaring internal critical incidents and the system declaring system level OPEL 4 during the first week of January 2022. There are a number of other systems and Trusts both within the South West region and across England in the same position.

The number of patients needing hospital care for COVID has remained stable albeit the modelling data demonstrates that the peak hospitalisation will be mid Jan – early Feb 2022. The community rates of COVID in Wiltshire have been increasing significantly over the last 2-3 weeks and as seen across England moving into the older and more vulnerable population over the last 7 days.

We have been asked to prepare plans for additional surge and in extremis capacity over and above our current escalation beds which the Chief Operating Officer is leading on our behalf.

We have taken the difficult decision to restrict visiting in line with the national guidance which I recognise is really hard for families, friends and loved ones. We will keep this under constant review and lift the restrictions when the community rates of COVID reduce and we have past the peak of the expected hospital admissions.

The vaccination team at City Hall have done an incredible job and delivered on the ask to get boosters to a minimum of 80% of the population. I am very grateful to everyone involved and thankful to our local communities who have taken up this offer.

I know the Board will want to join me in paying tribute to all of our staff at SFT. Staff have worked incredibly hard to respond with adjustments being made to facilitate better patient flow and discharge given the context.

Managing staff shortages continues to be an area of focus for all teams and work has been done to commence our volunteer ward buddy programme from the 7th January 2022. Staff wellbeing is an ever present concern and actions have been taken to support staff during this difficult period. Despite this I am aware that some of our colleagues are finding the continued pressures and challenges stressful and distressing.

3. Finance

We finalised and submitted both our BSW system and Trust level operating plans for the second half of the financial year in November, in both cases meeting the requirement to deliver a financially balanced outturn. Our funding will remain predominantly as block contracts for this period, supplemented by national funding streams designed to support in delivering the core operational objectives of stabilising waiting lists and managing winter pressures.

Initial planning assumptions were prior to the emergence of the Omicron variant, and the costs of covering increased staff absence through sickness and isolation are already beginning to rise. Plans are being put in place to meet these challenges and we remain confident we that we have sufficient controls and processes continue to live within our financial means.

4. Workforce

The details of the key performance indicators are provided within the Trust Board Integrated Performance with any material escalations to Board coming via the OD and People Board sub-committee.

I would like to recognise the work of colleagues who have been supporting targeted recruitment drives in key areas which have resulted in the following:

- Maternity HCA's with 10 offers
- Facilities event with 16 offers.
- HCA event with 11 offers.
- In addition, a Locum Respiratory Consultant post has been offered and 9 International nurses arrived in month.

5.

Christmas and New Year
Once again Christmas activity in the hospital was limited with official and informal events and activities curtailed. However with support from The Stars Appeal Christmas trees and lights were installed across the site and additional Christmas music was made available to lift staff and patients spirits.

And finally, in very different ways two recent launches have clearly summed up the commitment and self-sacrifice of Salisbury Hospital staff over the past few years.

Firstly, the innovative poetry collection *My Name is Mercy,* based on the experiences of staff here at the hospital has been published. It is a collection of new poems based on the experiences of Salisbury staff during the pandemic – exploring how it felt to work here rather than simply what was done. It is a great testament to everything we have all been through together during the pandemic. The work has been incredibly well received and attracted large

amounts of broadcast and print media attention - it's now available locally at the League of Friends shop and in the Cathedral Shop. (this was funded by League of Friends and The Stars Appeal)

Secondly, the Discovery + documentary that examines the Novichok poisonings was released on Boxing Day and features colleagues explaining some of the details about how the hospital responded to these extraordinary series of events.

Both the poetry collection and the documentary clearly demonstrate the incredible work undertaken here at Salisbury and should make us all very proud of what we do.

To:
- Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
- GP practices and PCNs
- Providers of community health services
- NHS111 providers
- PCN-led local vaccination sites
- Vaccinations centres
- Community pharmacy vaccination sites
- ICS and STP leads

cc.
- NHS regional directors
- NHS regional directors of commissioning
- Regional incident directors
- Regional heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of public health

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

13 December 2021

Dear Colleagues,

Preparing the NHS for the potential impact of the Omicron variant and other winter pressures

Thank you for everything you and your teams have done since the COVID-19 pandemic began to treat those with the virus, including over half a million people who have needed specialist hospital care, as well as delivering the largest and fastest vaccination programme in our history. This is while maintaining urgent non-COVID-19 services and now working to recover the backlogs that have inevitably built up, providing around 90% of pre-pandemic levels of activity this year, despite continuing to care for thousands of hospital inpatients with COVID-19 over that period.

The discovery of the Omicron variant once again requires an extraordinary response from the NHS. Last night, the Prime Minister announced the new vaccination challenge which will see the NHS deliver more vaccines over the coming weeks than ever before, and will require us to prioritise activities to deliver this.

However, even with the additional protection that vaccine boosters will give, the threat from Omicron remains serious. The UK chief medical officers on 12 December increased their assessment of the COVID-19 threat level to 4, and advice from SAGE is that the number of people requiring specialist hospital and community care could be significant over the coming period.

In light of this, we are again **declaring a Level 4 National Incident**, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in COVID-19 cases.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to prepare for and respond to the Omicron threat.

These will:

- Ensure the successful ramp up of the vital COVID-19 vaccine programme.
- Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation.
- Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes.
- Support patient safety in urgent care pathways across all services and manage elective care.
- Support staff, and maximise their availability.
- Ensure surge plans and processes are ready to be implemented if needed.

1. Ensure the successful ramp-up of the vital COVID-19 vaccine programme

You will be aware of the Prime Minister's announcement yesterday outlining the latest situation with regards to the Omicron and other variants. The Prime Minister launched an urgent national appeal calling for people to get vaccinated and set out the commitment that all adults in England would be offered a booster jab by the end of the year.

In just over a year since the vaccination programme was launched, more than 100 million jabs have been given. In their December update, the UKHSA estimated that, as of 24 September, 127,500 deaths and 24,144,000 infections had been prevented as a result of the COVID-19 vaccination programme. This is a remarkable achievement, but the urgency of this new national mission requires the NHS to once again step up to support an immediate, all out drive to protect the health of the nation.

A separate letter will set out the immediate next steps for the vaccination programme, describing the ask of systems including:

- Clinically prioritising services in primary care and across the NHS to free up maximum capacity to support the COVID-19 vaccination programme over the next few weeks, alongside delivering urgent or emergency care and other priority services. As the Prime Minister said, this means some other appointments will need to be postponed.

- Delivering at scale whilst also retaining the focus on vaccination of those at greatest risk, including those who are housebound. Continuing to maximise uptake of first and second doses including through identifying dedicated resources to work alongside directors of public health locally.

- Creating capacity, both by maximising throughput, efficiency and opening times of existing sites to operate 12 hours per day as standard, seven days per week as well as running 24 hours where relevant for the local community, and through opening additional pop-up and new sites.

- Increasing training capacity with immediate effect to support lead employers with rapid onboarding and deployment of new vaccinators.

The letter also describes support available including a removal of the current cap on spend against the budget for programme costs, additional vaccine supply and significant expansion of volunteering and recruitment activity.

The NHS has been clear that staff should get the life-saving COVID-19 vaccination – and that is even more important now – to protect themselves their loved ones and their patients, and the overwhelming majority have already done so.

Working with NHS organisations, we will continue to support staff who have not yet received the vaccine to take up the evergreen offer of COVID-19 vaccination. NHS England has released resources on how to help engage and communicate with staff to encourage vaccine uptake within your organisations. We also recommend that CQC regulated services review the new Planning and Preparation guidance which will help organisations prepare for when the regulations (which are subject to parliamentary passage) are introduced.

Flu can be a serious illness for some people and the flu vaccine provides vital extra protection as well as minimising transmission. NHS staff should take every opportunity to encourage patients, including pregnant women, to receive their COVID-19 and flu

vaccines if they are eligible. Healthcare colleagues are asked to make every contact count this winter with pregnant women – and those planning pregnancy – to advise them of the benefits of COVID-19 and flu vaccination.

2. Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation

Having discovered the efficacy of dexamethasone as a treatment for COVID-19 and begun rolling it out just hours after trial results were announced, saving thousands of lives both here and across the world, the NHS is again at the forefront of new treatments for COVID-19.

The UK was the first country in the world to approve an antiviral (monupiravir) able to be taken at home. It will be available for use by patients at highest risk in the community from 16 December alongside other treatments including monoclonal antibodies. Arrangements for deployment of these treatments was set out in a letter on 9 December alongside the UK policy for use.

Local ICS teams should finalise preparations for COVID-19 Medicine Delivery Unit service implementation, working with regions on final assurance of delivery models.

Separately, the Government also announced the PANORAMIC national study for oral antivirals treatment for at-risk patients. The study will allow medical experts to gather further data on the potential benefits of oral antivirals for the UK's predominately vaccinated population. General practices can refer patients into this study as per the GP and community pharmacy letter.

3. Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes

The operational imperative is to create the maximum possible capacity within acute care settings to support patient safety in the urgent care pathway, which is currently under significant pressure as the data on ambulance response times and 12 hour waits in A&E shows, to maintain priority access for elective care, particularly P1, P2 and cancer assessment, diagnostics and treatment, and to create capacity to respond to a potential increase in COVID-19 demand.

To that end, you are asked now to work together with local authorities, and partners across your local system including hospices and care homes to release the maximum number of beds (and a minimum of at least half of current delayed discharges) through:

A) An immediate focus to support people to be home for Christmas. Throughout the period between Christmas and New Year, ensure there is support in place to discharge medically fit patients across all seven days of the week.

B) Those patients who do not need an NHS bed, because they do not meet the reasons to reside criteria, must be discharged as soon as practically possible. Working with local authorities, every system will need to put in place sufficient measures in order to reduce by half their own number of patients not meeting the reasons-to-reside criteria. This will necessitate senior system leaders across the NHS and local authorities meeting daily to ensure sufficient progress is made.

C) A significant proportion of discharge delays are within the gift of hospitals to solve. Hospitals should work to eliminate avoidable delays on pathway zero, ie straight home without the need for social care support. Where necessary, this could include using personal health budgets, which has been successfully piloted in Cornwall and Lancashire; or use of hotel beds.

D) Making full use of non-acute beds in the local health and care system. NHS England has today switched back on the full use of spare hospice capacity – both beds and community contacts, through the same national arrangement with Hospice UK that was in place earlier in the year. As well as making use of personal health budgets, hotel beds, and hospices, systems can also make use of independent sector capacity in the community using the following framework. We encourage systems to explore surging community rehabilitation capacity and securing spare capacity from care homes. To support safe discharge of COVID-19 patients, DHSC will be expanding the number of designated beds from CQC accredited providers.

E) Expanding the use of virtual wards and hospital at home models with the full confidence of knowing these models will be supported in forthcoming planning guidance with significant additional funding, to enable a major expansion over the next two years.

Systems already have access to resources within core funding, COVID-19 allocations and through the Hospital Discharge Programme to fund these measures. Where systems can show further funding is necessary in addition to existing budgets then, to facilitate this drive, NHS England will fund additional costs incurred. Commissioners and providers

should notify regional teams of the estimated additional cost and bed benefit as plans are firmed up and claim the actual cost through the existing quarterly claims process.

The NHS will need to increase its effective capacity next year and we are planning on ring-fencing significant national funding for the further development of virtual wards (including hospital at home). Therefore, where steps taken now on virtual wards can have an enduring benefit to overall capacity and have recurrent costs those should be notified at the same time so that we can allow for them on top of core system allocations for 2022/23.

To facilitate this drive, and maintain it thereafter through winter and into next year:

- the Government has announced a further additional £300 million support for domiciliary care workforce, to boost capacity, on top of the existing £162 million workforce scheme.

- A new national discharge taskforce including the NHS, ADASS, national and local government, led by Sarah-Jane Marsh, has been established. Working to both DHSC and NHS England, it will focus on the local authority and NHS actions required to drive progress. This will dock with enhanced regional and local system arrangements that need to be put in place.

4. Support patient safety in urgent care pathways across all services, and manage elective care

Ambulance response: Systems must focus on eliminating ambulance handover delays in order to ensure vehicles and paramedic crews are available to respond to urgent 999 calls as set out in the letter of 26 October, and take action to see patients quickly and avoid 12 hour waits in emergency departments. Working with health, social care, voluntary sector partners and CQC, systems should take a balanced view of risk and safety across all parts of the health system, recognising that the greatest risk may be the patient waiting for an ambulance response.

Prioritising the recruitment of 999 and 111 call handling capacity will be crucial to ensure patients have rapid access into urgent and emergency care services when required. It is therefore important that Regions work closely with Ambulance Trusts and 111 providers to monitor progress on a weekly basis.

Community crisis response: Local systems should take immediate steps to maximise referrals from 999 to the two-hour Urgent Community Response services**.** Good progress has been made in developing and rolling out UCR services across England faster than

planned trajectories, with 27 ICSs now providing UCR services 8-8pm seven days a week.

Further expansion and join-up with other services is needed now, as part of a wider drive to reduce ambulance response times and support people in their own homes. Systems should:

- Where possible, accelerate coverage and capacity of UCR services in line with the 2 hour guidance, to make an impact in January. This includes supporting equipment purchases such as lifting chairs and point of care testing equipment.
- Maximise the number of patients being referred and transferred to UCR from ambulance services.
- Work together with local councils and providers of local pendant alarm/Technology Enabled Care (TEC) providers and reduce the demand on 999 ambulance services through the re-direction of appropriate patients.
- Refresh your local Directory of Services (DoS) so that NHS Service Finder profiles are accurate, up to date and are updated to show that UCR teams will accept referrals from health & social care colleagues including TEC providers.
- Ensure accurate and complete data to via the Community Services Data Set for UCR, so you can track how much the services are being used and helping reduce pressures.

Further information, webinar recordings and tools, such as legal advice, information governance documents and case studies, are available on the Urgent Community Response FutureNHS platform.

Mental health, learning disability and autism: The pandemic has had an impact on the nation's mental health, disrupting daily routines. In response, the NHS has extended mental health support, including introducing 24/7 all-age mental health crisis support lines earlier than planned, and continued to expand services to meet growing need in line with the Long-Term Plan.

Systems are asked to ensure that access to community-based mental health services and learning disability and autism services are retained throughout the COVID-19 surge to ensure that people at risk of escalating mental health problems and those who are most vulnerable can access treatment and care and avoid escalation to crisis point, with face-to-face care retained as far as possible.

Healthcare colleagues are asked to make every contact count this winter with people with SMI and LD – to ensure promotion of health checks and interventions as well as

access to COVID-19 and flu vaccination, in the context of stark health inequalities for these patients.

Managing critical care: Over the course of the pandemic, the NHS showed its determination and flexibility time and time again, not least in rapidly expanding critical care capacity. Indeed, the Health and Social Care Select Committee wrote in their recent report on lessons learned to date that it was ‘a remarkable achievement for the NHS to expand ventilator and intensive care capacity’.

We do not know what the demand from Omicron will be on critical care facilities, but it is essential that trusts familiarise themselves with existing plans for managing a surge in patients being admitted with COVID-19, with particular focus on the management of oxygen supplies, including optimising use at ward level. This work should also include a review of how critical care capacity can be expanded and of surge arrangements in critical care networks – acknowledging these will already have been activated in some parts of the country. Further guidance on surge planning will be published based on good practice from the early phases of the pandemic.

Managing elective care: As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – continue to be prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential.

There are now 6 million patients waiting for elective care, of whom 16 thousand have been waiting over 104 weeks, as a result of the inevitable disruption caused by the COVID-19 pandemic. It is therefore even more important that diagnostic, first outpatient, elective inpatient and day case capacity should be maintained as far as possible, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. Systems and NHS trusts should work collaboratively, particularly using the provider collaborative arrangements you have in place to prepare elective contingency plans against different COVID-19 scenarios for discussion and agreement with Regions.

A key feature of plans should be the separation of elective and non-elective capacity where possible, and the use of mutual aid between trusts and across systems and regions where necessary to maintain access to urgent elective care. You should maintain your focus on eliminating waits longer than two years, as set out in H2 planning guidance as far as possible.

Independent sector (IS): Local systems need to significantly step up use of available capacity in the independent sector to help maintain services. IS capacity should be one of the main protected 'green' pathways for treating elective patients during the final quarter of this year. Systems should take action now to agree plans with your local IS providers, building on existing H2 plans, to maximise use of local IS capacity so that as many patients can be treated as possible through the IS route. This should include, where clinically appropriate, additional pathways including cancer.

Any work will be funded consistent with original H2 planning guidance.

Primary care: The vaccination ramp up is the current priority for primary care, supported by the additional funding already announced and changes to GP contract arrangements. Continued access to general practice remains essential for those who need care and the £250 million Winter Access Fund remains available through systems to support general practice capacity more generally, including through the use of locums and support from other health professionals.

Cancer: local systems should stress test their plans to confirm that the elements that helped to sustain cancer services in previous waves are in place, and to ensure that:

- rapid access, including tests and checks for patients with suspected cancer, as well as screening services, are maintained
- provision for P1 and P2 cancer surgery is prioritised
- cancer surgical hubs have been established with cancer surgery consolidated on COVID-19-protected sites, and that centralised triage is in place across local systems to prioritise patients based on clinical need
- arrangements are in place to centralise high volume or high complexity work such as upper GI or head and neck surgery
- local systems have adapted cancer pathways in line with the advice on streamlining cancer diagnostic pathways and keeping them COVID-19-protected
- local systems are maximising the use they make of IS capacity for cancer services, where clinically appropriate
- effective communications with patients and safety netting is in place, and patients are involved in decisions around their care, including when they chose to reschedule
- anyone with concerning symptoms is encouraged to come forward, in line with our 'Help us, Help You' messages.

5. Support staff, and maximise their availability

The experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and its of vital importance that we collectively support them over the months ahead.

Support for staff to stay well and at work: We also ask you to revisit your staff wellbeing offer to ensure it has kept pace with the changing nature of the pandemic, with a continued focus on ongoing health and wellbeing conversations taking place for staff. Health and wellbeing conversations are the best route for exploring the many drivers and root causes of sickness absence and for offering individualised support to staff where it is needed, including with work pressures, worries and relationships.

Employers should be ready to communicate any changes in testing and isolation guidance associated with Omicron as we learn more, as these may well evolve, and to offer staff options wherever possible to continue to contribute when they are unable to come into work, if they are able to do so. In addition, organisations should consider contingency options for significant staff absences to ensure essential services can be maintained.

The pandemic has had a disproportionate impact on our staff from ethnic minority communities. It is therefore vital that as we prepare for this next phase, we take action to address systemic inequality that is experienced by some of our staff including by allowing staff network leads the dedicated time they need to carry out this role effectively. We will continue to collect and publish data on the experiences of our ethnic minority colleagues via the Workforce Race Equality Standard (WRES).

Mental health and wellbeing support: We have strengthened the mental health support offer for health and social care staff to ensure they can get rapid access to assessment and evidence-based mental health services and support as required.

This includes your own occupational health services as well as the 40 local staff mental health and wellbeing hubs across the country which provide proactive outreach and clinical assessment, and access to evidence-based mental health services and support where needed.

Please continue to promote the mental health hubs and the confidential helplines that are available for all staff, and in particular the bereavement helpline (0300 303 4434, 8am-8pm) to support staff who may have been affected by the death of patients and colleagues.

Workforce planning, flexibility and training: System leaders and NHS organisations should review workforce plans for the next three months to ensure that, as per your surge plan testing, you have the appropriate workforce in place to deal with an increase in the number of COVID-19 patients and are able to support the ramp up of the COVID-19 vaccination programme. Organisations should continue to use their staff flexibly to manage the most urgent priorities, working across systems as appropriate.

Where staff require particular support or training to enable their potential redeployment, including for vaccination or to support critical care services, please use the next few weeks to provide this.

Recruitment: Trusts should seek to accelerate recruitment plans where possible, including for healthcare support workers, and where possible bringing forward the arrival of internationally recruited nurses, ensuring they are well supported as they start work in the NHS.

Volunteers: Volunteers play an important part in supporting patients, carers and staff over winter months. In particular, there are a number of high-impact volunteer roles which free up clinical time for clinical tasks, improve communication with families and assist with discharge, and support staff wellbeing. Although volunteers have been active in many NHS trusts, many more experienced volunteers are willing to help yet remain inactive. Trusts are encouraged to take advantage of the available support to restore volunteering and strengthen volunteer management in ways which can contribute significantly to reducing service pressures, including NHS Reserves.

6. Ensure surge plans and processes are ready to be implemented if needed

Incident Co-ordination: In light of the move to a Level 4 national incident, systems and NHS organisations will need to review incident coordination centre arrangements, and should ensure that these are now stood up, including to receive communication and act as the single point of contact.

Surge Plans: As we have done previously, we are asking all systems and NHS organisations to review and test their incident management and surge plans to assess their number of beds (G&A, community and critical care), supplies and staffing, learning the lessons from previous waves of COVID-19, and making preparations to have the capacity in place to meet a potentially similar challenge this winter.

Systems should ensure that preparedness includes making plans to deliver the services needed to vulnerable groups within systems as well as maintaining essential services in primary, community, mental health and learning disability and autism services.

To support regional and national planning, we will ask you to submit your identified maximum capacity, including your plans for critical care capacity, by 17 December.

These plans should detail the incident coordination arrangements, including leadership roles and responsibilities, hours of operation of the incident coordination centre, including out-of-hours contact arrangements. The plans should also detail how organisations will deal with timely information/SitRep reporting.

We will keep under review the timing and scope of the regular sitrep returns and we ask for your cooperation in continuing to make timely returns as requested.

Supplies: As a result of the work undertaken over the past 18 months, nationally held stock levels are more than adequate to respond to any additional increases in demand caused by a new variant. You should maintain normal ordering patterns and behaviours. In advance of the Christmas period, you may wish to review your local current stock levels particularly oxygen supplies, medical equipment and relevant consumables and it is key that you connect into the regional incident arrangements as and when needed.

Oxygen: In addition, through the testing of your surge plans, trusts must ensure that their oxygen delivery systems and infrastructure are able to bear at least the same level of demand when COVID-19 inpatients were at their highest point, and that any improvements or adaptations identified as necessary have been put in place.

Infection prevention and control: Staff and organisations should continue to follow the recommendations in the UK Infection Prevention and Control (IPC) guidance. According to research, IPC measures prevented 760 in-hospital COVID-19 infections each day in wave 1. Organisations must ensure that application of IPC practices is monitored using the IPC Board Assurance Framework and that resources are in place to implement and measure adherence to good IPC practice.

The past two years have arguably been the most challenging in the history of the NHS, but staff across the NHS have stepped up time and time again to do the very best for the nation – expanding and flexing services to meet the changing demands of the pandemic; introducing new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without; pulling out all the stops to recover services that have been disrupted, whilst rolling out the largest and fastest vaccination programme in our history. The Omicron variant presents a new and significant threat, and the NHS must once again rise to the national mission to protect as many people as possible through the vaccination programme whilst also now taking steps to prepare for and respond to this threat.

Thank you for everything you have done and continue to do – as we have said before, this is a time when the NHS will benefit from pulling together again in a nationally co-ordinated effort, but please be assured that within the national framework you have our backing to do the right thing in your particular circumstances.

We look forward to speaking to you at the virtual regional events later this week and will keep in regular contact over the coming weeks and months.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Professor Stephen Powis
Chief Executive of NHS Improvement

To:
- ICS and STP leads

cc.
- CCG accountable officers
- PCN-led local vaccination sites
- Community pharmacy-led LVS
- All NHS trust and foundation trust chief executives
- NHS regional directors
- NHS regional directors of commissioning
- All directors of public health
- All local government chief executives
- All GP practices

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

13 December 2021

Dear Colleagues,

National call: Next steps for the NHS COVID-19 vaccine deployment

You will have seen the Prime Minister's address to the nation last night on the latest situation with regards to the Omicron and other variants. Yesterday, the chief medical officers also recommended that the alert level is raised from three to four.

We are writing to you now to ask you once again to support an immediate, all out drive to protect the health of the nation.

Immediate next steps for deployment

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December. To respond to this national mission, all systems are now asked to work with system partners, including local authorities, other public sector organisations and the voluntary and community sector, to prioritise delivery.

All NHS and local government organisations need to prepare to redeploy their administrative and clinical staff to support delivery of the vaccination programme between now and the new year. CCGs, should do all they can to offer immediate additional administrative support to all PCN and CP sites, to support the organisation and delivery of community outreach vaccination through the use of mobile and pop up clinics.

All General practice teams (not just LVS sites) are now asked to clinically prioritise your services to free up maximum capacity to support the COVID-19 vaccination programme alongside delivering urgent or emergency care and other critical services such as cancer. That could include pausing routine and non-urgent care and redeploying staff to support delivery of COVID-19 vaccinations. Further guidance will follow in an operational note and from RCGP and BMA. **All community pharmacy sites** will be supported to extend their opening hours and ensure they can deliver at their maximum capacity. Further detail will follow in an operational note. **All NHS trusts, including secondary, community and mental health providers**, will need to make alternative arrangements for prescription and sick note requests that are usually sent to primary care. As the Prime Minister said last night, this means that some other appointments will need to be postponed to the new year. If we don't do this now, the wave of Omicron could be so big that cancellations and disruptions would be even greater. We will work with you to ensure consistent messaging to the public to reflect this.

To support the rollout, the Care Quality Commission has confirmed it will postpone on-site inspections in mainstream NHS services for three weeks (ie hospitals, ambulances, GPs, 111), **except** in cases where we have reason to believe serious failings in safety pose a risk to life, or serious harm.

Prioritisation of vaccination

Scientists are very concerned about the spread of Omicron due to the speed with which it spreads and because two doses do not appear to provide much protection, threatening a new wave of infections, hospitalisations and deaths greater even than those seen in previous waves. Thankfully, a booster dramatically improves protection which is why we need to do all in our power to deliver top up jabs and reduce the impact of Omicron.

The JCVI are clear that those at greatest risk must be prioritised, including those residing and working in care homes, health and care staff, those who are housebound, and those severely immunosuppressed.

As the NHS opens bookings to all adults over 18 for a booster by Wednesday 15 December, all systems are asked to ensure that they are both able to deliver at scale and retain their focus on reaching the most vulnerable and ensuring access for all communities. Therefore, all systems are asked to ensure GP-led and community pharmacy-led teams are supported to complete care home and housebound vaccination as soon as possible, preferably by the end of week commencing 13 December as previously advised.

Now is the time to pull out all of the stops to ensure maximum uptake, including first and second doses. Every system, working with their directors of public health and local authority leads, should continue to offer mobile and pop up clinics, community engagement and to support access (eg providing community transport). To do this, all systems are now asked to identify dedicated resource (vaccine, vaccinators and any further resource) work side by side with directors of public health to reach those still yet to have a first or second dose. Funding is available to support this through ICSs, and requests will be processed speedily.

Creating capacity

The immediate priority for all sites is to stand up additional capacity to support this major acceleration. This will need to include maximising throughput and efficiency at existing sites, opening additional pods and extending opening times. Sites should request resources to enable them to operate 12 hours a day as standard, seven days a week. In every community there should be slots available at least 16 hours a day. This should extend to 24 hour operations where relevant for the local community. In earlier phases this was particularly helpful for those working shifts.

Do Not Attend rates are currently running nationally at around 10 per cent so all sites are now asked to review their DNA rates and adjust capacity uploaded to the National Booking Service accordingly. From today, the NBS will automatically cancel appointments where an individual has already received a booster dose and we will continue to encourage the public to remember to cancel if they receive a vaccine at a walk in or at their local GP-led site.

All vaccination sites, including hospital hubs, should be utilising the national protocol as the default legal mechanism to deliver the vaccine programme as it gives the greatest opportunity to utilise the unregistered workforce and create additional vaccinating capacity.

As well as creating capacity for those aged 18 years and over, all systems must ensure that eligible children are able to access vaccination. Guidance for systems on vaccination for 12-15s, including delivery of second doses, will be issued shortly.

Workforce

Lead employers will continue to co-ordinate the workforce, and will now implement a push of workforce out to systems, rather than a traditional demand-led approach. Each lead employer will have up to three military personal deployed to further support co-

ordination and delivery. A full list of lead providers and their contact details are set out here on NHS Futures, and have been provided alongside the cascade of this letter.

All NHS providers need to be prepared to redeploy staff to support the vaccination effort. All NHS providers are now asked to share their workforce availability, and a dedicated point of contact, with their lead employer.

Systems will need to release additional workforce beyond those currently working on the vaccination programme. Wider public sector organisations, including local authorities, fire and rescue and police forces are also asked to identify and release any staff members who are trained vaccinators.

NHS Professionals and St John Ambulance continue to accelerate recruitment and re-engagement. Details of the workforce will be shared with lead employers as it becomes available including offers to support housebound and care home vaccination from St John Ambulance.

All national health bodies are working at pace to share expressions of interest from their employees with lead employers. The civil service has also started a push of people to register with St John Ambulance, NHS Professionals and the Royal Voluntary Service as appropriate.

To ensure we have a safe and competent workforce, additional training capacity will be required. Systems are therefore asked to increase their training capacity with immediate effect to support lead employers with rapid onboarding and deployment.

Vaccine supply, equipment and estates

There are no supply challenges with either the Moderna or Pfizer booster stocks and vaccine supply will be pushed manually from Tuesday to enable you to increase capacity as quickly as possible.

This approach will ensure more than 8.9m doses of Pfizer and Moderna will be available across the network (3.2m already on site; 2.1m in immform; 3.6m planned (minimum additional supply). For VCs and HHs, additional vaccine supply has now been made available on immform.

For PCN and CP-led LVS, regional teams have been asked to provide details for sites that require additional deliveries on Thursday and Friday this week. All sites expecting a delivery on Tuesday can expect their volume doubled, for some sites this will arrive on

Tuesday for others an additional delivery day will be allocated later this week. Further detail will be communicated in an operational note.

For unexpected levels of demand, for example for pop up and mobile clinics, mutual aid policies can be found here. These existing policies allow movement of sufficient vaccines between end users, in quantities sufficient to meet demand and permits movement under NHS England and NHS Improvement direction; NHS regions should therefore feel empowered in the current circumstances to direct supplies to those areas where they are required.

This guidance is there to support good professional decision making to ensure that patients are vaccinated safely and effectively as well as promptly and therefore, it is for pharmacy professionals at a local level to determine what's best to do. If you require additional vaccine supply, please follow the usual processes.

Local authorities are asked to identify opportunities to use existing estate to offer vaccination centres and mobile clinics, drawing on their knowledge and understanding of their local communities. As the school term comes to an end, schools and school halls should be considered.

We recognise that smaller sites are limited by estate, especially in the colder months. Therefore, if you require temporary buildings such as Portakabins, tents, outdoor weather-protective cover to support queues or extended estate, please flag your requirements as soon as possible to your SVOC.

Finance

Recognising this sprint into the New Year will require additional support, additional funding has been requested from HMT, and this framework allows for the current cap on spend against the budget for programme costs to be removed. This means programme resources can be sourced and deployed to support delivery with immediate effect.

The support of local authorities in delivering facilities and resources has been critical to success. To ensure local authorities can continue to support, funding can be made available to support enhancement of the vaccination programme. Where costs are agreed between the local authority and ICS, local authorities should invoice the lead CCG for their ICS system and continue to report costs incurred to the Department for Levelling Up, Housing and Communities to support appropriate accounting and analysis.

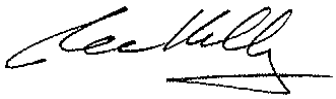
Further details including details on contracting, estates and consumables, will shortly be shared with regional directors of finance and directors of finance for local authorities.

Thank you in advance for everything you are doing to continue to deliver the vaccination programme.

Yours sincerely,

Amanda Pritchard
Chief Executive Officer
NHS England and NHS Improvement

Emily Lawson
NHS Senior Responsible Officer, Vaccine Deployment



Eleanor Kelly
LA CEO Advisor

Dr Nikita Kanani
Medical Director for Primary Care
NHS England and NHS Improvement

To:
- Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
- GP practices and PCNs
- Providers of community health services
- NHS 111 providers
- PCN-led local vaccination sites
- Vaccinations centres
- Community pharmacy vaccination sites
- ICS and STP leads

cc.
- NHS regional directors
- NHS regional directors of commissioning
- Regional incident directors
- Regional heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of public health

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

24 December 2021

Dear Colleague

Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic

Once again, the NHS is facing a significant challenge from COVID-19. As we continue to manage infections from the Delta variant, the Omicron variant is growing substantially and once again there is a risk of significant levels of COVID-19 hospitalisations with the challenges these place across the whole NHS. At the same time, the NHS is delivering a national COVID booster vaccination programme and continuing to provide essential non-COVID care.

This letter should be read in conjunction with 'Preparing the NHS for the potential impact of the Omicron variant and other winter pressures', which declared a Level 4 National Incident.

Following our letters in March and July last year and January, this letter updates our position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- streamlining oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focusing our improvement resources on COVID-19, vaccination, discharge, UEC and elective recovery priorities
- only maintaining development workstreams that support recovery and safety.

Our intention is that the measures here will collectively help you free up resource to address the priorities we have set out.

We will keep this under close review, making further changes where necessary to support you and remaining mindful of the balance between timely information and not flooding the service with requests. We will review and update the measures set out in this letter in Q1 2022/23.

Once again, we appreciate the incredible level of commitment and hard work from you and your teams that has helped the NHS rise to meet the challenge of COVID-19 since March 2020.

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

A) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers and focus agendas. No sanctions for technical quorum breaches (eg because of self-isolation). For board committee meetings, trusts should continue quality committees, but consider streamlining other committees. While under normal circumstances the public can attend at least part of provider board meetings, government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation. All system meetings to be virtual unless there is a specific business reason to meet face to face.	Organisations to inform audit firms where necessary
2.	FT governor meetings	Face-to-face meetings should be stopped wherever possible at the current time[1] – virtual meetings can be held for essential matters e.g. transaction decisions. FTs must ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19, eg via webinars/emails.	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary. Annual members' meetings should be deferred. Membership engagement should be limited to COVID-19 purposes.	FTs to inform lead governor
4.	Annual accounts and audit	Wherever possible the NHS England and NHS Improvement accounts team will reduce the administrative burden of year-end accounts as far as is possible, but the current intention is to stick with the published timetable. We will, as ever, remain responsive to challenges as they emerge.	Organisations to continue with year-end planning in light of updated guidance
5.	Quality accounts – preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. As in previous years, we intend to write to all providers concerning the requirements for 2021/22 Quality Accounts.	No action for organisations at the current time

[1] This may be a technical breach of foundation trusts' constitution but acceptable given government guidance on social isolation.

No.	Areas of activity	Detail	Actions
6.	Quality accounts and quality reports – assurance	We are removing requirements for FTs to include quality reports within their 2021/22 annual report and removing the need for assurance of quality reports and quality accounts from all trusts.	Organisations to inform external auditors where necessary
7.	Annual report	We wrote to the sector on 15 January 2021 confirming that the options available to simplify parts of the annual report that were introduced in 2019/20 and kept for 2020/21 are available for 2021/22.	Organisations to continue with year-end planning in light of updated guidance
8.	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

B) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, cancer, ambulance waits, mental health and learning disability measures)	See Annex A
2.	Friends and Family Test	Reporting requirement to NHS England and NHS Improvement has been resumed. Note that trusts have flexibility to change their arrangements under the new guidance, and published case studies show how trusts can continue to hear from patients while adapting to pressures and needs. We emphasise local discretion.
3.	Long Term Plan: mental health	NHS England and NHS Improvement will maintain the Mental Health Investment Guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.
4.	Long Term Plan: learning disability and autism	Systems should continue learning disability and autism investment and transformation to support the LTP.
5.	Long Term Plan: cancer	NHS England and NHS improvement will maintain their commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. We will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response

No.	Areas of activity	Detail
		and restoration and maintenance of cancer screening programmes (including bowel and targeted lung checks) and symptomatic pathways.
6.	Long Term Plan: maternity and neonatal	Systems should ensure that maternity services can operate safely in the pandemic context and continue to implement initiatives which support this, such as Saving Babies' Lives and the seven Immediate and Essential Actions from the Ockenden report. We will work with local maternity systems to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will help them to maintain safe services. This will include reviewing planning milestones, such as submission of plans to roll out continuity of carer and improve equity.
7.	GIRFT and transformation programmes	Routine GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge co-ordination and HVLC work. National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, eg video consultation, personalised outpatients and patient-initiated follow-up, maximising diagnostics and clinical service capacity, supporting discharge priorities, etc.
8.	NHS England and NHS Improvement oversight meetings	Oversight meetings will continue to be held by phone or video conference unless it is agreed that there is a compelling business reason to hold them face-to-face, and they will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure it is appropriate, streamlining agendas to focus on COVID-19 issues/discharge/recovery/ winter and support needs.
9.	ICS development activity	System working is essential in managing the response to COVID-19 and delivering the NHS's priorities in 2022/23. Work to establish ICSs – and ICBs as statutory NHS bodies – continues, with a revised target date of July 2022. This will allow sufficient time for the remaining parliamentary stages of the Health and Care Bill and provide some extra flexibility for systems in preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response.
10.	Corporate data collections (eg licence self-certs, annual governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements. Delay the forward plan documents FTs are required to submit. We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.

No.	Areas of activity	Detail
11.	CQC routine assessments, Use of Resources assessments, HSIB investigations	With CQC, we continue to prioritise our Recovery Support Programme work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures. CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHS England and NHS improvement continue to suspend the Use of Resources assessments in line with this approach. Visits and inspections in connection with HSIB investigations will also be reduced.
12.	Provider transaction appraisals – mergers and subsidiaries Service reconfigurations	Potential for NHS England and NHS Improvement to deprioritise or delay transactions assurance if in the local interest given COVID-19 factors. Urgent temporary service changes on safety grounds in response to COVID-19 or other pressures can still be made with agreement from system partners. Should systems look to make these permanent, normal reconfiguration assurance processes will apply at a later stage.
13.	7-day services assurance	No changes – self-cert statements to continue.
14.	Clinical audit	Given the importance of clinical audit in COVID and non-COVID care, clinical audit platforms will remain open for data collection. It should be noted clinical teams should always prioritise clinical care over data collection and submission.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables. Trusts must also continue to support the prioritisation of covid testing and genotyping services within their own laboratories.

C) Other areas including primary care, HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	With staff absences likely to rise, new training activities – eg refresher training for staff and new training to expand the number of ICU staff – are likely to continue to be necessary. Reduce other mandatory training as appropriate.
2.	Appraisals and revalidation	Professional standards activities may need to be reprioritised: eg appraisals can be postponed or cancelled. Appraisal is a support for many doctors, so it is helpful to keep the option available, but if going ahead, please use the shortened Appraisal 2020 model. Medical directors may also use discretion to decide which concerns require urgent action and which can be deferred.

		The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between December 2021 and March 2022.
3.	Primary care	We have already announced a series of changes to GP contract arrangements and some changes for community pharmacy.
4.	CCG clinical staff deployment	Review internal needs to retain a skeleton staff for critical needs and redeploy the remainder to the frontline. CCG governing body GPs to focus on primary care provision and booster campaign.
5.	Repurposing non-clinical staff from CCGs	Non-clinical staff to focus on supporting primary care and providers to maintain and restore services and the vaccine booster programme.
6.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc.

Annex A – constitutional standards and reporting requirements

While existing performance standards remain in place, we continue to acknowledge and appreciate the challenges in maintaining them during the continuing COVID-19 response. Our approach to tracking those standards most directly impacted by the COVID-19 situation is set out below.

A&E and ambulance performance – Monitoring and management against the four-hour standard and ambulance performance continues nationally and locally, to support system resilience.

RTT – Monitoring and management of RTT and waiting lists will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. Application of financial sanctions for breaches of 52+ week waiting patients occurring during 2020/21 continue to be suspended. Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital.

Discharge – Monitoring and management of delayed discharge for patients who no longer meet the reasons to reside will continue, and from Tuesday 21 December daily calls will take place in every region with every ICS discharge SRO to discuss performance and actions to decrease the number of people with a delayed discharge.

Cancer: referrals and treatments – Cancer treatment remains a priority and should be protected. We will continue to track cancer referral and treatment volumes to provide oversight of the delivery of timely identification, diagnosis and treatment for cancer patients. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Screening: cancer (breast, bowel and cervical) and non-cancer (abdominal aortic aneurysm, diabetic eye and antenatal, newborn screening and targeted lung checks) – Screening remains a priority and should be protected.

Immunisations – All routine invitations should continue to be monitored via the NHS England and NHS Improvement regional teams.

The Weekly Activity Return (WAR) will continue to be a key source of national data, and through the urgent and emergency care daily SitRep return we now capture data on the clinical priority ('P code') of elective cancellations and patients who have not yet been booked for treatment. This is vital management information to support our operational response to the pandemic, and we require 100% completion of this data with immediate effect. Guidance can be found here.

Note: it has been necessary to institute a number of additional central data collections to support management of COVID – for example, the daily Covid SitRep and the Critical Care Directory of Service (DoS) collections. These collections continue to be essential during the pandemic response, but to offset some of the additional reporting burden that this has created, the following collections will be suspended:

Title	Designation	Frequency
Critical care bed capacity and urgent operations cancelled	Official Statistics	Monthly
Delayed transfers of care	Official Statistics	Monthly
Cancelled elective operations	Official Statistics	Quarterly
Audiology	Official Statistics	Monthly
Mixed-sex accommodation	Official Statistics	Monthly
Venous thromboembolism (VTE)	Official Statistics	Quarterly
Mental health community teams activity	Official Statistics	Quarterly
Dementia assessment and referral return	Official Statistics	Monthly
Diagnostics weekly PTL	Management Information	Monthly
26-week patient choice offer	n.a. - trial	weekly

(This has already been communicated to data submission leads via NHS Digital.)

Classification: Official

Publication approval reference: B1160

2022/23 priorities and operational planning guidance

24 December 2021

Dear colleague

Thank you to you and your teams for your continued extraordinary efforts for all our patients.

At the end of January, we will mark two years since paramedics from Yorkshire Ambulance Service and hospital teams in Hull and Newcastle started to treat this country's first patients with COVID-19, and earlier this month we marked the anniversary of the first COVID-19 vaccine dose – and the milestone of 100 million doses – delivered in the biggest and fastest vaccination programme in NHS history.

The last two years have been the most challenging in the history of the NHS, and staff across the service – and many thousands of volunteers – have stepped up time and time again:

- expanding and flexing services to meet the changing demands of the pandemic
- developing and rolling out new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without
- pulling out all the stops to recover services that have been disrupted.

At the time of writing, we are again operating within a Level 4 National Incident in response to the emergence of the Omicron variant. Teams from across the NHS and our partners are:

- significantly increasing vaccination capacity to provide the maximum level of immunity for the maximum number of people
- rolling out new antiviral and monoclonal antibody treatments through COVID medicines delivery units
- preparing for a potentially significant increase in those requiring life-saving care.

This concrete and rapid action in the face of uncertainty has characterised the NHS response to the pandemic. We face that uncertainty again now – in terms of the potential impact of Omicron over the coming weeks and months and the development of the pandemic as we look ahead to 2022/23. Despite this, the clear message I have had from colleagues across the NHS is that it is important to provide certainty and clarity where we can by now setting out the priorities and financial arrangements for the whole of 2022/23, recognising that they will have to be kept under review.

The objectives set out in this document are based on a scenario where COVID-19 returns to a low level and we are able to make significant progress in the first part of next year as we continue to rise to the challenge of restoring services and reducing the COVID backlogs.

Building on the excellent progress seen during 2021/22, this means significantly increasing the number of people we can diagnose, treat and care for in a timely way. This will depend on us doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available to us across health and social care, and ensure reducing inequalities in access is embedded in our approach. As part of this, and when the context allows it, we will need to find ways to eliminate the loss in non-COVID output caused by the pandemic.

Securing a sustainable recovery will depend on a continued focus on the health, wellbeing and safety of our staff. ICSs will also need to look beyond the immediate operational priorities and drive the shift to managing the health of populations by targeting interventions at those groups most at risk and focusing on prevention as well as treatment. Thank you for the significant progress that has been made in preparing for the proposed establishment of statutory Integrated Care Systems. To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for statutory arrangements to take effect and ICBs to be legally and operationally established.

Our ability to fully realise the objectives set out in this document is linked to the ongoing level of healthcare demand from COVID-19. Given the immediate priorities and anticipated pressures, we are not expecting you or your teams to engage with specific planning asks now. The planning timetable will be extended to the end of April 2022, and we will keep this under review.

On behalf of myself and the whole NHS leadership team I want to thank you for the way you are continuing to support staff, put patients first and rise to the challenges we face.

With best wishes

Amanda Pritchard
NHS Chief Executive

Introduction

In 2022/23 we will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. While the future pattern of COVID-19 transmission and the resulting demands on the NHS remain uncertain, we know we need to continue to increase our capacity and resilience to deliver safe, high quality services that meet the full range of people's health and care needs. We will:

- accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff
- use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
- work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows
- use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

Our goal is that these actions will support a significant increase in the number of people we are able to treat and care for in a timely way. Our ability to fully realise this goal is linked to the ongoing level of healthcare demand from COVID-19. The new Omicron variant reminds us that we will need to remain ready to rise to new vaccination challenges and significant increases in COVID-19 cases. We are not able to predict the timing or impact of new variants and must develop ambitious plans for what we can achieve for patients and local populations in a more favourable context. The objectives for 2022/23 set out in this document are therefore based on COVID-19 returning to a low level. We will keep these objectives under review as the pandemic evolves.

Effective partnership is critical to achieving the priorities set out in this document. After several years of local development, we have established 42 integrated care systems (ICSs) across England with four strategic purposes:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access

- enhancing productivity and value for money
- supporting broader social and economic development.

To underpin these arrangements, the Health and Care Bill, which intends to put ICSs on a statutory footing and create integrated care boards (ICBs) as new NHS bodies, is currently being considered by Parliament.

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established. This replaces the previously stated target date of 1 April 2022. This new target date will provide some extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

The establishment of statutory ICSs, and timing of this, remains subject to the passage of the Bill through Parliament. An implementation date of 1 July would mean the current statutory arrangements would remain in place until then, with the first quarter of 2022/23 serving as a continued preparatory period.

Joint working arrangements have been in place at system level for some time, and there has already been significant progress in preparing for the proposed establishment of statutory ICSs, including recruitment of designate ICB chairs and chief executives. Designate ICB leaders should continue to develop system-level plans for 2022/23 and prepare for the formal establishment of ICBs in line with the guidance previously set out by NHS England and NHS Improvement and the updated transition timeline (this is set out more fully in section J).

The NHS's financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. We will shortly issue one-year revenue allocations for 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23. It is in this context that we are asking systems to focus on the following priorities for 2022/23:

A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling

substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.

E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

Across all these areas we will maintain our focus on preventing ill-health and tackling health inequalities by redoubling our efforts on the five priority areas for tackling health

inequalities set out in guidance in March 2021. ICSs will take a lead role in tackling health inequalities, building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Improved data collection and reporting will drive a better understanding of local health inequalities in access to, experience of and outcomes from healthcare services, by informing the development of action plans to narrow the health inequalities gap. ICBs, once established, and trust board performance packs are therefore expected to be disaggregated by deprivation and ethnicity.

We will also continue to embed the response to climate change into core NHS business. Trusts and ICBs, once established, are expected to have a board-level Net Zero lead and a Green Plan, and are asked to deliver carbon reductions against this, throughout 2022/23.

ICS footprints represent the basis of strategic and operational plans for 2022/23 and beyond. Designate ICB leadership teams are asked to work with partners in their ICS to develop plans that reflect these priorities and are triangulated across activity, workforce and money. The immediate focus should remain on the priorities set out in Preparing the NHS for the potential impact of the Omicron variant and we have extended the planning timetable to reflect this.

A. Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

During the pandemic the focus has rightly been on the health, wellbeing and safety of our staff; this will continue. To support the restoration and recovery of services we need more people, working differently in a compassionate and inclusive culture where leaders at all levels inspire, empower and enable them to deliver high quality care in the most effective and efficient way.

We are therefore asking systems to accelerate work to transform and grow the substantive workforce and make the NHS a better place to work for all our staff. The actions to achieve this should be set out in whole system workforce plans that build on the progress made in delivering local people plans and reflect the ambitions to:

Look after our people:

- improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions
- continue to support the health and wellbeing of our staff, including through effective health and wellbeing conversations and the mental health hubs
- improve attendance by addressing the root causes of non COVID-related sickness absence and, where appropriate, supporting staff to return to work.

Improve belonging in the NHS:

- improve the Black, Asian and minority ethnic disparity ratio, delivering the six high impact actions to overhaul recruitment and promotion practices
- implement plans to promote equality across all protected characteristics.

Work differently:

- accelerate the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners
- develop the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models
- ensure the highest level of attainment set out by the ‘meaningful use standards’ for e-job planning and e-rostering is met to optimise the capacity of the current workforce
- establish, or become part of, volunteer services such as the NHS cadets and NHS reservists.

Grow for the future:

- expand international recruitment through ongoing ethical recruitment of high quality nurses and midwifes

- leverage the role of NHS organisations as anchor institutions/networks to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care
- make the most effective use of temporary staffing, including by expanding collaborative system banks and reducing reliance on high-cost agency staff
- ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines
- ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.

Health Education England (HEE) and NHS England and NHS Improvement regional teams will support systems to develop and deliver their workforce plans. We will support systems to deliver through:

- investment to expand the national nursing international recruitment programme and support to recruit more allied health professionals
- the national healthcare support worker (HCSW) recruitment and retention programme
- continued funding of mental health hubs to enable staff access to enhanced occupational health and wellbeing and psychological support
- a suite of national GP recruitment and retention initiatives to enable systems to support their PCNs to expand the GP workforce and make full use of the digital locum pool
- the Additional Roles Reimbursement Scheme (ARRS) to deliver 26,000 roles in primary care, to support the creation of multidisciplinary teams.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID vaccination programme and meeting the needs of patients with COVID-19

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December 2021 and the immediate next steps for deployment were set out in the recent letter to services. Delivery of the vaccine programme is expected

to remain a key priority as we look ahead to 2022/23 and systems are asked to plan to maintain the infrastructure that underpins our ability to respond as needed. We will set out further details as future requirements become clearer.

A number of new treatment options, including neutralising monoclonal antibodies and oral antivirals, are now available for non-hospitalised NHS patients at greater risk from COVID-19. These treatments are in addition to COVID-19 vaccines, which remain the most important intervention for protecting people from COVID-19 infection.

These new treatments, which reduce the risk of hospitalisation and death, are being rolled out initially for a targeted cohort of highest-risk patients and should continue to be prioritised. In parallel, the government has also launched a study to assess the efficacy of antivirals in the UK's predominately vaccinated population. Dependent on the results of that study, we will develop plans for wider access to antivirals from the spring.

The Office for National Statistics (ONS) estimates around one million people are living with post-COVID syndrome (long COVID) in England. The NHS in England has responded by establishing 90 specialist post-COVID clinics to assess, diagnose and help people recover from long COVID, as well as 14 paediatric hubs to provide expert advice to local services treating children and young people.

While good progress has been made, there is still wide local variation in referral rates, waiting times and access to the clinics across diverse demographic groups. Systems are asked to:

- increase the number of patients referred to post-COVID services and seen within six weeks of referral
- decrease the number of patients waiting longer than 15 weeks, to enable their timely placement on the appropriate management or rehabilitation pathway.

£90 million is being made available to support this work in 2022/23.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

C1: Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. Over the next three years, we will rise to the challenge of addressing the elective backlogs that have grown during the pandemic through a combination of expanding capacity, prioritising treatment and transforming delivery of services. Every system is required to develop an elective care recovery plan for 2022/23, setting out how the first full year of longer-term recovery plans will be achieved.

As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – are prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential. Wherever possible over winter, we need systems and providers to continue to separate services and to maintain maximum possible levels of inpatient, day case, outpatient and diagnostic activity, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. This should include the independent sector as separate green pathway capacity.

The ongoing uncertainties and challenges of COVID-19 and demand make it particularly hard to predict how quickly we will be able to recover elective services, but we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and specialist advice, including advice and guidance. We will continue to work to return to pre-pandemic performance as soon as possible with an ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and reduce long waits. Treatment should continue to be prioritised based on clinical urgency and steps should be taken to address health

inequalities. Systems should make use of alternative providers if people have been waiting a long time for treatment. Systems are asked to:

- eliminate waits of over 104 weeks as a priority and maintain this position through 2022/23 (except where patients choose to wait longer)
- reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022
- develop plans that support an overall reduction in 52-week waits where possible
- accelerate the progress we have already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 and going further where possible. We will agree specific targets with systems through the planning process.

Our ability to fully deliver on the objectives is linked to the ongoing level of healthcare demand from COVID-19 and will depend on:

- holding elective activity through the winter
- systems eliminating the loss in productivity caused by the operating constraints resulting from the pandemic.

A more personalised approach to outpatient follow-up appointments will ensure people who require a follow-up appointment receive one in a timely manner – protecting clinical time for the most value adding activity. The opportunity to reduce outpatient follow-ups will differ by trust and specialty and local planning should inform how the ambition will be delivered across the system, supported through a combination of:

- patient initiated follow-up (PIFU) – expanding the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023
- effective discharge, particularly of those patients for whom clinical interventions have been exhausted
- more streamlined diagnostic pathways
- referral optimisation, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including

advice and guidance (A&G), per 100 outpatient first attendances by March 2023.

Systems are asked to plan how the redeployment of the released capacity (including staff) is used to increase elective clock-stops or reduce clock-starts proactively.

£2.3 billion of elective recovery funding has been allocated to systems to support the recovery of elective services in 2022/23. We will set out further details in additional guidance.

£1.5 billion of capital above that funded within core envelopes has been made available to the NHS over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover. Systems are asked to demonstrate how their capital proposals support a material quantified increase in elective activity, eg through schemes that enable the separation of elective and non-elective activity, the setting up or expansion of elective hub sites, day case units or increased bed capacity. Further detail on these requirements and the process will be set out in additional guidance.

Systems are asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2022 to March 2023. These plans should set out how:

- systems will meet the ambitions set out above, reflecting the additional revenue and capital funding being made available. We will set out further details in additional guidance
- services will be organised and delivered to maximise productivity opportunities and secure the best possible outcomes for patients
- local independent sector capacity is incorporated as a core element to deliver improved outcomes for patients and reduce waiting times sustainably
- the updated UK Health Security Agency (UKHSA) guidance will be implemented, ensuring safety concerns are appropriately balanced.
- systems will ensure inclusive recovery and reduce health inequalities where they are identified
- elective care, UEC, social care and mental health will be managed in a way that ensures elective recovery can be protected and any disruptions minimised.

C2: Complete recovery and improve performance against cancer waiting times standards

The number of patients seen following an urgent suspected cancer referral has remained at a record high since March 2021. However, backlogs remain for those who have been referred for treatment, and we would have expected at least 36,000 more patients to have come forward to start treatment during the pandemic than have done so. Systems should therefore, as a priority, complete any outstanding work on the post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance, to:

- return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020)
- meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments.

Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog (lower GI, prostate and skin), including:

- provision of sufficient commissioned capacity so that every urgent suspected lower GI cancer referral is accompanied by a faecal immunochemical test (FIT) result
- delivery of the optimal timed pathway for prostate cancer, including ensuring mpMRI prior to biopsy to eliminate the need for biopsy wherever possible
- making teledermatology available as an option for clinicians in all providers receiving urgent cancer referrals.

Systems are asked to work with Cancer Alliances to develop and implement a plan to:

- improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
- make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower.

Delivery of these plans is expected to support:

- Timely presentation and effective primary care pathways including:
  - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)
  - running local campaigns to complement national advertising to raise public awareness of cancer symptoms and encourage timely presentation.
- Faster diagnosis, including:
  - extending coverage of non-specific symptom pathways – with at least 75% population coverage by March 2023
  - ensuring at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones.
- Targeted case finding and surveillance, including:
  - maximising the uptake of targeted lung health checks (TLHC) and the effective delivery of follow-up low dose CT scans, to meet trajectories agreed with the national team. From 2022/23, all Cancer Alliances will have at least one TLHC project
  - ensuring that every person diagnosed with colorectal and endometrial cancer is tested for Lynch syndrome (with cascade testing offered to family members), and patients who qualify for liver surveillance under National Institute for Health and Care Excellence (NICE) guidance are identified and invited to surveillance.

The national cancer team will provide data and guidance to Cancer Alliances to support the development of their plans. Plans will form the basis of Cancer Alliance funding agreements.

ICBs and Cancer Alliances are also asked to work with trusts to:

- ensure they have fully operational and sustainable patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by the end of the first quarter of 2022/23; and for two further cancers (one of which should be endometrial cancer) by March 2023
- for systems participating in colon capsule endoscopy and cytosponge projects, deliver agreed levels of activity

- increase the recruitment and retention of clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.

Maintaining and restoring cancer screening programmes is critical to our efforts to fully restore cancer services. For breast cancer screening in particular, any systems that have not restored compliance with the three-year cycle by the end of March 2022 are expected to have done so by the end of June 2022.

C3: Diagnostics

Recovery of the highest possible diagnostic activity volumes is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. This will be supported by the timely implementation of new community diagnostic centres (CDCs). Systems are asked to:

- increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23 to support these ambitions and meet local need
- develop investment plans that lay the foundations for further expansion of capacity through CDCs in 2023/24 and 2024/25.

Three-year capital funding allocations will be included in system envelopes for this purpose. National investment through HEE is planned to facilitate training and supply of the workforce to support these goals. Systems will be able to access dedicated revenue funding to support set up and running of CDCs, subject to the necessary business case approvals. Revenue will be allocated to align with the programmes of work or agreed capital business cases.

Systems are asked to utilise targeted capital allocations to:

- increase the number of endoscopy rooms, levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age. Systems should consider using this funding to locate endoscopy services in CDCs and supplement available CDC funding allocations, seeking to co-locate endoscopy and imaging services where possible. Funding will also be available to units that have yet to meet Joint Advisory Group (JAG) on Gastrointestinal Endoscopy Endoscopy accreditation to upgrade their services

- invest in CT capacity to support expansion the Target Lung Health Checks programme from 2023/24, with target coverage to be agreed between Cancer Alliances and the National Cancer Programme team. Cancer Alliances will receive this targeted funding on the basis of their remaining unscreened population and existing CT capacity and should coordinate with ICSs.
- develop additional digitally connected imaging capacity and ensure that acute sites have a minimum of two CT scanners
- procure new breast screening units to deliver the 36-month cycle.

Operational capital resources should continue to be used to reduce the backlog of diagnostic equipment replacement over 10 years old.

Pathology and imaging networks are asked to complete the delivery of their diagnostic digital roadmaps as part of their digital investment plans. National funding will be provided that is broadly consistent with these roadmaps, taking account of progress to date. Refreshed roadmaps need to include specific plans setting out how pathology and imaging networks and CDCs will with their systems support artificial intelligence (AI) research and innovation, and the scalable and sustainable integration of AI-driven diagnostics. The implementation of digital diagnostic investments is expected to deliver at least a 10% improvement in productivity by 2024/25, in line with the best early adopters.

Systems should ensure that pathology networks reach, as a minimum, the 'maturing' status for delivery of pathology services on the pathology network maturity framework by 2024/25. They should also meet the requirements of all national data collections for diagnostic services and support the work to scope creation of endoscopy and clinical physiology networks.

Programme funding of £21 million is available to support pathology and imaging networks to deliver on these priorities in 2022/23 alongside the implementation of CDCs.

C4 Deliver improvements in maternity care

Systems working through local maternity systems (LMSs) are asked to continue to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, more personalised and more equitable. ICSs should undertake

formal, structured and systematic oversight of how their LMS delivers its functions and there should be a direct line of sight to the LMS board.

Providers are asked to continue to embed and deliver the seven immediate and essential actions identified in the interim Ockenden report, along with any future learning shared in the second Ockenden report and East Kent review (when published). LMSs should continue to oversee quality in line with Implementing a revised perinatal quality surveillance model.

LMSs are asked to support providers to prioritise reopening any services suspended due to the pandemic, ensuring women can take somebody with them to all maternity appointments and supporting work to increase vaccination against COVID-19 in pregnancy. LMSs should implement local maternity equity and equality action plans in line with Equity and equality: Guidance for local maternity systems.

LMSs are also asked to continue to work with providers to implement local plans to deliver Better Births, the report of the national maternity review, including:

- delivering local plans for midwifery continuity of carer (MCoC) in line with Delivering midwifery continuity of carer at full scale, prioritising MCoC so that most Black, Asian and mixed ethnicity women and most women from the most deprived areas receive it once the building blocks are in place
- offering every woman a personalised care and support plan in line with the Personalised care and support planning guidance
- fully implement Saving Babies' Lives. Providers should have a preterm birth clinic and act so that at least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on-site neonatal care.

Funding of c£93 million to support the implementation of Ockenden actions through investment in workforce will go into baselines from 2022/23. Programme funding will also be made available to support the delivery of the Better Births priorities.

D. Improve the responsiveness of urgent and emergency care and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting

Sustaining UEC performance has been very challenging due to the pandemic. We need to continue reforms to community and urgent and emergency care to deliver safe, high quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients, reducing length of stay and restoring ambulance response times. An essential requirement is to increase the capacity of the NHS by the equivalent of at least 5,000 G&A beds and return, as a minimum, to pre-pandemic levels of bed availability through a combination of:

- national funding for the further development of virtual wards (including hospital at home)
- system capital plans to increase physical bed capacity as part of elective recovery plans
- re-establishing bed capacity consistent with latest UKHSA IPC guidance.

D1: Urgent and emergency care

The urgent and emergency care system continues to be under significant pressure ahead of what is expected to be an extremely challenging winter. These pressures are exacerbated by delayed ambulance handovers and ambulance response times. A longer term improvement approach is required for the full recovery of urgent and emergency care services. Expected performance levels in 2022/23 therefore represent a first step towards recovery.

Systems are therefore asked to:

- reduce 12-hour waits in EDs towards zero and no more than 2%
- improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards

- minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
  - eliminating handover delays of over 60 minutes
  - ensuring 95% of handovers take place within 30 minutes
  - ensuring 65% of handovers take place within 15 minutes
- ensure stability of services and have planned contingency in advance of next winter.

Systems are asked to build on the work already commenced, as indicated in the UEC 10 Point Action Recovery Plan. This should incorporate:

- Increasing capacity within NHS 111 to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting, including:
  - call handling capacity to meet growing demand
  - clinical capacity within the clinical assessment service to support decision-making, with >15% of calls received having clinical input
  - ensuring there is a full range of available options in the Directory of Services to meet local need
  - adopting the new regional/national route calling technology.
- Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

Systems are asked to put in place integrated health and care plans for children and young people's services that include a focus on urgent care; building on learning from pilots placing paediatric staff within NHS 111 services; better connections between paediatric health services; joining up children's services across the NHS and local authorities; improving transitions to adult services; and supporting young people with physical and mental health needs within acute and urgent care settings.

Systems are asked to consistently submit timely Emergency Care Data Set (ECDS) data, now seven days a week.

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

The transformation of out-of-hospital services is a key element of the NHS recovery. National funding, alongside additional growth within core allocations for community services funding, will support systems to increase overall capacity of community services to provide care for more patients at home and address waiting lists, develop and expand new models of community care and support timely hospital discharge.

Community care models

Virtual wards

The NHS has already had considerable success in implementing virtual wards, including Hospital at Home services. Over 53 virtual wards are already providing over 2,500 ‘beds’ nationwide, enabled by technology. In addition to managing patients with COVID, they also support patients with acute respiratory infections, urinary tract infections (UTIs), chronic obstructive pulmonary disease (COPD) and complex presentations, such as those who are frail as well as having a specific medical need.

The scope for virtual wards is far greater. Given the significant pressure on acute beds we must now aim for their full implementation as rapidly as possible. We are therefore asking systems to develop detailed plans to maximise the rollout of virtual wards to deliver care for patients who would otherwise have to be treated in hospital, by enabling earlier supported discharge and providing alternatives to admission. These plans should be developed across systems and provider collaboratives, rather than individual institutions, based on partnership between secondary, community, primary and mental health services. Systems should also consider partnerships with the independent sector where this will help grow capacity.

By December 2023, we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of 40–50 virtual wards per 100,000 population. Successful implementation will require systems to:

- maximise their overall bed capacity to include virtual wards
- prevent virtual wards becoming a new community-based safety netting service; they should only be used for patients who would otherwise be admitted to an NHS acute hospital bed or to facilitate early discharge
- maintain the most efficient safe staffing and caseload model

- manage length of stay in virtual wards through establishing clear criteria to admit and reside for services
- fully exploit remote monitoring technology and wider digital platforms to deliver effective and efficient care.

Up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 (subject to progress of systems) to support the implementation of these plans. We expect plans to cover two years. The scale of funding awarded in 2022/23 will depend on credible ambition for delivery of virtual wards by December 2022 to provide capacity for next winter. Systems will want to consider approaches that address patients with lower intensity and higher intensity needs (ie Hospital at Home services). We will set out further guidance on the virtual ward model, the support available and the funding criteria.

Urgent community response

By April 2022 all parts of England will be covered by 2 hour urgent community response services and over 2022-23 providers and systems will be required to:

- Maintain full geographic rollout and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance
- Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.
- Increase the number of referrals from all key routes, with a focus on UEC, 111 and 999, and increase care contacts
- Improve capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development
- Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth

Anticipatory care

Anticipatory care (AC) is a Long-Term Plan commitment focused on provision of proactive care in the community for multimorbid and frail individuals who would benefit most from integrated evidence-based care. ICSs should design, plan for and commission AC for their system. Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for AC.

Enhanced Health in Care Homes

Ensure consistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework.

Community service waiting lists

Systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting. Specifically, systems are asked to:

- develop a trajectory for reducing their community service waiting lists
- significantly reduce the number of patients waiting for community services
- prioritise patients on waiting lists
- consider transforming service pathways and models to improve effectiveness and productivity.

Hospital discharge

As outlined in the H2 2021/22 planning guidance, the additional funding for the Hospital Discharge Programme will end in March 2022. As part of preparing the NHS for the potential impact of the Omicron variant and other winter pressures, we have asked systems to work together with local authorities and partners, including hospices and care homes, to release the maximum number of beds, as a minimum this should be equivalent to half of current delayed discharges. Systems should seek to sustain the improvement in delayed discharges in 2022/23 working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.

Digital

Digital tools and timely, accurate information are key to delivering on these aims and systems are asked to:

- identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
- ensure providers of community health services, including ICS-commissioned independent providers, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards
- deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK).

E. Improve timely access to primary care – expanding capacity and increasing the number of appointments available

The NHS Long Term Plan commits to increasing investment in primary medical and community services (PMCS) by £4.5 billion real terms investment growth by 2023/24. We expect systems to maximise the impact of their investment in primary medical care and PCNs with the aim of driving and supporting integrated working at neighbourhood and place level. Systems are asked to look for opportunities to support integration between community services and PCNs, given they are an integral part of solutions to key system challenges that require a whole system response, including elective recovery and supporting more people in their own homes and local communities. Systems should also consider how community pharmacy can play a greater role in local plans as part of these integrated approaches.

Expanding the primary care workforce remains a top priority to increase capacity. Systems are expected to:

- support their PCNs to have in place their share of the 20,500 FTE PCN roles by the end of 2022/23 (in line with the target of 26,000 by the end of 2023/24) and

to work to implement shared employment models, drawing on more than £1 billion of Additional Roles Reimbursement Scheme (ARRS) funding across system development funding (SDF) and allocations

- expand the number of GPs towards the 6,000 FTE target, with consistent local delivery of national GP recruitment and retention initiatives, thereby continuing to make progress towards delivering 50 million more appointments in general practice by 2024.

In line with the principles outlined in the October 2021 plan, systems are asked to support the continued delivery of good quality access to general practice through increasing and optimising capacity, addressing variation and spreading good practice. Every opportunity to secure universal participation in the Community Pharmacist Consultation Service should be taken. Systems should drive the transfer of lower acuity care from both general practice and NHS 111 under this scheme, supported by a new investment and impact fund indicator for PCNs which incentivises contributions to a minimum of two million appointments in 2022/23. Performance at the rate of the best early implementers of 50 referrals a week would move more than 15 million appointments out of general practice. Systems will need to implement revised arrangements for enhanced access delivered through PCNs from October 2022.

Systems are asked to support practices and PCNs to ensure the commitment that every patient has the right to be offered digital-first primary care by 2023/24 is delivered. By 'digital-first primary care' we mean a full primary care service that patients can access easily and consistently online, that enables them to quickly reach the right service for their needs (whether in person or remotely), that is integrated with the wider health system, and that enables clinicians to provide efficient and appropriate care.

2022/23 will see the implementation of GP contract changes, including those to the DES. In addition to the five services already being delivered by PCNs, from April 2022 there will be a phased introduction of two new services – anticipatory care and personalised care – and an expanded focus on cardiovascular disease (CVD) diagnosis and prevention.

Systems are asked to support their PCNs to work closely with local communities to address health inequalities. Practices should continue the critical job of catching up on the backlog of care for their registered patients who have ongoing conditions, to

ensure the best outcomes for them and to avoid acute episodes or exacerbations that may otherwise result in avoidable hospital admissions or even premature mortality.

Systems are asked to take every opportunity to use community pharmacy to support this; for example, in the delivery of care processes such as blood pressure measurement under new contract arrangements. This will drive detection of hypertension across our communities, address backlogs in care and deliver longer-term transformation in integrated local primary care approaches. Systems should also optimise use of pharmacy services around smoking cessation on hospital discharge, the expanded new medicines service and the discharge medicines service.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing IPC measures, and targeting capacity to meet urgent care demand, minimise deterioration in oral health and reduce health inequalities.

Subject to the passage of the Health and Care Bill, ICBs will become the delegated commissioners for primary medical services and, in some cases, also dental, community pharmacy and optometry services, during 2022/23 – the target date now being 1 July 2022. Once established, ICBs should develop plans, working with NHS England regional commissioning teams to take on effective delegated dental, community pharmacy and optometry commissioning functions from 2023/24.

F. Grow and improve mental health services and services for people with a learning disability and/or autistic people

F1: Expand and improve mental health services

The complexity of needs for those requiring mental health services has risen because of the pandemic. In addition to a pre-existing treatment gap within mental health, this is increasing pressures within community services, mental health UEC and inpatient pathways across all ages. To address these pressures and continue to make progress against the NHS Long Term Plan ambitions, systems are asked to:

- Continue to expand and improve their mental health crisis care provision for all ages. This includes improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute

hospitals. Systems are also asked to increase the provision of alternatives to A&E and admission, and improve the ambulance mental health response. Over the next three years £150 million targeted national capital funding will be made available to support improvements in mental health UEC, including mental health ambulances, extending Section 136 suites, safe spaces in or near A&E.

- Ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team, utilising the expansion of mental health provider collaboratives across the whole mental health pathway where systems plan such developments. These collaboratives will support systems to transform services and reduce reliance on hospital-based care delivered away from people's local area.
- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, to improve the quality of mental healthcare across all ages. The mental health LTP ambitions tool will support systems to understand their delivery requirements for expanding access, as well as the Mental Health Delivery Plan 2022/23.
- Continue to grow and expand specialist care and treatment for infants, children and young people by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months and through continuing to expand access to children and young people’s mental health services.
- Subject to confirmation, encourage participation in the first phase of the national Quality Improvement programme to support implementation of the Mental Health Act reforms.

We ask that systems maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy.

Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory minimum requirement, ensuring appropriate investment of baseline funding and SDF to deliver the mental health NHS Long Term Plan objectives by 2023/24. Where SDF funding supports ongoing services, these will continue to be funded beyond 2023/24. This will support the continued expansion and transformation of the mental health workforce. For this:

- systems are asked to develop a mental health workforce plan to 2023/24 in collaboration with mental health providers, HEE and partners in the voluntary, community and social enterprise (VCSE) and education sectors
- PCNs and mental health trusts are asked to continue to use the mental health practitioner ARRS roles to improve the care and treatment for adults, children and young people in line with NHS Long Term Plan ambitions.

Capital funding made available through system allocations is expected to support urgent patient safety projects for mental health trusts, such as those that address ligature points and other infrastructure concerns that pose immediate risks to patients. Funding to eradicate mental health dormitories will continue in 2022/23 and 2023/24.

Systems are asked to work with the Mental Health Provider Collaboratives to produce a clear plan of requirements for CYPMH general adolescent and psychiatric intensive care in-patient beds to meet the health needs of their population, strengthen local services and eliminate out of area placements for the most vulnerable young people. These bed plans should be an integral part of the overall plan for CYP mental health services to ensure a local, whole patient pathway for patients with mental health, learning disability and/or autism needs. The plans should be complete by the end of Q1 2022/23 and should be funded through system operational capital. Investing in this way is expected to reduce operating costs as a direct result of improving access to local services and reducing out of area patient flows. Further guidance on the development of these plans will be issued before the start of 2022/23.

All NHS commissioned services must flow data to the national datasets and relevant bespoke collections. Provision for this must be included and agreed in commissioning arrangements planned for 2021/22, as part of this process.

F2: Meeting the needs of people with a learning disability and autistic people

The pandemic has highlighted and exacerbated the significant health inequalities experienced by people with a learning disability and autistic people. As we recover from the pandemic, we must ensure that people with a learning disability and autistic people are not further disadvantaged in fair access to healthcare. As digital healthcare develops, this means making sure there are reasonable adjustments and tailored responses, including consideration of the ongoing need for face-to-face appointments. Systems are asked to:

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24. Every annual health check should be accompanied by a health action plan to identify actions to improve the person's health.
- Continue to improve the accuracy of GP learning disability registers so that the identification and coding of patients is complete, and particularly for under-represented groups such as children and young people and people from ethnic minority groups.
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- Build on the investment made in 2021/22 to develop a range of care and diagnostic services for autistic people delivered by multidisciplinary teams. This includes access to community mental health services; support for autistic children and young people and their families; and access to the right support and housing. Systems should adopt best practice to improve local diagnostic pathways to minimise waiting times for diagnosis, improve patient experience and ensure that there is accurate and complete reporting of diagnostic data.
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people with a learning disability; these have been exacerbated by the pandemic.

Service development funding support of £75 million is being made available in 2022/23 to achieve the above ambitions.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities

Working alongside local authorities and other partners we will continue to develop our approach to population health management and prevention so that people can play a more proactive role in promoting good health. ICSs will drive the shift to population

health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment. ICSs will take a lead role in tackling health inequalities by building on the Core20PLUS5 approach introduced in 2021/22.

The safe and effective use of patient data is key to this. Systems are asked to develop plans by June 2022 to put in place the systems, skills and data safeguards that will act as the foundation for this. By April 2023, every system should have in place the technical capability required for population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities. Systems are encouraged to work together to share data and analytic capabilities.

To support this, we will:

- continue to operate national data platforms for key, individually identified clinical data driven national programmes (eg the COVID pass, vaccine registries)
- provide a clear set of technical requirements and standards.

We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated senior responsible officer (SRO). These plans should reflect the primary and secondary prevention deliverables as outlined in the NHS Long Term Plan, and the key local priorities agreed by the ICS. Plans should set out how system allocations will be deployed to:

- Support the rollout of tobacco dependence treatment services in all inpatient and maternity settings, in line with agreed trajectories and utilising £42 million of SDF funding.
- Improve uptake of lifestyle services, the Diabetes Prevention Programme, Low Calorie Diets, the new Digital Weight Management Programme and digitally supported self-management services.
- Restore diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels in 2022/23, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets.

- Progress against the NHS Long Term Plan high impact actions to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation, including remote and digital models, and increasing respiratory, hypertension, atrial fibrillation and high cholesterol detection and monitoring/control to pre-pandemic levels. This should include how systems plan to implement national procurements and population health agreements such as those in place for inclisiran and direct oral anticoagulants (DOACs). NHS England's new DOAC framework agreement will make treatment more affordable, allowing the NHS to provide DOACs to 610,000 additional patients. Uptake of DOAC treatment at this level will help prevent an estimated 21,700 strokes and save 5,400 lives over the next three years
- Reduce antibiotic use in primary and secondary care through early identification and treatment of bacterial infections, and support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary, with a switch to oral antibiotics as soon as appropriate.

There is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups. Smoking is the single largest driver of health disparities between the most and least affluent quintiles. Obesity is the next biggest preventable risk factor and obesity in children has seen a major increase during the pandemic, especially in the least well off.

Systems are also asked to:

- renew their focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services
- continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average uptake as of March 2022
- continue to deliver on the personalised care commitments set out in the NHS Long Term Plan – social prescribing referrals, personal health budgets, and personalised care and support plans are key enablers of population health and prevention.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

During the pandemic digital technologies transformed the delivery of care. The opportunity now is for the health and care sector to build on this and use the potential of digital to help the NHS address both its long-term challenges and the immediate task of recovering from the pandemic. In practice this means better outcomes for patients, better experience for staff and more effective population health management.

We will support health and care systems to 'level-up' their digital maturity, and ensure they have a core level of infrastructure, digitisation and skills.

A core level of digitisation in every service within a system is essential. Acute, community, mental health and ambulance providers are required to meet a core level of digitisation by March 2025, in line with the NHS Long Term Plan commitment. By March 2022, systems should develop plans that set out their first year's priorities for achieving a core level of digitisation across all these settings (as set out by the Frontline Digitisation minimum viable product, which will be published by 31 December).

Costed three-year digital investment plans should be finalised by June 2022 in line with What Good Looks Like (WGLL). We will fund systems to establish dedicated teams to support the development and delivery of their plans, which should:

- include provisions for robust cyber security across the system. We will continue to provide and further enhance centralised cyber security capabilities systems; however, local organisations are responsible for managing their own cyber risk
- reflect ambitions to consolidate purchasing and deployment of digital capabilities, such as electronic patient records and workforce management systems, at system level where possible
- set out the steps being taken locally to support digital inclusion
- consider how digital services can support the NHS Net Zero Agenda.

Capital will be available to systems for three years from 2022/23, to support digitisation of acute, mental health, ambulance and community services. £250 million will initially

be allocated to systems for 2022/23 while they develop their digital investment plans. This funding will be directed towards those services and settings that are the least digitally mature.

A digitised, interoperable and connected health and care system is a key enabler of delivering more effective, integrated care. Systems are asked to ensure that:

- by March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024. Standards will be published to support this
- local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system
- suppliers comply with interoperability standards as these are finalised by April 2022
- general practice promotes the NHS App and NHS.UK to reach 60% adult registration by March 2023
- plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions.

The ambition is for the NHS e-Referral Service (e-RS) to become an any-to-any health sector triage, referral and booking system by 2025. This will support two-way digital advice and guidance between clinical teams, ensuring patients are managed safely, and the referral is triaged and processed according to clinical priority. We will support systems with adoption as this functionality is made available to support triage, bookings and referrals. Mental health and other additional services are being evaluated for inclusion in 2022/23.

I. Make the most effective use of our resources

The 2021 Spending Review (SR21) provided the NHS with a three-year revenue and capital settlement covering 2022/23 to 2024/25. The government committed to spend an additional £8 billion to support tackling the elective backlog over the next three

years, from 2022/23 to 2024/25. This allows us to prioritise £2.3 billion in 2022/23 to support elective recovery.

SR21 also confirmed that the NHS will receive total capital resources of £23.8 billion over the next three years, including £4.2 billion of funding to support the building of 40 new hospitals and to upgrade more than 70 hospitals; £2.3 billion to transform diagnostic services; £2.1 billion for innovative use of digital technology; and £1.5 billion to support elective recovery.

We will shortly issue one-year revenue allocations to 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23.

I1: Use of resources

With this funding, the NHS is expected to fully restore core services and make significant in-roads into the elective backlog and NHS Long Term Plan commitments. The SR21 settlement assumes the NHS takes out cost and delivers significant additional efficiencies, on top of the NHS Long Term Plan requirements, to address the excess costs driven by the pandemic response, moving back to and beyond pre-pandemic levels of productivity when the context allows this.

The scale of the efficiency requirement will be sustained throughout the SR21 period and systems should ensure they develop plans that deliver the necessary exit run-rate position to support delivery of future requirements.

We will continue to provide tools, information and support to help systems work together to deliver cost improvement plans that maximise efficiency and productivity opportunities, and reduce unwarranted variation. We will set out additional information on the support programmes available in additional guidance.

I2: Financial framework

The COVID-19 pandemic necessitated simplified finance and contracting arrangements that supported systems to dedicate maximum focus to responding to immediate operational challenges. To support the next phase of service restoration, the financial and contracting frameworks need to evolve to enable systems to take the appropriate funding decisions for their populations.

The future financial framework will continue to support system collaboration with a focus on financial discipline and management of NHS resources within system financial balance. Partner organisations should work together to deliver the new duties on ICBs and trusts.

Advice and guidance on the establishment of ICB financial management and governance arrangements is available as part of the ongoing support offer for ICB establishment. Regional teams are working with clinical commissioning groups (CCGs) and designate ICB board appointees to ensure that ICBs are ready to operate as statutory bodies from 1 July 2022, subject to the passage of legislation. ICBs and the boards of their constituent partners must be clear on the lines of financial accountability in managing NHS resources. This includes meeting core principles for managing public money, statutory responsibilities and other national expectations.

The 2022/23 financial and contracting arrangements are summarised as:

- A glidepath from current system revenue envelopes to fair share allocations. ICB revenue allocations will be based on current system funding envelopes, which continue to include the funding previously provided to support financial sustainability. In addition to a general efficiency requirement, we will apply a convergence adjustment to bring systems gradually towards their fair share of NHS resources. This will mean a tougher ask for systems consuming more than their relative need.
- Increased clarity and certainty over capital allocations, with multi-year operational capital allocations set at ICB level, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.
- A collective local accountability and responsibility for delivering system and ICB financial balance. The Health and Care Bill includes provisions which are designed to ensure that ICBs and trusts are collectively held responsible for their use of revenue and capital resources. Each ICB and its partner trusts will have a financial objective to deliver a financially balanced system, namely a duty on breakeven.
- A return to signed contracts and local ownership for payment flows under simplified rules. To restore the link between commissioning and funding flows, commissioners and trusts will have local ownership for setting payment values on simplified terms, supported by additional guidance from NHS England and

NHS Improvement. While written contracts between commissioners and all providers (NHS and non-NHS) will be needed to cover the whole of the 2022/23 financial year, systems and organisations should continue to take a partnership approach to establishing payment terms and contract management such that focus on delivery of operational and financial priorities can be maximised. We are separately publishing an updated draft of the NHS Standard Contract for 2022/23 for consultation; the final version of the contract, to be used in practice, will be published in February 2022.

- A commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding will be provided to systems to support elective recovery, with access to additional revenue where systems exceed target levels. Provider elective activity plans will be funded as per the aligned payment and incentive approach, with payment linked to the actual level of activity delivered. ICBs will continue to be required to deliver the MHIS, as well as to meet other national investment expectations. We will set these out in additional guidance.
- A continued focus on integration of services to support the transition for future delegations. For those services that continue to be commissioned by NHS England in 2022/23, mechanisms to strengthen joint working with ICBs will be established.

J. Establish ICBs and collaborative system working

The establishment of ICBs, and everything that follows regarding the process and timing for this, remains subject to the passage of the Health and Care Bill through Parliament.

The continued development of ICSs during 2022/23 will help to accelerate local health and care service transformation and improve patient outcomes. As stated in the introduction to this document, a new target date of 1 July 2022 has been agreed for new statutory arrangements for ICSs to take effect and ICBs to be legally and operationally established. National and local plans for ICS implementation will now be adjusted to reflect this timescale, with an extended preparatory phase from 1 April 2022 up to the point of commencement of the new statutory arrangements. During this period:

- CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively in cases where there are multiple CCGs within an ICS footprint) through existing governing bodies.
- CCG leaders will work closely with designate ICB leaders in key decisions that will affect the future ICB, notably commissioning and contracting.
- NHS England and NHS Improvement will retain all direct commissioning responsibilities not already delegated to CCGs.

During Q4 2021/22, NHS England and NHS Improvement will consult a small number of CCGs on changes to their boundaries, to align with the ICS boundary changes decided by the Secretary of State in July 2021. Those CCG boundary changes coming into effect from 1 April 2022 would support the smooth transition from CCGs to ICBs at the implementation date. Arrangements for people affected will be discussed directly with the relevant CCG and designate ICB leaders.

We do not plan to implement any further CCG mergers before the establishment of ICBs.

Next steps

CCG leaders and designate ICB leaders should continue with preparations for the closure of CCGs and the establishment of ICBs, working toward the new target date. NHS England and NHS Improvement will support CCG and designate ICB leaders to reset their implementation plans, to ensure the safe transfer of people, property (in its widest sense) and liabilities from CCGs to ICBs from their establishment. The national programme team will work closely with colleagues in systems and in regional teams to identify what support is needed to manage the new timetable.

We will work with national partners, including trade unions, to communicate the changed target date and any implications for the transfer process. Systems should also ensure they have clear and effective plans for local communications and engagement with the public, staff, trade unions and other stakeholders.

ICB designate chairs and chief executives should continue to progress recruitment to their designate leadership teams, adjusting their timelines as necessary while managing immediate operational demands. Current/planned recruitment activities for designate leadership roles should continue where this is the local preference, but

formal transition to the future leadership arrangements should now be planned for the new target date of 1 July 2022.

Regional teams will work with CCG leaders to agree arrangements that ensure that:

- CCGs remains legally constituted and able to operate effectively, working in partnership with the designate ICB leadership
- individuals' roles and circumstances are clear during the extended preparatory phase.

The employment commitment arrangements for other affected staff and the talent-based approach to people transition previously set out will be extended to reflect the new target date.

The requirements for ICB Readiness to Operate and System Development Plan submissions currently due in mid-February 2022 will be revised to reflect the extended preparatory period. Further details of these plans along with specific implications for financial, people or legal arrangements during the extended preparatory period will be developed with systems and set out in January 2022.

Designate ICB leaders, CCG accountable officers and NHS England and NHS Improvement regional teams will be asked to agree ways of working for 2022/23 before the end of March 2022. This will include agreeing how they will work together to support ongoing system development during Q1, including the establishment of statutory ICSs and the oversight and quality governance arrangements in their system.

Planning during 2022/23

The Health and Care Bill before Parliament will require each ICB to publish a five-year system plan before April each year. This plan must take account of the strategy produced by the integrated care partnership (ICP), and the joint strategic needs assessments and joint health and wellbeing strategies produced by the relevant health and wellbeing board(s).

We expect to require ICBs' refreshed five-year system plans in March 2023. This will give each ICB and its local authority partners sufficient time to agree a strategy for the ICP that has broad support, and to develop a plan to support its implementation, including the development of place based integration. ICBs will undertake preparatory work through 2022/23 to ensure that their five-year system plans:

- match the ambition for their ICS, including delivering specific objectives under the four purposes to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - support broader social and economic development
- reflect the national priorities and ambitions for the NHS
- take account of the responsibilities that they will be taking on for commissioning services that are currently directly commissioned by NHS England, such as primary care and some specialised services.

Plan submission

The planning timetable will be extended to the end of April 2022, with draft plans due in mid-March. We will keep this under review and publish further guidance setting out the requirements for plan submission.

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

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Salisbury NHS Foundation Trust

Report to:	Trust Board Choose an item.	**Agenda item:**	2.1
Date of Meeting:	13th January 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	21st December 2021
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 21st December 2021. 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:
  - The paediatric matron gave an update on the service and the developments and improvements in train. Key topics included a further update on the CAMHS workstream, assurance in relation to the winter respiratory workload (RSV), an update on BSW working together, the new clinical assessment tool (PEWS) and the recent peer review by the critical care network. A key challenge remains the gap in paediatric nursing in the emergency department and day surgery unit.
  - The Executives provided an update on the whistleblowing incidents to the CQC. The committee were told that the Chief Inspector of Hospitals has confirmed that this is increasing nationally since the pandemic. Assurance was provided that the Executives are managing the concerns identified in partnership with the Divisional leadership teams.
  - The winter staff assurance framework was presented to CGC. A detailed discussion took place in relation to the current issues and risks and how staff shortages are being managed. It was noted, and is being escalated through this report, that several areas are reporting red on occasions. This is due to a range of reasons, including the impact of Covid-19. A further update will be presented to the January CGC on the impact of the latest variant. The assurance framework will come to Board as part of the annual reporting requirements.

- The integrated performance report was discussed. An area for further consideration and to escalate to Board is the 5 steps to safety issues identified. The internal audit report flagging this is due to come to a future CGC for consideration. The committee were informed that work is already underway in this area. From a complaints perspective, the Outpatient department flagged this month. This is being reviewed to understand the issues involved.
- Of concern were the 3 Never Events recorded in the incident report. Whilst assurance was provided that they weren't in the same area, the committee wanted further information, especially in light of the 5 steps to safety findings. The lead registrar informed the meeting that she was working with the quality team to emphasise learning and spreading improvement with juniors and trainees. A key point flagged to the committee was the time the process is taking. It is expected that this will improve with the implementation of the new approach to incident management planned for 2022.
- Detailed reports were provided in relation to clinical audit and external reviews. In summary, the Trust does what it does well from an audit perspective and is average or above average in most audits. Where issues are identified, these are not serious ones. Due to the need to allow the Executives to deal with the increasing pressures from the new variant on the day of the meeting, the reports were taken as read with committee members asked to raise any questions outside the meeting. This would be coordinated via the committee administration. It was agreed that a future CGC would have a clinical effectiveness focus to allow for more detailed discussion.
- The patient experience report was noted, again with any questions not addressed in the report being raised outside the meeting.
- The committee extended its thanks to the Trust workforce for all the continued hard work in difficult circumstances.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	13th January 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	21st December 2021
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 21st December 2021. *Please note this escalation report is written based on the performance of Salisbury NHS FT and not the wider performance of the Bath, Wiltshire and Salisbury (BSW) Integrated Care System (ICS), unless otherwise indicated.*

Items for Escalation to Board
(1) Integrated Performance Report – The key issues to report are the nearly the same as reported in the November 2021 meeting (a) the hospital continues to be extremely busy (b) there is a continuing increase of patients with no criteria to reside (nearly 80 patients as at 30th November 2021), which will if not addressed by the system will lead to a risk of the hospital "filling up through the back door" over the winter (c) stroke performance has improved slightly 38.5% of stroke patients arrived at the stroke unit within 4 hours (up from 30% in the previous month) and 48.5% of patient had a CT within one hour (up from 38.5% the previous month but still below the 50% national target). However a new issue to highlight is breast cancer 2 week wait performance has significantly decreased again due to an increase in referrals and a shortage of radiology capacity. **(2) Covid-19 Winter Updated Planning advice** – The committee was verbally briefed by Stacey Hunter (Chief Executive) on very recent advice around further winter planning for Covid-19 and the Omicron variant in particular. The committee thanked Stacey Hunter for the update and following a further discussion were assured that the Executive Team would do everything possible to plan for the new advice. **(3) Finance report as at 31st October 2021** – Financial performance for the year to

date is nearly on plan (£6k overspent as at month 8) and there is optimism that given in-year NHS funding that the Trust will achieve a year end break-even, which would be significantly better than the original 2021/22 Operational Plan deficit of £3.3m. Though concerns about the Trusts recurrent financial position going forward remain.

(4) **Trust Operational Planning 2022/23** – NHS Planning guidance for next year is expected in the week before Christmas.

(5) **Productivity Update Report –** The Committee received a detailed report on the relative productivity of the Trust which compared a sample period in 2019/20 to the same period in 2021/22. This excellent report produced by Lynne Abbot (Associate Director of Finance – Contracts and Income) found that although the Trusts productivity had decreased (based on both activity and costs), this decrease had not been as large as our regional peers. The Committee commended this work and encouraged further benchmarking analysis taking into account other sources of information e.g. GIRFT and RightCare etc.

(6) **Financial Forecast and capital update –** The Committee noted the possibility of significant capital slippage in 2021/22 and supported the recommendations to minimize this potential year end capital underspend. However the Committee requested an update early in the summer of 2022 on how this situation could be avoided going forward.

(7) **Emergency Planning Assurance report, including chemical, biological, radiological and nuclear (CBRN) report –** The Committee noted this report and in particular formally congratulated Andy Hyett (Chief Operating Officer) and his team for the excellent work that they have undertaken in this area.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	13 January 2022		

Report Title:	Trust Management Committee Escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Approval Process (where has this paper been reviewed and approved)	Reviewed and signed off by Stacey Hunter, Chief Executive Officer.			
Prepared by:	Gavin Thomas, Executive Services Manager.			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report from the Trust Management Committee held on 22nd December 2021.

Executive Summary:
This month's Trust Management Committee Meeting had a full agenda of items to be considered, but owing to operational pressures this month, the committee was reduced in length with a focus on business cases and business critical priorities. The committee received 2 Business cases, namely • Lead Cancer Nurse Business Case • Associate Director of HR Operations business case In respect of the Lead Cancer Nurse Business case the committee heard that the case proposes recurrent investment in cancer services specifically to enable the substantive recruitment of a Lead Cancer Nurse. The committee heard that this investment will enable the Trust to: 1. Continue to achieve and deliver high quality cancer care across SFT. 2. Support the strategic delivery of Cancer services in line with Integrated care systems, STP and National directives.

3. Work with Health education England and Local Cancer alliances to plan, review and implement workforce planning and initiatives to recruit and retain the right staff with the right skills.
4. Impact on patient experience through collaborative working with user groups, local support groups, Health watch Wiltshire, trust wide PALs team, CNS's, MDT's.
5. Reduce healthcare inequalities in our local population

Following discussion, the committee approved the case.

In respect of the Associate Director of HR Operations business case, the committee noted that the case relates to a proposal for investment of £99K per annum for two years funded by reduction in both recruitment costs and agency spend, to support a 2-year fixed term secondment for a new Associate Director of HR Operations, reporting to the Chief People Officer. This role will strengthen capacity and capability within the team to deal with the critical priorities within the workforce plan.

The committee was told that the Trust has a 4% staffing gap against budgeted establishment and agency spend at c.£3.38m per year. It is critical that the trust has sufficient staff recruited and sufficient bank workers to meet the needs of the Trust alongside a proactive and supportive approach to retention, building a sustainable workforce and case management.

The committee approved the case.

The committee received an update on the capital plan, and approved a number of proposed amendments to the capital programme in line with the Trust delegated approval limits including IM&T computers and devices and medical equipment. The Committee supported the recommendation of any capital slippage to be used to support the STL purchase of replacement equipment.

The committee received the updates from the Subgroups of Trust Management Committee which were all noted by the committee. There are no additional exceptions to report that are not covered by the Board Sub Committee reports to this public meeting.

END

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

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	13th January 2022		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	16th December 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Recommendation
The Trust Board is asked to note the matters below. Three internal audit reports were presented to the Committee. Although all were scored overall as medium risk, each had elements that were of concern to the Committee and are escalated to the Board for information and discussion. ➢ A review of governance of the service contract with Sterile Supplies Limited (SSL), a joint venture with STERIS Group of companies, concluded that the Trust has inadequate governance and contract management. ➢ A review of capacity management and discharge processes identified a high risk finding of inconsistencies between Criteria to Reside documentation and that shown in the patient's notes ➢ A review of compliance with the Five Steps to Safer Surgery checklist found failure of staff to properly engage with the process and a consistent theme of failure to complete documentation in a timely manner, as required. Management has documented plans to remediate all of the issues noted, but concern was expressed by the committee as to the timings for completion proposed, given the current workload conditions in the clinical areas of the Trust.

Key Items for Escalation

Internal Audit Report – Sterile Supplies Limited Governance

A report was received into the governance and management of the services contract between the Trust and Sterile Supplies Limited (SSL), a 50:50 joint venture between the Trust and a member of the STERIS group of companies to provide sterile instruments for surgery. The report listed five medium priority findings, highlighting;

- That the contract is not fit for purpose and does not reflect the actual service arrangements
- The SSL Contract does not have a clearly articulated governance structure in place.
- The performance report does not provide meaningful insight and limits the ability for readers to hold SSL to account for its performance
- Risks arising from the arrangement with SSL are not captured in the Trust's risk reporting nor the SSL Board reporting
- There has been a lack of project management of the SSL Joint Venture to monitor delivery against the original aims and objectives

These findings are particularly frustrating, as the Committee expressed concerns in this area in October 2020 and undertook a deep dive review of these arrangements in July 2021, which identified all of these issues and for which management committed to resolve matters by September 2021. In response to the PWC report, management have submitted actions to resolve the first four findings by the end of February 2022. The committee will review in March.

Internal Audit Report – Contract Management and Discharge Processes

A report was received regarding Capacity Management and Discharge processes within the Trust. This review highlighted two findings, one of which was regarded as high risk. The high risk finding was that, in a check of a random sample of patients discharged after 1st April 2021, six of 25 records reviewed showed discrepancies between the Criteria to Reside (C2R) checklist and the patient's notes.

It was also noted that, as part of the review of the relevant control processes, five of the eight elements were regarded poorly designed, including availability of relevant checklists to relevant staff and the consistency of application of processes across the Trust.

Management had proposed a review and revise policy, with a view to training and embedding of new processes by the end of February 2022. The Committee expressed concern at the deliverability of this timeline, given the current and likely immediate future clinical workload in the hospital. Management agreed to review the delivery timeline for the action, reporting back to the March Audit Committee.

Internal Audit Report – Five Steps to Safer Surgery

A report was received reviewing Trust compliance with the Five Steps to Safer Surgery process. The report contained five findings, four of which were rated as medium risk;

- Failure of staff to engage with the completion of the checklist
- Failure to complete the checklist in a timely manner

- An incident of failure to obtain timely patient consent to surgery, leading to a conclusion of a degree of duress in obtaining that consent in the operating room
- Failure to consistently undertake a team debrief at the end of the day, as required

There were expressions of concern from all members of the Committee as to the seriousness of these findings, particularly in respect to possible correlation between these process shortfalls and the incidence of Serious Incident or similar potential patient harm reports. Management were asked to undertake a more detailed analysis of any correlation between Datix reports relating to SI/CR incidents and the findings of this review, to report back the Clinical Governance Committee.

Deep Dive – Close Out of Pharmacy Controls Review

The committee received a presentation from Suzanne Hakes detailing how inventory control processes within pharmacy have been improved in response to the drugs theft incident earlier in the year and the subsequent audit report.

The presentation was both comprehensive and clearly showed careful thought into the redesign of the relevant processes. The Committee was also assured that there were appropriate levels of compliance testing embedded in these procedures and an appropriate focus on controlled drugs.

The Committee thanked Suzanne for an excellent presentation and noted that the response of management to the audit report had been appropriately completed. Further scrutiny of this area would now revert to the regular schedule

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	13 January 2022		

Report Title:	Charity Funds committee escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Prepared by:				
Executive Sponsor (presenting):	Nick Marsden, Chair			
Appendices (list if applicable):	N/A			

Recommendation:
The Board is asked to note the report outlining items raised at the Charitable fund committee meeting held on 16th December 2021.

Executive Summary:
The committee reviewed and received the annual accounts for the charity and approved for submission. It was noted a tender process would start in 2022 to secure new external auditors following discussion with Grant Thornton who would be ceasing the contract for 2022/23. The committee approved funding for Genetics laboratory, and medical equipment bids in addition, four would require further individual business cases to enable the committee to assess value for money before approvals were made. The committee noted the positive working with medical equipment teams to identify appropriate medical equipment bids. The committee also approved Art care funding for another two years, with a review mid term to evaluate value for money. In addition the charity approved enhancements to the new outpatient departments for artworks and co-ordinating furnishings. An additional part time admin resource was approved to support the charities ordering and procuring processes. The committee approved a proposal for a branding refresh of the stars appeal using external professional resource

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	☒

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:	13 January 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):	Lisa Thomas, Chief Finance 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:
The Trust continued to operate under significant operational pressure, with bed occupancy increasing again to 95% (94.6% in M7) and escalation bed days exceeding 2000. The challenges that this presented to effective flow throughout the organization can be seen in ED performance (reduced to 76.6% from 78% in M7), ambulance handover delays (16% of ambulance arrivals waiting longer than 30 minutes), and the average number of patients with no criteria to reside increasing to 77 from 68 in M7. Workforce related metrics also demonstrate the pressure the organisation faces, sickness absence was at just over 4%, with all divisions above the 3% target. Benchmarking across the BSW system shows SFT is in a slightly better position than the neighboring acute Trusts in the BSW system. Anxiety, Stress and Depression remains the top reason. Mandatory training and non medical appraisal compliance levels reduced again, operational pressures and high vacancy rates are the biggest factor preventing staff being released to complete training and appraisals. There are currently around 95wte registered nursing vacancies leading to high use of agency nursing. There has been a slight increase in the number of patients a) reaching the stroke unit within 4hrs and, b) having a CT within 1hr this month (38.5% and 48.5% respectively). The stroke unit has received a SNNAP score of C for Q2 (2021/22). Analysis of stoke performance has been undertaken and a new neurology pathway has been developed.

Despite the non elective challenges, further progress was made on reducing elective pathways. The total waiting list size reduced slightly, with the number of patients waiting longer than 52 weeks falling from 688 in M7 to 618 in M8. Theatre activity increased, with the 21/21 plan levels being achieved. Activity in November in day cases recorded 233 spells more than in October and exceeded the plan for the month. Activity in elective inpatients was higher than in October with improved performance in T&O/Spinal.

The Trust continued to maintain achievement of the 6 week diagnostic standard for the third consecutive month. Importantly, the 62 Day suspected Cancer referral to treatment standard was achieved. The suspected cancer referral Two Week Wait standard deteriorated further to 77%. This was largely due to the continued issues with the Breast pathway and limited ability to undertake additional clinics because of lack of radiology cover. The average wait to first appointment for breast referrals is 15-16 days.

With a modest deficit of £6k the Trust remains broadly in line with the H2 plan, however increase staff absence due to Covid and a November spike in the cost of clinical supplies means that the forecast is under pressure. A significant proportion of these pressures will be mitigated in the coming months by the funding awarded for the winter resilience element of the Targeted Investment Fund (TIF).

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

January 2022

(data for November 2021)

An outstanding experience for every patient

Summary

NHS Salisbury NHS Foundation Trust

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Summary Performance
November 2021

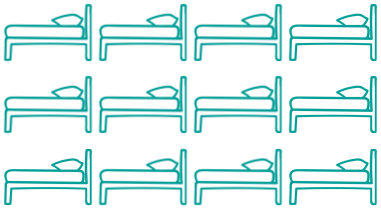
Salisbury NHS Foundation Trust

There were **2,724** Non-Elective Admissions to the Trust

We delivered **39,519** outpatient attendances, **18.4%** through video or telephone appointments

We met **4 out of 7** Cancer treatment standards

We carried out **295** elective procedures & **2,056** day cases



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

RTT 18 Week Performance: **72.2%** ↓

Total Waiting List: **19,327** ↑

99.2% ↓ of patients received a diagnostic test within **6 weeks**

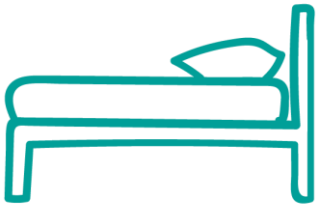
Our income was **£26,556k** (£915k above plan)

17.6% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance **76.7%** ↓

(Target trajectory: 95%)

86 patients stayed in hospital for longer than 21 days



Our overall vacancy rate was **4.17%** ↓

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

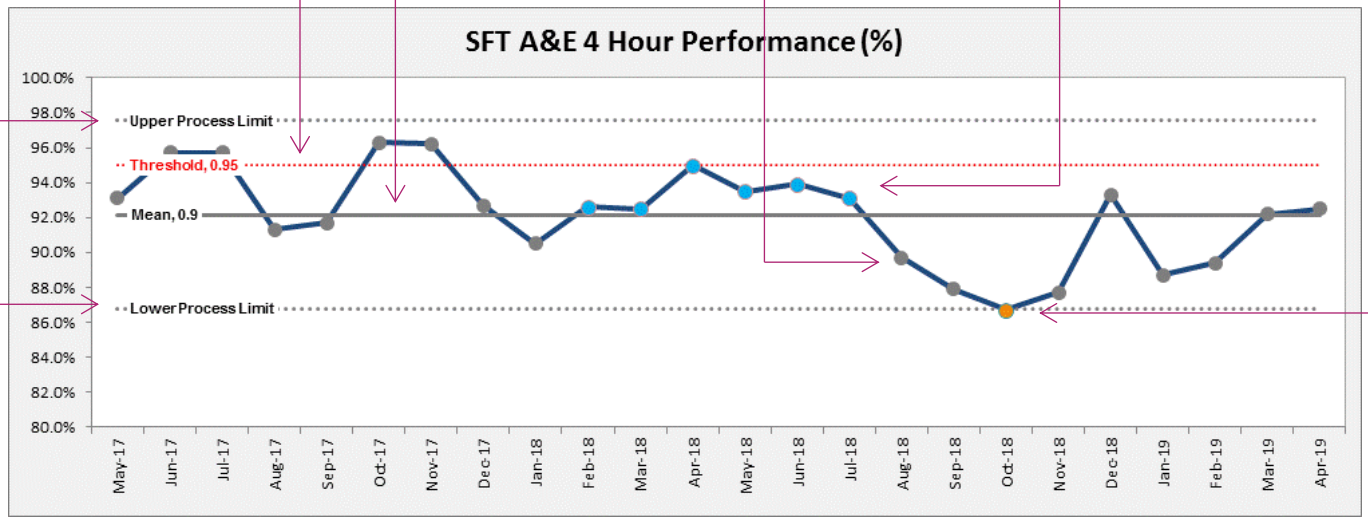
The red line shows the target for the KPI, if there is one

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
- 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

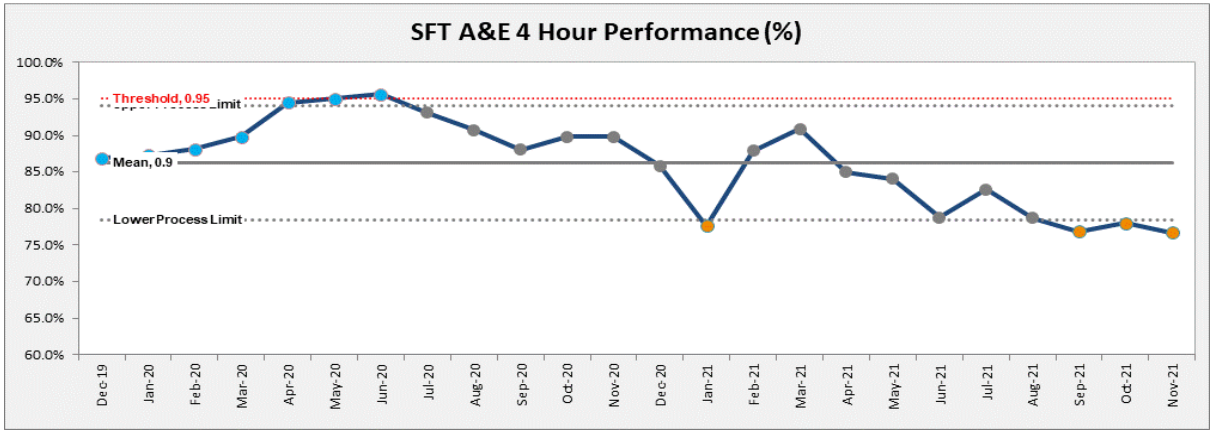
Part 1: Operational Performance

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:	76.7%
Attendances:	5736
12 Hour Breaches:	0
ED Conversion Rate:	30.2%

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

M8 saw a decrease in attendances of 5736 compared to 6401 in M7. Performance against the Four hour standard decreased slightly to 76.7% from 78% in M7. We continue to see a rise in our military attendances with an increase in M8 of 329 compared to pre covid figures in M8 of 219.

Flow out of the department remains one of the biggest challenges both in ED & AMU with beds often not becoming available till late evening. This is one of the main contributory factors which affects 4 hour performance standard and ambulance handover rates. The ambulatory area in AMU is consistently escalated overnight, impacting on ability for AMU to review patients quickly the following day, resulting in ED taking the medical take at times.

Staffing gaps also remain extremely challenging from a middle grade and nursing perspective both in ED and AMU.

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

We have been working closely with the Walk In Centre Team. We will be locating a free phone within Majors waiting room to the Walk in Centre in Salisbury. This will enable suitable patients to telephone the Walk In Centre to request a telephone triage appointment with a GP. Patients will then be called back on their mobile telephones. The Walk In Centre will then contact reception to advise if patient still requires treatment. There is also a big media drive to encourage children under the age of 10 to visit The Walk in Centre first. This pilot will go live in M10.

Piloting a Consultant Rapid Access Triage on certain days (when staffing permits) in M9. This pilot aims to alleviate delays in off loading ambulances and identifying the more acutely unwell patients in the waiting room.

New Divisional Manager who has started in M9 and will support across ED and AMU. In addition, a Medicine Matron has been seconded to ED to support the nursing staff in the Emergency Department.

Building works have commenced in the department to expand the Foot print of ED. The works will be in 2 phases to minimise the impact, with phase 1 due to be completed by end of M9. Phase 2 to commence in M10 and due to be completed by end of M11.

Two dedicated daily CT slots for AMU have been agreed in order to assist with ambulatory care. This will go live in M9.

ED Improvements and SDEC work groups remain ongoing.

Risks to delivery and mitigations

Nursing gaps and Middle Grade Doctor gaps continue to be extremely challenging. There are currently nursing gaps on every shift, with the majority unsuccessfully being backfilled.

We continue to see a high volume of attendances. Building works may impact on capacity at times, but by doing works in 2 phases this should be able to be kept to a minimum.

Flow out of the department still remains the biggest factor affecting the 4 hour performance standard and the ability to off load ambulances at times of pressure. The department are consistently working at full capacity. ED & AMU continue to work collaboratively with specialty teams in order to improve flow out of the departments.

Coming into M9 capacity will be a concern with predicted high volume of patients

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)
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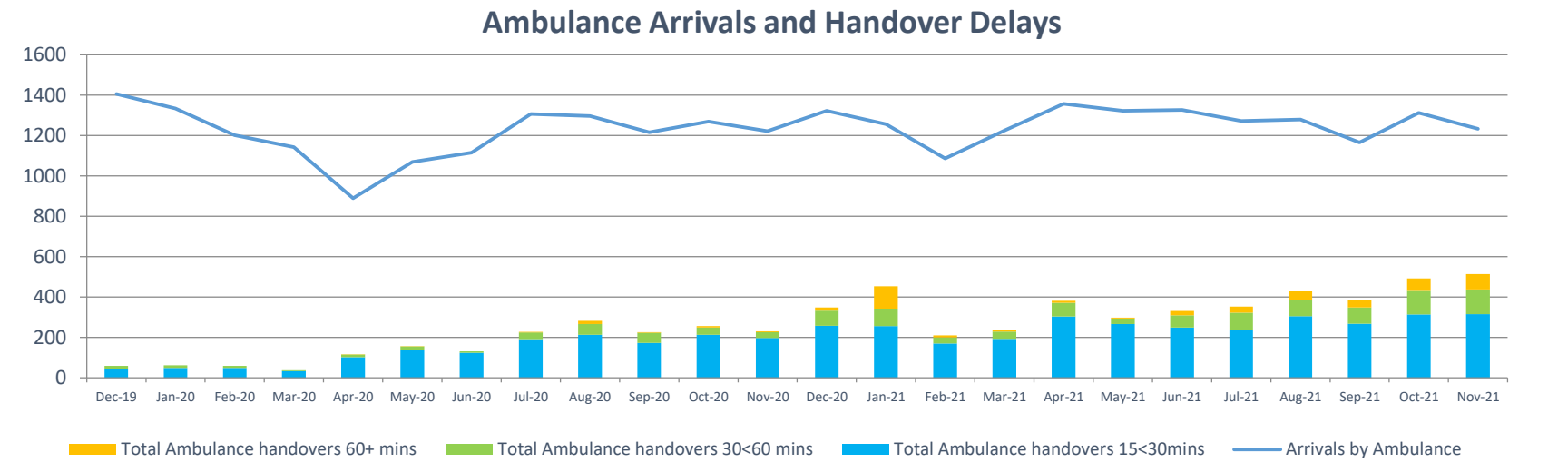
Ambulance Handover Delays

National Key Performance Indicators



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

Ambulance arrivals were slightly lower in M8, but number handovers that were delayed increased, particularly in delays of over an hour (49 in M7 vs 76 in M8).

Capacity and flow in the department is still the most contributory factor in being able to off load ambulances within 15 minutes, with the department becoming full with often limited flow out of the department until the evening.

Paediatric area is regularly converted into a nursing out area in order to off load ambulances.

AMU ambulatory area is regularly escalated overnight and this impacts ED as the medical take is often diverted due to capacity within AMU.

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

The Physician Response Unit car will be operated by an ED Consultant and paramedic and will pilot on the SWAST reset day in M9. Criteria is for falls, oral and IV antibiotics and will be able to give clinical advise to crews. If no suitable calls they can take jobs direct from SWAST stack or stream to assist at the Front door. The opportunity to look at how we integrate our service with WH&P hospital avoidance scheme in collaboration with SWAST is being explored.

SWAST will be having a second reset day in M9 in order to respond to the significant and sustained pressures on their service.

Continued collaborative working with SWAST and the employment of HALO when required. SWAST have been able to provide a HALO when requested to ensure crews are released.

Trials of RATTING (rapid assessment and triage) process taking place in the department on days that staffing allows, assisting with the ability to off load ambulances in a timely manner.

Risks to delivery and mitigations

It remains challenging to off load ambulances when there are more than 3 ambulances presenting at the same time.

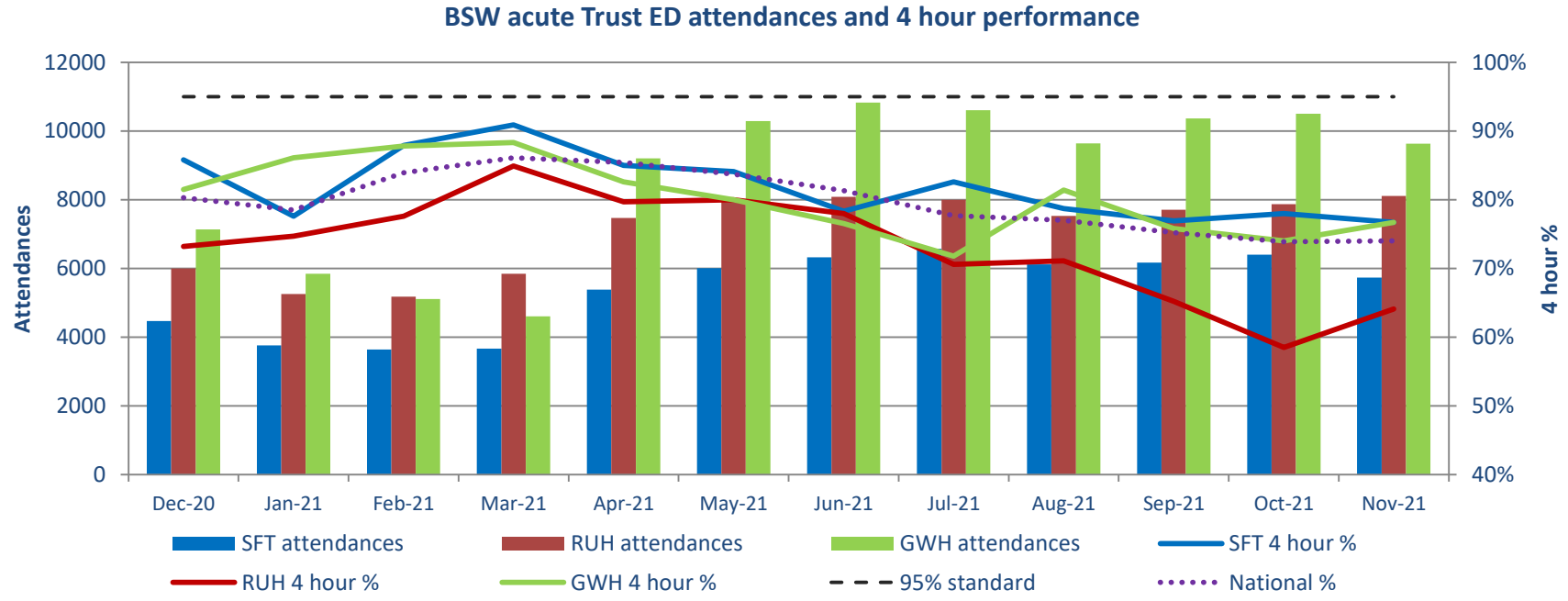
With significant flow issues out of the department, it will remain challenging to be able to off load patients within 15 minutes when the department becomes full, this is continually monitored and escalated.

Staffing gaps, particularly nursing have a significant impact on ambulance handover within the department, gaps in workforce continue to remain a challenge.

With limited capacity in ED and an expected increase in attendances over the coming winter months, it will undoubtedly impact on our ability to off load ambulances. The department will continue to use the ambulances escalation plan and endeavor to off load ambulances as quickly and safely as possible.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

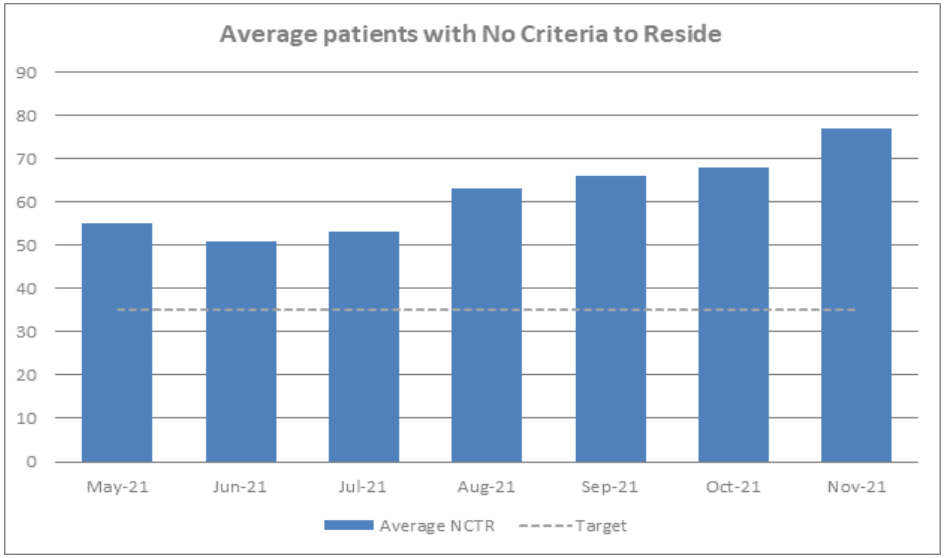


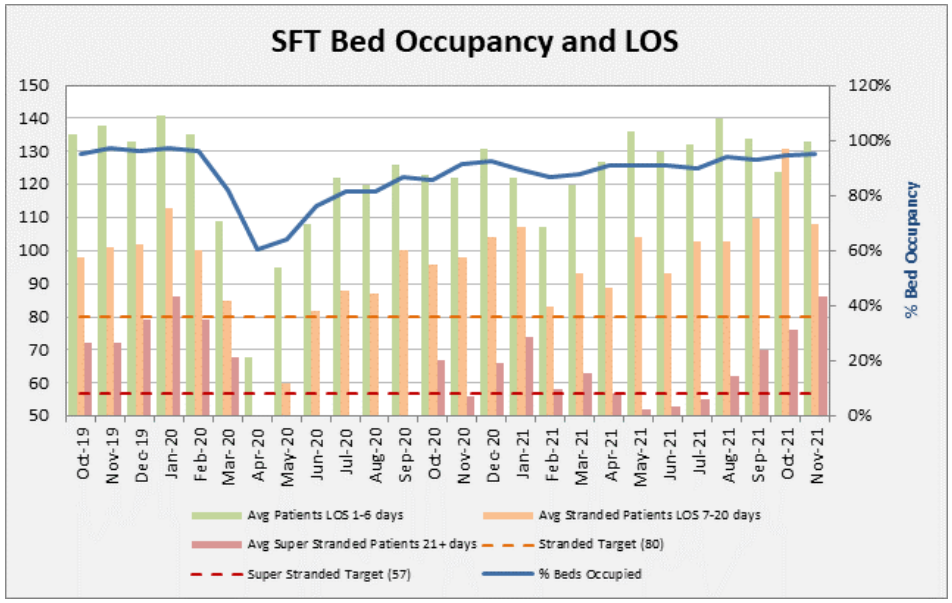
Emergency access 4 hour performance continues to be very challenging with the proportion of patients being discharged or admitted within 4 hours at 74%. RUH in particular had a challenging month, with 64% of patients being treated within the standard, however this was an improved position in comparison to M7 (58.5%)

Attendances overall at RUH and SFT are broadly in line or exceeding 2019/20 levels. At SFT Type 1 attendances

Patient Flow and Discharge

Are We Effective?





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

The patients with NC2R has increased and is showing as the highest since May 2021. This, together with the increasing number of patients in the 21 days LOS group is reflective of the pressures in both the Trust and the wider health and care system. Patients are in the Trust for longer, and more are waiting for services to facilitate their discharge

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

The patient flow board continues to develop work in areas supporting flow, but has put criteria led discharge on hold given the nursing and therapy staffing levels on wards and the management of such a stretched workforce.

Criteria to reside work continues, and communications and updated leaflets are due for distribution in December to support decision making and the sharing of the discharge when NC2R message with patients and families.

Voluntary services are also a focus for both the acute and community partners, to explore how this resource might support appropriately where statutory services are unable. Results from this are planned into the new year

Risks to delivery and mitigations

The Trust has experienced significant shortfalls in nursing staffing that has already contributed to the cessation of the criteria led discharge element of the patient flow work and so staffing continues to be a risk to work ongoing to improve patient flow.

COVID infections although steady in November are difficult to predict and so will present a challenge if a change in hospitalisations was to occur.

Community health and social care services also are looking to expedite discharges for patients in the NC2R category. This group are predominantly waiting for services either in their own homes or in bedded capacity for rehab or further assessment. The risk is again staffing in these areas is challenged and restricts the impact of planned interventions.

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				
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	Oct 21
% Utilisation	Day Surgery Theatres	90%	75%
	Main Theatres	85%	89%
Turnaround	Day Surgery Theatres	8 mins	18 mins
	Main Theatres	12 mins	30 mins
% short notice Hospital Cancellations (0-3 days)	Total	2%	1.61%
% Short notice Patient Cancellations (0-3 days)	Total	2%	9.22%

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

An average of 120 theatre sessions a week were run in M8, an increase of 3 per week on M7, and now consistently achieving more than baseline plan but still 7 sessions a week short of 19/20 levels and 9 short of Plan+. Target of 10.7 baseline weekday theatres open in November (plus 2 for Insourced Teams). High staff sickness led to 10.3 theatres open on average in the week, and weekend comparable with October.

Underperformance of elective activity accounts for overall theatre activity still being lower than plan in M8 as although elective activity improved in M7 it was still short of pre-Covid levels. This has been further exacerbated by issues around late starts, high levels of emergency and trauma and high numbers of cancellations. Theatre Staff Incentive Payment Scheme uptake low in November (£9k), but slightly up on October (£6k)

T&O activity has increased with T&O now higher in the list prioritisation. With the current theatre capacity this is likely to continue to be below pre-COVID average, and bed pressures are now starting to impact the casemix on the elective programme.

Daycase activity has increased again in November and was in excess of pre-COVID activity and current month plan. Most significant increase was in Plastic Surgery due to the high level of weekend TXM LA high volume, low complexity lists

Increased cancellations due to the impact of increasing prevalence of COVID and self-isolation requirements were also seen throughout M8 which is reflected in the high percentage of patient driven cancellations

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

Significant improvements have been maintained in both TXM compliance with contract and quality. TXM workforce now stable and skilled but scrubs still covering HCA shifts at full cost. However, Theatres Recruitment and Retention plan well underway with plans for another Theatre open using substantive staff in January 22, and another in March 22. Overseas nurses have started arriving with 5 joining the Theatre team in November and 2 in December. Theatre Education continues with increased numbers of Scrub Nurses, ODP's and SFA's in full time training

Overseas nurses have started arriving with 3 in Theatres joining in October, 5 in November, 6 planned for early December and 3 over the Christmas period. Advert now closed for Theatres Manager role

SFT IPC guidelines updated 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. However move to pre-surgery LFT testing rather than PCR for low risk pathways still awaiting authorisation. This will further improve booking efficiency and flexibility so will have a significant impact on utilisation if approved

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. Work ongoing to increase additional capacity by reinvigorating Theatre Staff Incentive Payment Scheme

The Four Eyes productivity and efficiency work continues focused in the Day Surgery Unit. This is being underpinned by weekly specialty Scheduling Meetings and the Operational Theatre Group where there is representation from multidisciplinary teams. Current focus point is prevention/reduction of late starts

Risks to delivery and mitigations

Theatre workforce for local lists continues to be a significant blocker. High levels of sickness continued to impact lists in M8 leading to the cancellation of elective work and the opening of fewer theatres than planned. The mitigation for this issue is linked to the Theatre Workforce Review being led by OD&P with support from both the Theatres Specialty Team and DMT.

TXM workforce stability and skill mix to allow running of all planned additional activity. Work ongoing with Procurement and the Division to ensure this remains robust especially over winter and holiday periods

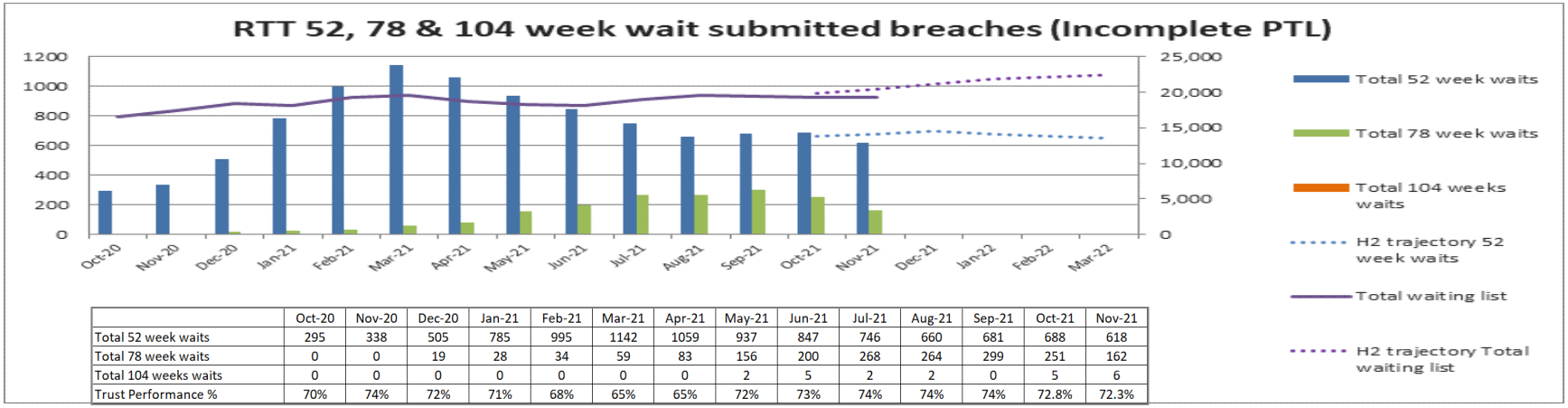
An ongoing risk to elective activity remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand. This is being mitigated by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately.

Bed pressures are now starting to impact the casemix on the elective programme and has led to some elective cancellations. 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

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
Total 52 week waits	295	338	505	785	995	1142	1059	937	847	746	660	681	688	618
Total 78 week waits	0	0	19	28	34	59	83	156	200	268	264	299	251	162
Total 104 weeks waits	0	0	0	0	0	0	0	2	5	2	2	0	5	6
Trust Performance %	70%	74%	72%	71%	68%	65%	65%	72%	73%	74%	74%	74%	72.8%	72.3%

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	Mar-22
	101	106	110	108	112	103	106	110				

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

Treatment function	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	% change from
Plastic Surgery	148	139	145	140	133	130	129	129	111	-14%
Urology	96	89	94	88	78	52	54	59	60	2%
Ophthalmology	253	203	158	120	92	92	90	71	55	-23%
Trauma and Orthopaedic	134	130	114	99	85	74	59	56	48	-14%
Oral Surgery	135	146	102	87	76	63	63	44	38	-14%

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

The number of patients waiting longer than 52 weeks has decreased by 72 to a total of 618 in M8 which is ahead of the H2 trajectory. Similarly, the number of patients waiting longer than 78 weeks has significantly decreased by 89 to a total of 162. Among this cohort who have waited longer than 78 weeks approximately 11% are patients who have requested to pause their pathway.

The number of reportable patients waiting 104 weeks in M8 was 6, with the longest waiting patient waiting 110 weeks. These patients have all been dated for their surgery in M9 or M10 apart from 2 patient choice delays due to COVID concerns. Both these patients are being supported by the clinical teams to identify solutions or alternative treatment options.

Of the patients waiting on non-admitted pathways the majority continue to be within Ophthalmology. Of the patients on admitted pathways awaiting surgery the split is broader as illustrated in the 'Top 5' table.

Overall PTL size in M8 19,327 against the H2 target of 19,367.

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

HVLC lists for Plastics LA lists have continued to run throughout the month of November to further address this long waiting cohort. The impact of this is measurable in the reported activity figures.

H2 trajectories reflect the national guidance to eliminate 104 week breaches by March 22 (unless a P5 or 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.

Ongoing use of IS with the transfer of Hand pathway patients to Sulis Hospital in Bath, suitable Orthopaedic Patients to Newhall and Ophthalmic Cataract patients to two external providers continuing.

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 both the Theatres Specialty Team and DMT.

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

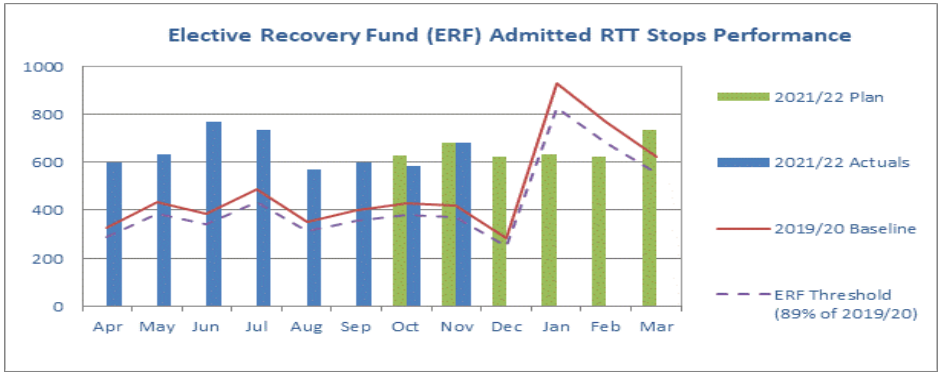
Another ongoing risk remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand as this may result in the cancellation of long waiting, clinically routine patients. This is being mitigated by daily reviews by the Specialty, Theatre and DMT to ensure patients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

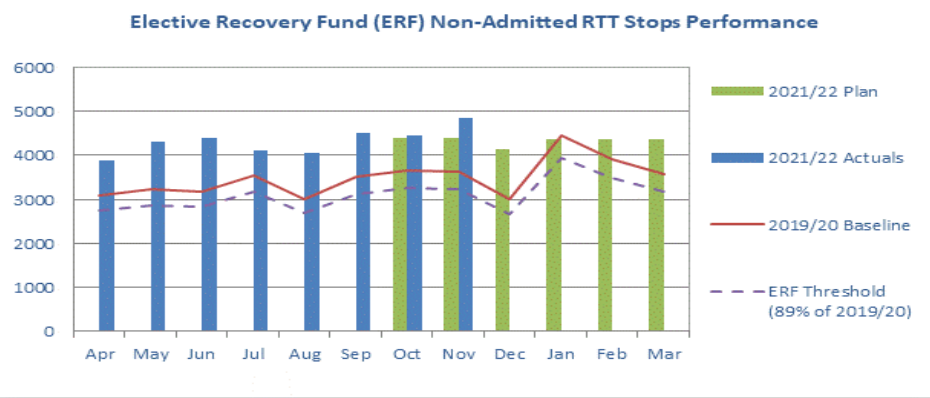
Bed pressures are now starting to impact the casemix on the elective programme and led to some elective cancellations in M8. Daily review by the Matrons and DMT undertaken as required avoiding cancellations whenever practical. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimalise cancellations.

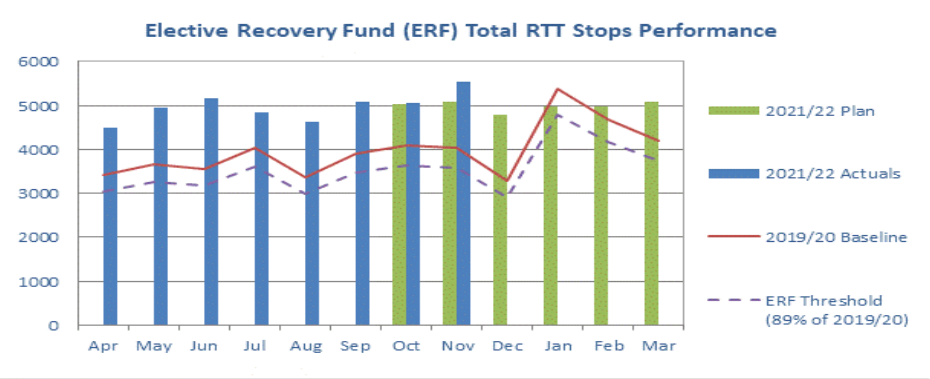
Increased patient led cancellations are also a risk to delivery especially in light of increasing COVID prevalence.

Elective Recovery Fund - RTT Stops

National Key Performance Indicators







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

ERF total RTT stops performance exceeded plan in M8 with the non-admitted RTT stops performance being significantly above reported admitted stops baseline.

Outpatient attendances in M8 exceeded both pre-COVID levels and current month plan

Virtual appointments are working well in a number of specialties with Gastroenterology and Cardiology seeing high numbers of their outpatients virtually

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

SFT IPC guidelines updated in M7 to reflect change to national processes reducing the social distancing requirements which has allowed increased throughput in outpatient areas. This will facilitate increases in activity for specialties impacted by this constraint. This will be particularly effective for Ophthalmology

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 is currently being undertaken to identify challenges and opportunities for improvement.

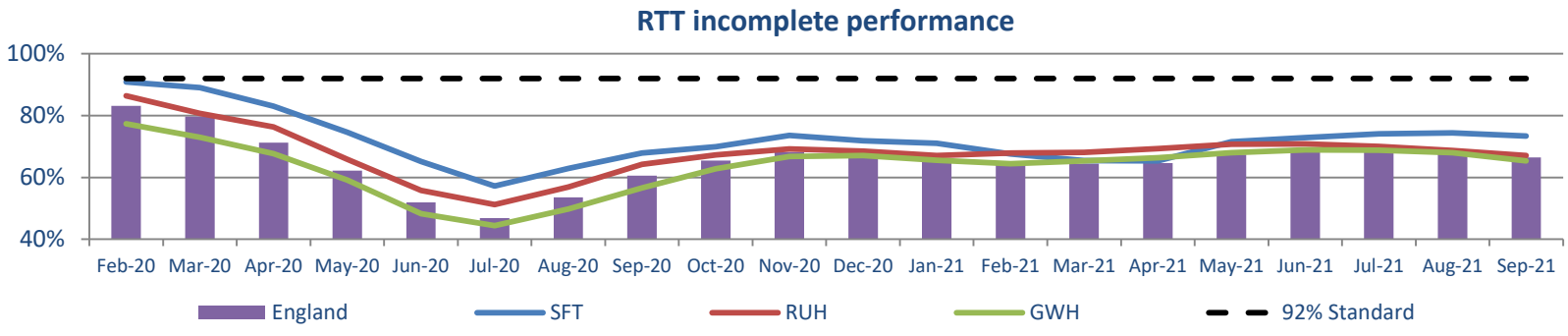
Risks to delivery and mitigations

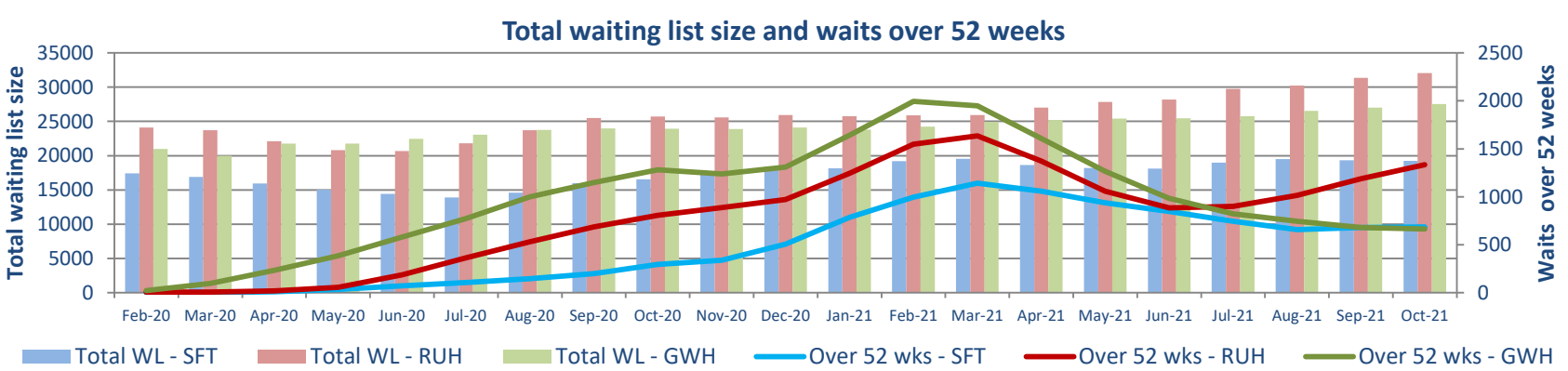
Continuing space constraints across outpatient departments continue to be a significant risk as social distancing requirements have been reduced but not removed

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

BSW Context – Referral To Treatment (RTT)

Are We Effective?





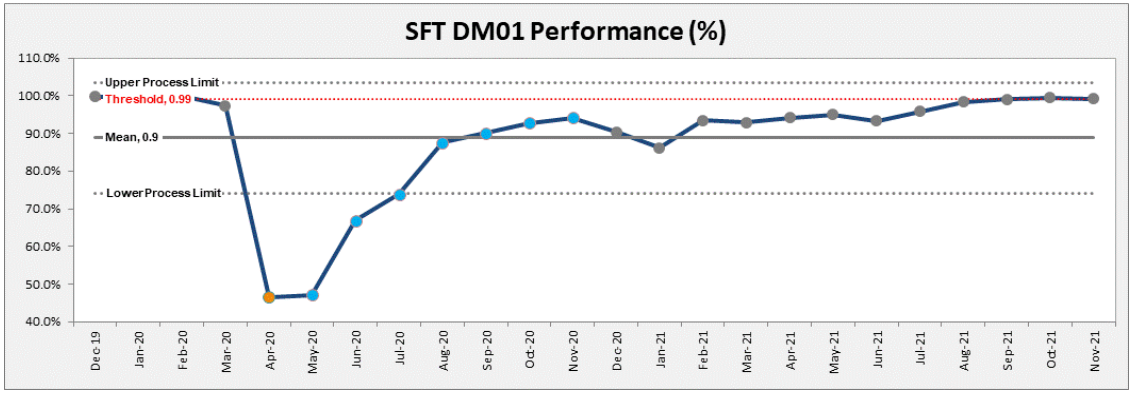
*Due to the time it takes to for NHSE to publish the data, RTT data on this slide is always a month behind

H2 requirements for Elective care is to maintain total waiting list and 52 week backlog sizes at M6 position, with no 104 week breaches by March 22 unless the patient has chosen to wait. In M7 SFT reduced total waiting list slightly, and small increases were seen at RUH and GWH.

At RUH the 52 week backlog grew for the third consecutive month, GWH and SFT were broadly static. All three Trusts made reductions to the number of patients waiting over 78 weeks.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	99.2%
Waiting List Volume:	3627
6 Week Breaches:	29
Diagnostics Performed:	7840

Modality performance

MRI	100.0%	US	100.0%	Audio	94.8%	Neuro	100.0%	Flexi sig	100.0%
CT	100.0%	DEXA	100.0%	Cardio	95.4%	Colon	98.7%	Gastro	100.0%

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

Small decrease in performance in M8 from 99.41% to 99.2% in M7 representing an increase from 21 breaches to 29 breaches.

Radiology reported zero breaches for a second month.

The increase in breaches as compared to M7 are within Audiology (increase from 6 to 13) and Cardiology (increase from 6 to 14). Endoscopy performance improved in M8, with number of breaches reducing from 9 in M7 to 2 in M8. There are 5 x long waiting patients (greater than 13 weeks) within Audiology.

Increase in breaches in Audiology was anticipated due to paternity leave of Head of Service (who conducts the complex cases, expect this to resolve within M9).

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

Audiology long waiters booked in M9 and M10.

Radiology reporting turnaround times and backlogs being monitored closely at weekly Radiology KPI meeting to ensure capacity for scanning can be retained and not reduced (reporting backlog reduced within M8 so scanning capacity has continued at same rates).

Waiting list entries (particularly where long waiters are identified) are being reviewed to confirm whether planned or active waiters and focus on resolving long waiters to ensure booked is occurring.

Risks to delivery and mitigations

Delivery of the standard remains vulnerable to workforce challenges. Cardiology remain heavily reliant on locum staff and overtime from substantive staff. Predicting deteriorating performance in M9 with possible improvement in M10.

USS team are supporting radiology reporting issues by increasing number of lists to release Consultant time for reporting (this is impacting their overall capacity, putting higher demand on the USS team). Also heavily overtime dependent to ensure DM01 compliant.

Neurophysiology impacted by some Covid isolation resulting in some loss of activity (mitigating with replacement activity but may make M9 vulnerable (would recover in M10).

Statistical Process Control Chart Key:

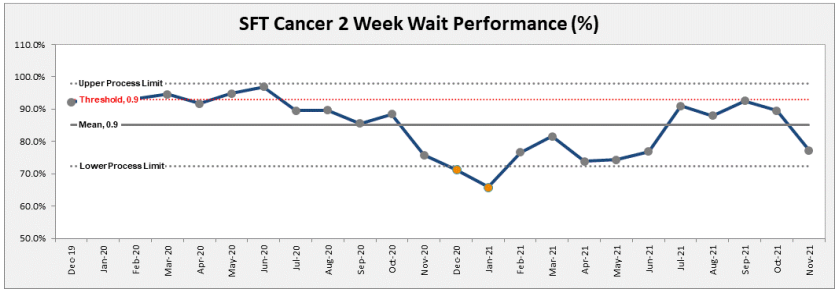
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)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

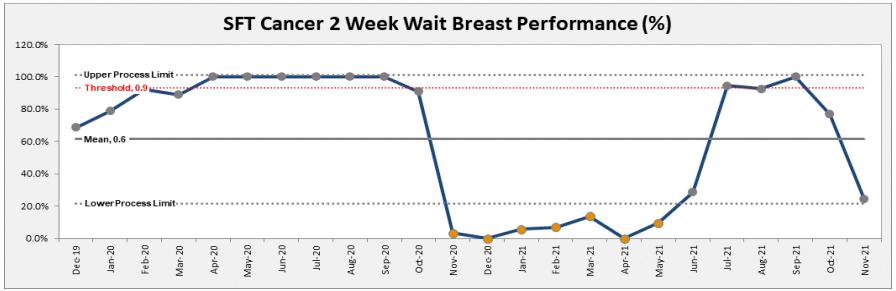
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	77.23%	858/1111	253 (60 patient choice)
Two Week Wait Breast Symptomatic Standard:	22.73%	10/44	34

Data Quality Rating:





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

Two week wait standard not achieved for Month 8, with month end validated performance of 77.23% (1111 patients seen; 858 in target; 253 breaches). Breach reasons associated with:

- Clinical capacity: 154 (predominantly lack of radiology cover to facilitate additional breast one stop clinics)
- Patient choice: 60 breaches
- Incomplete GP referrals: 18 breaches
- Delays as a result of testing COVID positive: 6 breaches
- Administrative delay: 8 breaches
- Endoscopy capacity: 7 breaches

Breast symptomatic two week wait standard not achieved in Month 8 (44 patients seen; 10 patients in target; 34 breaches), with validated month end performance of 24.32%. Breaches associated with patient choice and lack of breast one stop capacity due to insufficient radiology capacity to facilitate additional clinics.

28 day Faster Diagnosis Standard not achieved in Month 8, with month end performance of 74.8% (953 patients diagnosed, 713 in target, 240 breaches).

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

Breast two week wait performance: 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. Additional capacity established for patients not requiring mammograms, though no opportunities to facilitate addition >40s clinics due to lack of consultant radiology capacity for reporting. CSFS have obtained a locum as well as ad hoc support from previous member of staff. Significant capacity constraints within outsourcing companies, resulting in minimal opportunities to support.

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.

Incomplete GP referrals: Inconsistent completion of straight to test referral forms. Conversations ongoing with BSW ICS and Hampshire and Isle of Wight CCG to ensure referral quality and completeness remains consistent.

Risks to delivery and mitigations

Consultant radiologist capacity to support additional clinics within breast service: Deterioration in 2ww performance seen from October 2021 onwards due to increase in referrals and lack of consultant radiologist capacity to support additional one stop clinics.

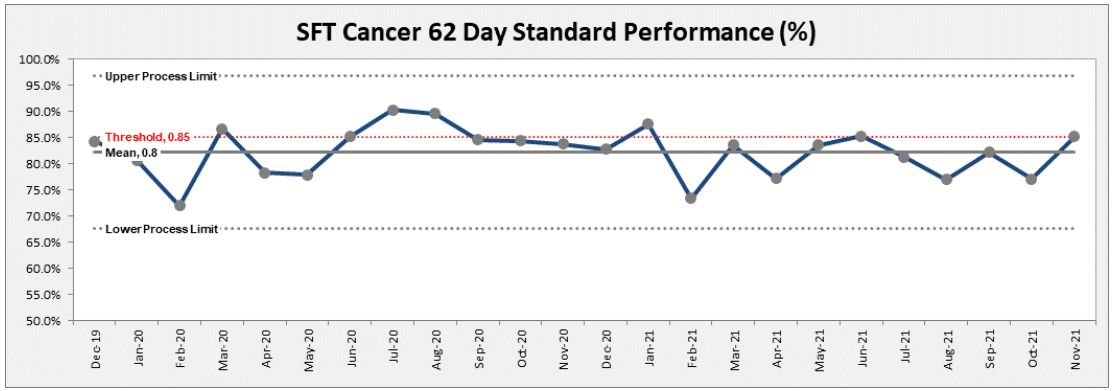
Patient choice: Incremental increase in patient choice 2ww breaches on a monthly basis. Delays associated with a variety of reasons, though as a Trust there are limited opportunities to offer a second appointment within the two week timeframe due to capacity.

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 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

October 21	Performance	Num/Den
62 Day Standard:	85.11%*	60/70.5
62 Day Screening:	50%	3.5/7

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

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

Month 8 62 day performance standard achieved, with validated month end performance of 85.11% (70.5 patients treated; 60 in target; 10.5 breaches)

- Breast: 1 breach (clinical delay)
- Colorectal: 4 breaches (complex pathways across multiple tumour sites, diagnostic delays)
- Gynaecology: 1 patient (complex diagnostic pathway and delays at tertiary centre)
- Haematology: 1 patient (complex diagnostic pathway and delayed transfer from upper GI service)
- Skin: 2 breaches (delayed transfer from another provider, delayed pathology reporting due to outsourcing)
- Upper GI: 1 breach (complex pathway)
- Urology: 2 breaches (complex diagnostic pathway)

62 day screening standard not achieved for Month 8, with validated month end performance of 50% (7 patients treated; 3.5 in target; 3.5 breaches). Breaches associated with BCSP capacity

31 day performance standard achieved for Month 8, with validated month end performance of 96.05% (119 patients treated; 115 in target; 4 breaches).

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

Radiology and histology reporting turnaround times: Increased waiting times for both radiology and histology reporting. Radiology delays associated with insufficient consultant radiologist capacity in light of management of routine backlog. Increase in number of histology reports being outsourced due to staffing constraints locally. Capacity has the potential to adversely affect pathways across all tumour sites and will hinder SFT's ability to deliver the nationally recommended optimum timed diagnostic pathways. Locum consultant radiologist now in post, with additional ad hoc support provided from former member of staff. Average wait time for radiology reporting has now reduced, though continues to be well above expected timeframe of reporting.

Patient fitness: Increase in number of 62 day breaches associated with patient fitness and comorbidities. Increase in number of patients requiring anaesthetic review and pre-habilitation ahead of treatment, as well as incidences 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 on 62 day performance going forward.

Access to PET CT: Service is provided by Alliance Medical. Capacity issues raised via Clinical Lead and Deputy COO directly with provider, as well as through SWAG/Wessex cancer alliance and BSW ICS. Capacity has the potential to adversely affect pathways across all tumour sites and will hinder SFT's ability to deliver against the 62 day standard.

Risks to delivery and mitigations

Impact of COVID-19 and patient complexity: Risk associated with delayed presentation as a result of the COVID-19 pandemic. There have been instances whereby patients are being diagnosed with more advanced stages of cancer, complex metastases and co-morbidities. Ongoing focus from BSW ICS and national campaigns to encourage patients to present to their GPs with any concerns.

Radiology and histology reporting turnaround times: Increased waiting times for both radiology and histology reporting. Radiology delays associated with insufficient consultant radiologist capacity in light of management of routine backlog. This is a significant risk to SFT's 28 day and 62 day pathways.

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

Stroke & TIA Pathways

Are We Effective?

SSNAP Case Ascertainment Audit

Highest level = Grade A

Lowest level = Grade E

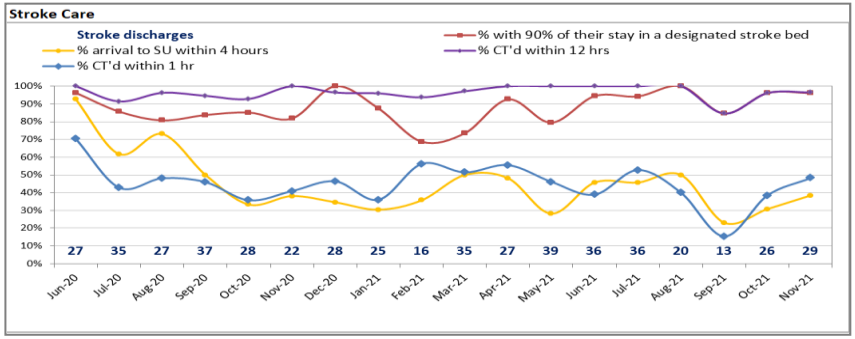
Quarterly	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22	C	C		

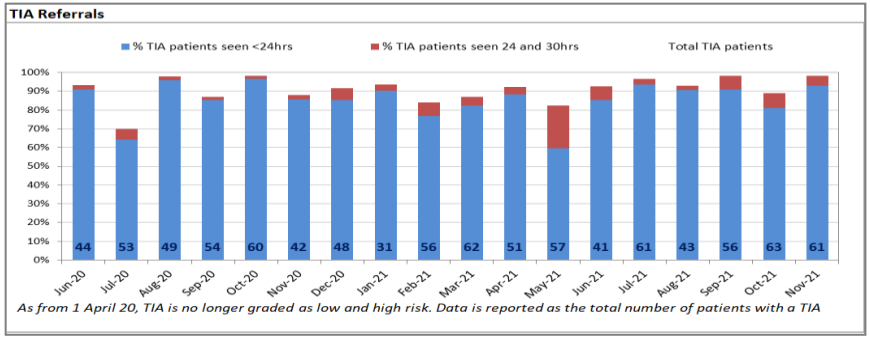
Data Quality Rating:

% Arrival on SU <4 hours: 38.5%

% CT'd < 12 hours: 96.6%

% TIA Seen < 24 hours: 92.9%





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].

The department has now received a SSNAP grade of C and a score of 68% for the period July – September 2021 (Q2). This is marginally up from 64% for the period April – June 2021 (Q1).

- There were 29 stroke discharges this month.
- There were 3 stroke deaths within the 7 day period and 5 in total within the 30 day period in November both numbers exceeded the national target by about 0.3%.
- 90% of stay in the stroke unit was 96% this month reflecting the additional stroke beds on Breamore Ward, 2 exceptions to ITU, 1 to SEU for CT, 1 to Whiteparish confusing symptoms, 2 SLOS.
- The number of patients reaching the stroke unit within 4 hours improved to 38.5% with Exceptions (1 unstable/deteriorating, 2 ITU, 1 transfers to UHS and 1 multi-speciality input) 8 waiting Bed, 3 waiting Specialist Doc, 2 to SSEU, 1 to Whiteparish,.
- A number of long stay patients were discharged this month resulting in an average stroke Unit length of stay of 24.7 days and an Average Total length of 25.2, 4 Patients each > 76 Days, 4 patients each > 30, 3 more > 19 days.
- 48.5% of patients had a CT within an hour which was an improvement of last month but still below the national target of 50%. CT within 12 hours was at 97%.
- 4 patients were discharged this month who had been thrombolysed with an average door to needle time of 55 minutes (27, 49, 60, 87 minutes).
- 11 of the eligible 19 patients were referred to ESD in November.
- 92.9% of the 56 TIA's had treatment completed within 24hrs; with 3 patients affected by full clinics, 1 No Am Clinic due to Clinical Governance.

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

A recent analysis undertaken by the stroke unit revealed that average time to CT head was missing the target of 1hr by approximately 20 minutes. Delays to 1st assessment are considered to be the main cause for this although the reasons have been multi-factorial.

Regarding admission to the stroke unit within 4 hours, an analysis has found multiple causes for the delays. Reasons have included:

- Crowding in ED
- Patients awaiting 1st/2nd clerking
- Awaiting discussion with the consultant prior to moving
- A patient moved to AMU in the first instance (as diagnosis of stroke unclear).

Discussions with ED and Radiology leads have been underway to identify solutions for improving performance times for CT scans. Education opportunities are being taken and an email reminding doctors of the importance has been circulated to ED and Medical teams. ED doctor teaching is also being expedited to highlight the importance of this.

A proposed pathway for the triage and subsequent management of patients presenting with new neurology has been discussed and agreed with ED leads. This should improve early identification of patients requiring CT head, whilst enabling early transfer to the right place, and ensuring that the patient is assessed by the most appropriate person.

Risks to delivery and mitigations

The Unit currently awaits 5 new members of staff to join the nursing team (now expected to commence from late December).

Whilst a new neurology pathway has been proposed the implementation of this has not always been feasible due to ongoing Covid-19 pressures.

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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Perinatal Morbidity and Mortality							
Total number of Perinatal Deaths							
Number of late fetal loses (22+0 to 23+6 weeks excl TOP)							
Number of stillbirths (>+ 24 weeks excl TOP)	0	1	0	0	1	0	0
Number of neonatal deaths : 0-28 days	0	1	0	0	1	1	0
Maternal Morbidity and Mortality							
Number of Maternal Deaths	0	0	0	0	0	0	0
Number if women requiring admission to ITU	0	0	1	2	1	0	0
Insight							
Number or datix incidents - moderate or above						3	0
Datix incidents moderate harm (not SII)						2	0
Datix incidence SII						1	1
HSIB referrals					1	0	0
HSIB/NHSR/CQC or other organisation with a concern or request	1	0	0	0	1	0	1
Coroner Reg 28 made directly to trust	0	0	0	0	0	0	0
Workforce							
Minimum safe staffing in maternity services :Obstetric cover	40	40	40	40	40	40	40
Minimum to Birth ratio	1:26	1:33	1.35	1.41	1.40	1.31	1:29
Provision of 1 to 1 care in established labour (percentage)	100	100	100	100	100	100	100
Datix relating to workforce							1
Numbers of times maternity unit on divert	0	0	0	0	0	0	0
Involvement							
Service user feedback : Number of Compliments	6	9	15	0	24	9	9
Service user feedback : Number of Complaints	2	1	1	2	1	1	1
Staff feedback from Safety walkabouts							
Number of SOX						12	2
Assurance/Improvement							
Progress in achievement of 10 safety actions(CNST)	6	6	6	6	6	6	6
Training compliance - MDT PROMPT (percentage)	47.6	56.8	66.7	68	68	68	56.2
Continuity of Carer (percentage of overall)	7	7	7	4	1	0	0

This dashboard remains under development and therefore some data is currently unavailable

Perinatal Quality Surveillance Tool

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

Maternity Incentive Scheme (CNST)year four

Released in August 2021. Currently underway at SFT with a submission date to NHS Resolution of Thursday 30 June 2022.

Continuity of Carer

Revised National guidance published on Continuity of Carer in October 2021. An implementation plan is being worked up and will be presented to Board for approval before submission to region by January 22nd 2022.

External organisation with a concern or request

Public Health England raised concern regarding the number of Screening Incident Assessment Forms (SIAF's) received for the postnatal screening service. An action plan is in place.

Maternity Dashboard

Data Quality Rating:

Are We Safe?

Measure	Min	Median	Max	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Q1 Total	Q2 Total
Babies (incl Non Reg)	88	334	545		186	158	183	191	222	271	198	**187**	**532**	**606**
Homebirth rate	0.0%	1.7%	7.8%		2.7%	3.2%	1.6%	1.6%	4.7%	4.1%	5.1%	**4.8%**	**2.5%**	**3.4%**
Inductions %	21.6%	34.0%	43.0%		40.1%	38.9%	32.6%	33.0%	38.3%	32.0%	37.4%	**39.1%**	**37.2%**	**31.1%**
Total CS rate (planned & unscheduled)	17.8%	27.4%	73.9%	32% National Dash Mar21	26.9%	37.6%	24.1%	29.7%	29.3%	32.4%	26.6%	**26.6%**	**29.5%**	**30.4%**
Elective caesarean sections %	5.9%	11.7%	21.7%	15% National Dash Mar 21	13.7%	15.9%	10.2%	12.1%	12.2%	13.7%	10.3%	**16.3%**	**13.3%**	**12.6%**
Emergency caesarean sections %	0.1%	15.7%	25.0%	17% National Dash Mar 21	13.2%	21.7%	13.9%	17.6%	17.1%	18.7%	16.3%	**10.3%**	**16.0%**	**17.8%**
Instrumental deliveries %	5.1%	12.0%	21.0%	12.5% NMPA	10.2%	13.5%	12.0%	9.9%	12.6%	9.2%	10.6%	**12.8%**	**11.8%**	**10.5%**
PPH >= 1, 500 %	0.0%	3.4%	21.0%	Green <2.7%, red >5.6% NMPA	2.2%	4.5%	4.8%	2.2%	4.5%	4.6%	4.4%	**3.8%**	**3.8%**	**3.7%**

Safety agenda

ATAIN – Avoiding Term Admissions in Neonatal Units (>37 weeks gestation)

- This programme aims to identify harm leading to term admissions, with a focus on reducing unnecessary separation for mother and baby.
- It aligns with the national ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030

SFT Performance	May 21	Jun 21	July 21	Aug 21	Sept 21	Oct 21
% of term admission (aim < 6%)	3.7	6.0	2.6	5.4	5.4	5.1

SBLv2 – Saving babies lives

Element 1- Fully compliant

Element 2- Non compliant with 1 requirement

- Uterine Artery Doppler scans for High risk women by 24 weeks

Element 3- Fully Compliant

Element 4- Fully Compliant

Element 5- Non compliant with 2 requirements

- Preterm birth guideline – awaiting ratification through CMB
- Non compliant with recording of antenatal corticosteroids on Maternity Information system

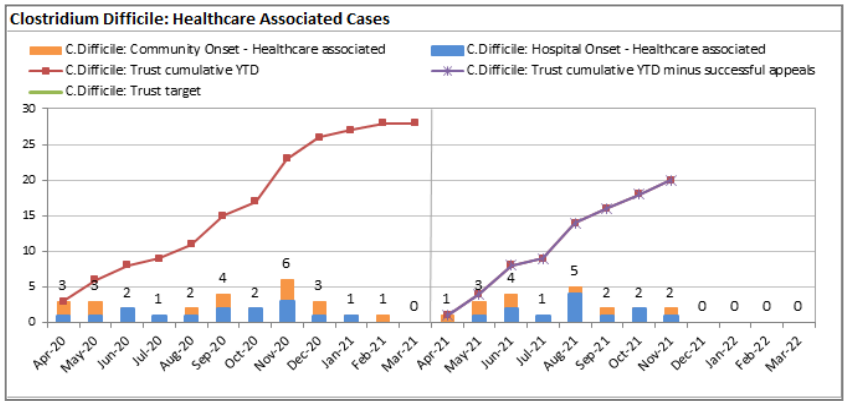
Infection Control

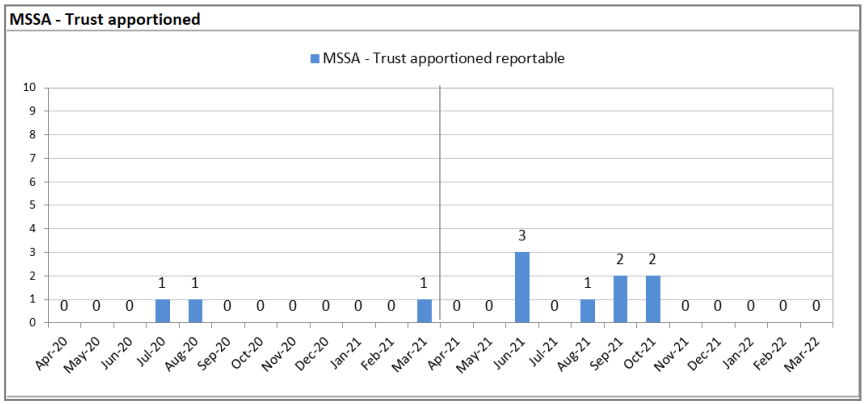
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Cases Appealed	0	0	0	0	0	0	0	0	0	
Successful Appeals	0	0	0	0	0	0	0	0	0	

MRSA	2020-21	2021-22
Trust Apportioned	3	0





Summary

C.difficile – healthcare associated cases reportable to UKSHA (formerly PHE) = 2:

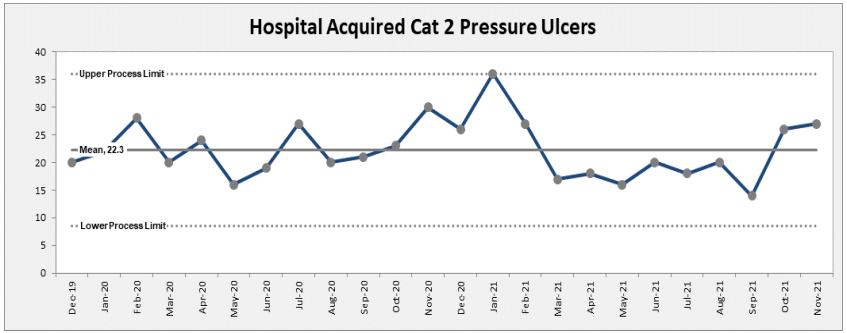
- Hospital onset; healthcare associated reportable cases = **1** (where sample sent for inpatient on Odstock Ward).
- Community onset; healthcare associated reportable cases = **1** (GP sample sent, for a patient who had been discharged from SFT on 20.10.21).

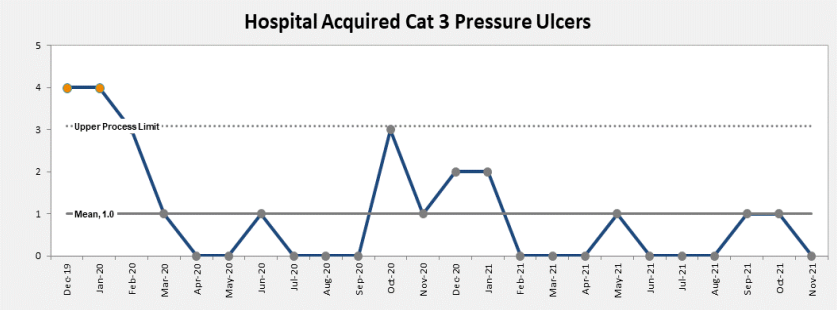
- **MRSA bacteraemia = zero hospital onset cases.**
- **MSSA bacteraemia = zero hospital onset cases.**
- **E.coli bacteraemia = 1 hospital onset case:**
  - Inpatient on Spire Ward with source determined as unknown.
- **Other gram-negative bacteraemia cases = 2 cases:**
  - 2 hospital onset cases for *Klebsiella spp.* (1 for an inpatient on Pembroke Ward with source determined as no underlying focus of infection and 1 for an inpatient on Radnor Ward with unknown source. This was a patient with severe COVID-19).

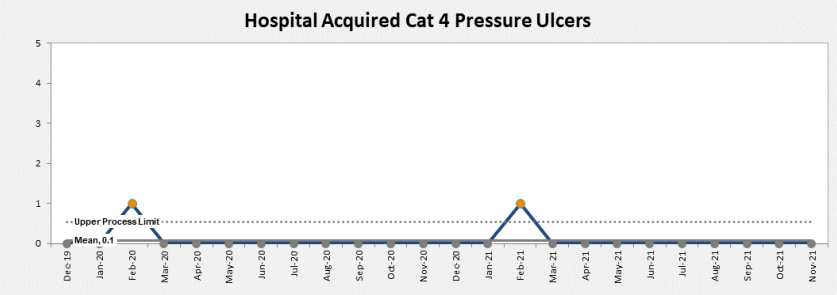
Pressure Ulcers

Are We Safe?

Data Quality Rating:







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	

Summary and Action

Category 2 PUs have increased marginally to 27 in November from 26 in October with both divisions contributing to this number (15 in medicine and 12 in surgery). There are no clear identifiable themes in terms of location or area of body.

No category 3 or 4 PUs have been identified in November.

Deep tissue Injuries have increased to 14 in November from 10 in October. The medical division acquired the majority of these (12 acquired in medicine and 2 in Surgery). No clear theme has been identified for these in terms of location or area of body, however it is notable that several of these deep tissue injuries were acquired on the same patient, likely caused by bilateral leg braces. We will continue to monitor this patient and advice has been given RE the use of medical/orthotic devices and their monitoring.

Unstageable PUs have increased to 6 in November from 2 in October. 5 of these were acquired within medicine and will likely not have significant depth once treated. 1 unstageable PU was identified and has been confirmed as minimum cat 3 PU once further wound management has been undertaken and slough cleared. A SWARM has been undertaken for this area and 72 hour report completed and discussed at Patient Safety Summit. Omissions in care, communication and documentation were noted with the 2 areas involved. This will be taken to Clinical Review in the near future to identify learning and further actions. This PU was device related due to a closed cast in situ on a patient with complex health needs. Several learning points have been identified and discussed with the relevant departments at the SWARM.

The increase in all categories of PU will continue to be discussed at the weekly Matron huddle meeting and key learning identified at the monthly Share and Learn meeting from ward RCA investigations. Causes for the increase in figures will be discussed, noting the significant operational pressures and staffing problems across both divisions coupled with the increased acuity of patients being admitted into the trust. Matrons from both divisions continue to highlight staffing issues each week and we have received several Datix reports from wards highlighting delays in pressure area care and citing high patient acuity and poor staffing levels/skill mix as the key cause for this delay.

Orthotic offloading boot use continues to be good across both divisions. We will continue to monitor this and encourage their use, both as a preventative and reactive measure.

Pressure Ulcer Prevention education had no attendance again in November- staff were booked on to one session but did not attend, the other session had no staff booked to attend. We continue to chase this and the recurring theme for non-attendance is ward acuity and/or poor staffing levels. Tissue Viability continue to offer Pressure Ulcer Prevention education sessions twice a month and encourage attendance from all staff. Pressure Ulcer Prevention education remains a non-mandatory education subject.

Themes and learning identified from monthly Share and Learn meeting include poor patient compliance with pressure area care, poor documentation and/or accuracy of patient assessment, lack of medical photography for review and ward operational pressures/staffing levels. December meeting to discuss November figures will take place on 15th December.

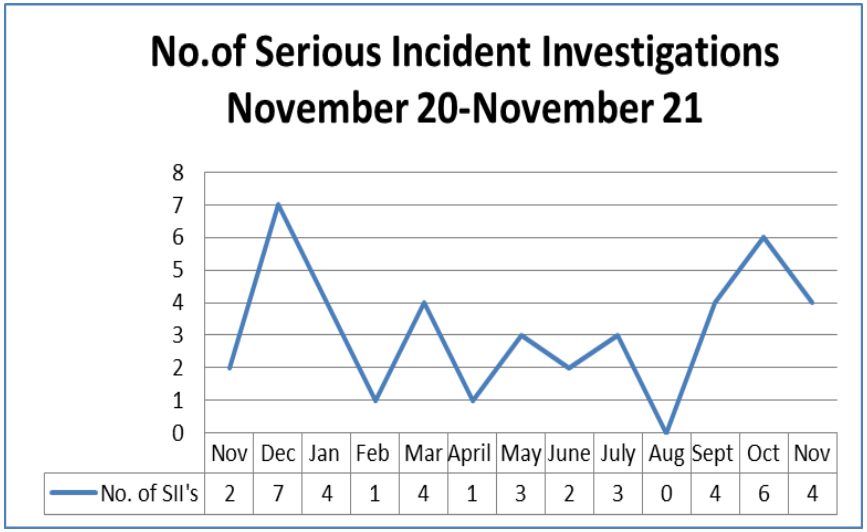
Statistical Process Control Chart Key:

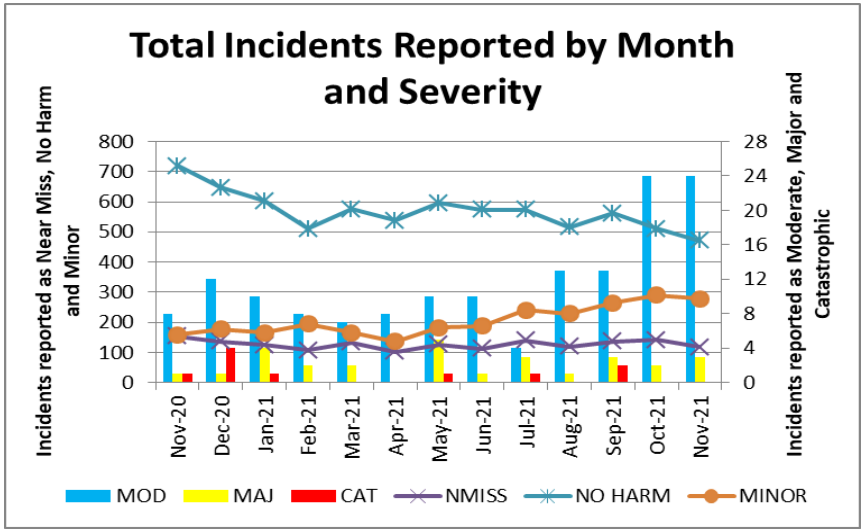
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)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

Incidents

Are We Safe?

Year	2020-21	2021-22
Never Events	0	3





Summary and Action

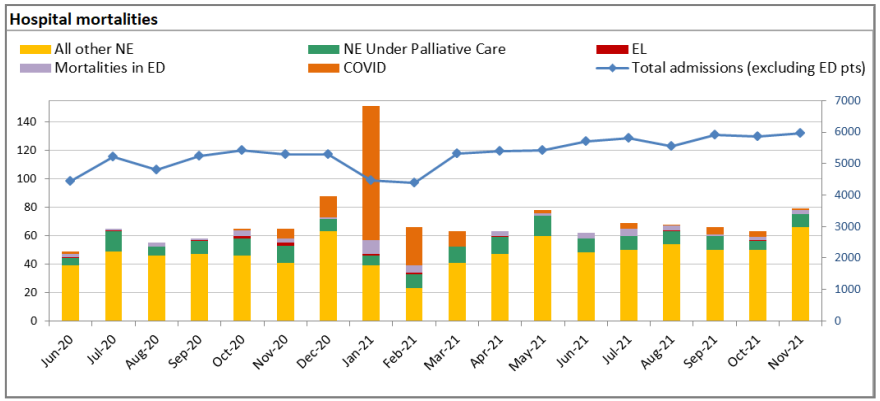
There were 4 SII's commissioned in November, one of which was a 'never event':

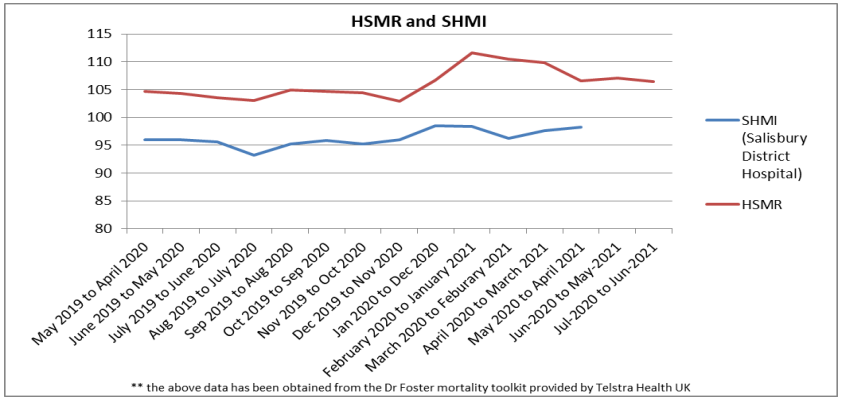
- SII 441 - Wrong Site anaesthetic block **(Never Event)**
- SII 442 - Secondary PPH (maternity)
- SII 443 – A fall with head injury
- SII 444 - Wrong dose intra venous drug given.

Mortality Indicators

Are We Safe?

Data Quality Rating:





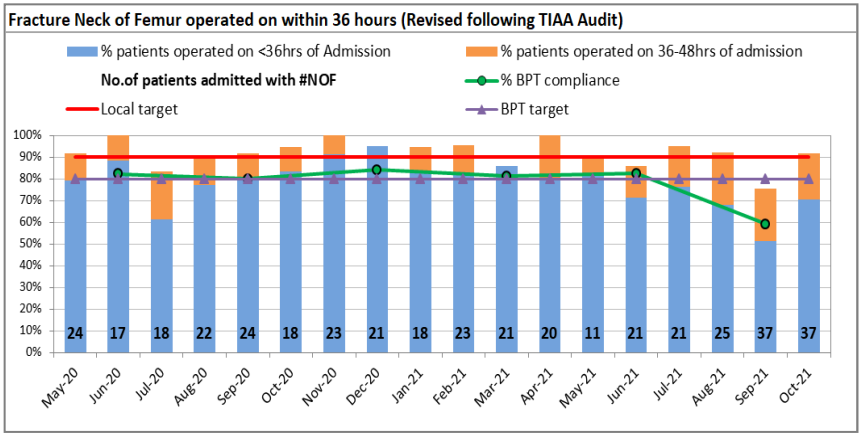
Summary and Action

- 1 death was reported in November due to Covid-19.
- A case note review of all 2nd wave COVID deaths (170 deaths from 11th October 2020 to end August 2021) has been completed, and data from this is now being analyzed. Preliminary data from this was discussed at the Mortality Surveillance Group meeting in early December. A separate review has been undertaken of a selection of non-COVID deaths to ensure that care was not compromised as a result of COVID, and this report will be presented at the Clinical Governance Committee in January.
- HSMR to the year ending June 2021 is 106.4. The latest published SMHI for Salisbury District Hospital (by NHS Digital) is 1.02 and this is within the expected range (August 2020 – July 2021).

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:



(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)

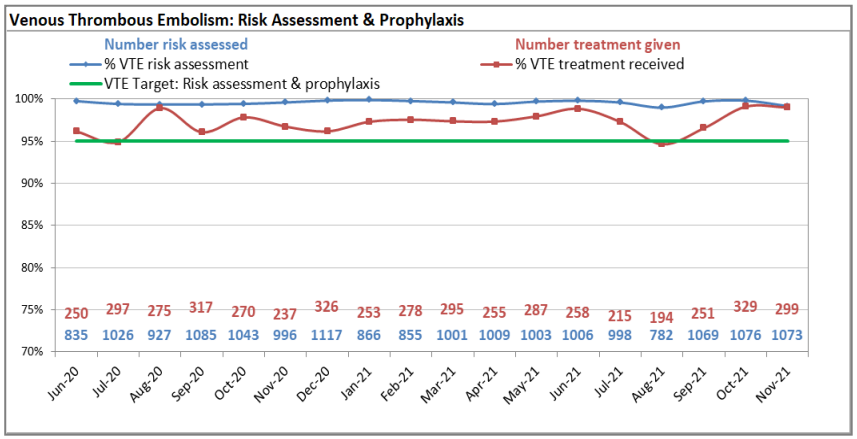
BPT data for November:

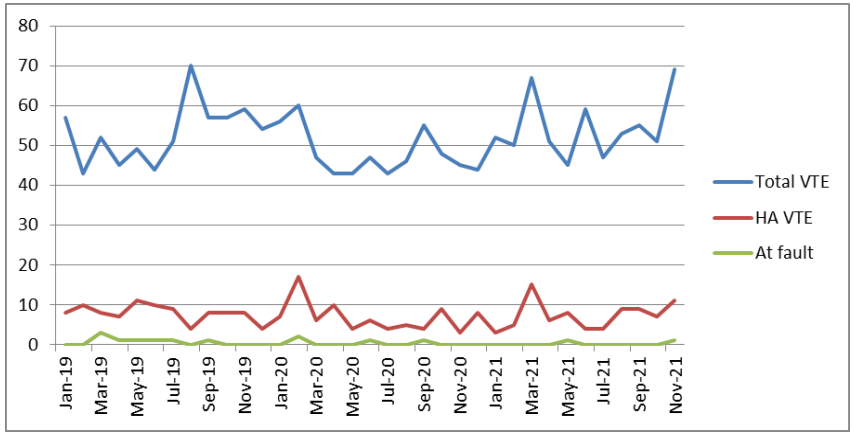
- Total patients discharged: 29
- Not applicable for BPT: 6 (PP#)
- Number of patients who failed to meet BPT: 8

Reason for failure:

- Awaiting space: 5 patients
- Awaiting medical review/investigation or stabilisation (OGD): 1 patient
- Other (Awaiting kit): 1 patient
- Awaiting orthopaedic diagnosis/investigation: 1 patient

A task-finish group was recently established to review performance, and recommendations from this are currently being actioned. Breach timelines are now visible at trauma meetings and this is helping to inform prioritisation of #NOF cases. A new interim lead for #NOF has also been identified.



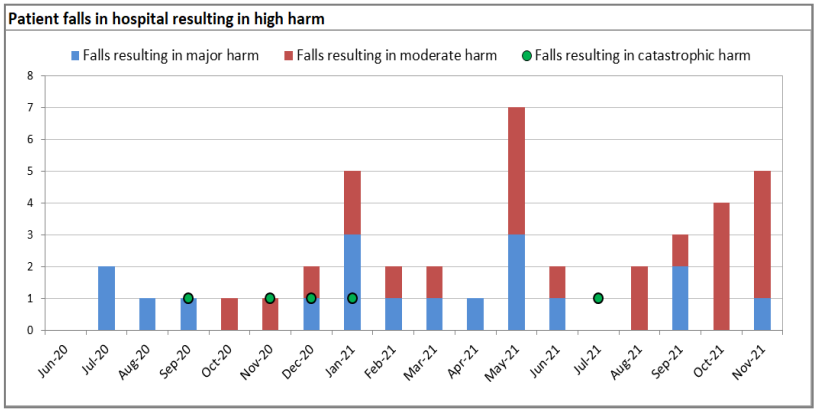


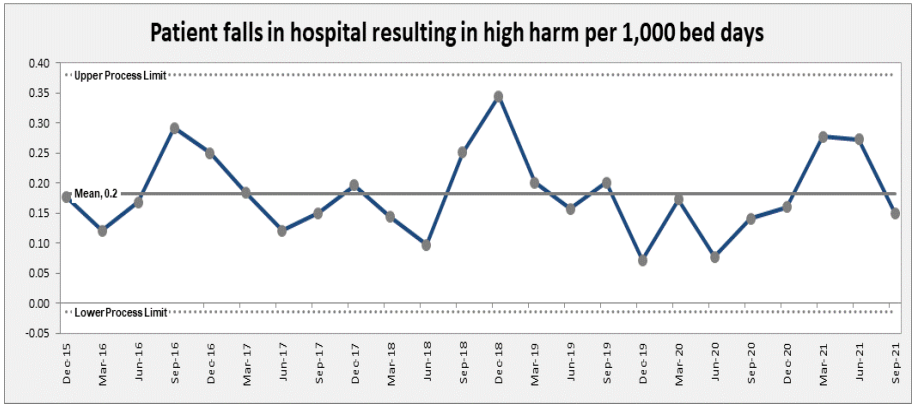
- VTE risk assessment and prophylaxis: 99.2% of patients had a VTE risk assessment completed and 99% received appropriate thromboprophylaxis.
- All patients diagnosed with VTE are assessed and a RCA is performed on all events that have been associated with a hospital admission within 12 weeks of the VTE diagnosis.
- HA VTE: We have seen 11 VTEs in November associated with SDH care (0.1% of total admissions) – National average: 0.5 – 1.6%.
- The RCA from 1 of these events shows an omission in VTE prophylaxis provision. Further information has been requested from the clinician in charge of the patient care.

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

The falls Reduction Specialist has been in post since the middle of October. SWARMs for the falls causing harm have all been completed on time and presented to the patient safety summit weekly. There were 4 falls with moderate harm and 1 with major harm in November. With all in patient falls in the Trust, the falls lead has been able to provide the staff and the patient with advice and guidance by reviewing in real time. Weekly reports are written for the matrons as a group so that they can review themes and cases for their areas. Themes currently involve:

- Datix writing (a guide to completion has been devised by the falls lead-waiting approval)
- Risk assessment on admission and review
- Assessment of the deteriorating patient (following head injury).
- Lack of availability of enhanced care nurses in addition to already depleted staffing numbers.

The falls group has been relaunched and are meeting on the 18th of January.

Falls champions have been sourced for every in-patient area and the first meeting is on 20th December.

A training programme has been developed and trialed, however with high demand and staffing shortages, this will be difficult to implement in a formal teaching environment, therefore, the falls lead will be working with small teams within the ward environments starting with Downton and Spire Wards.

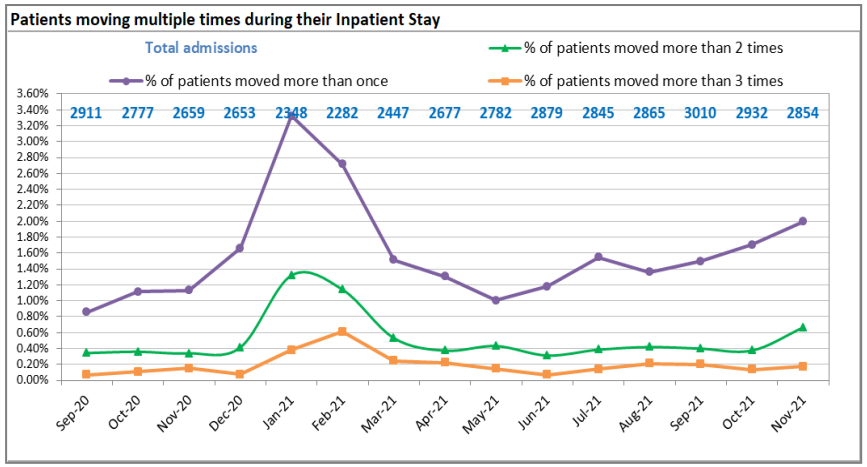
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

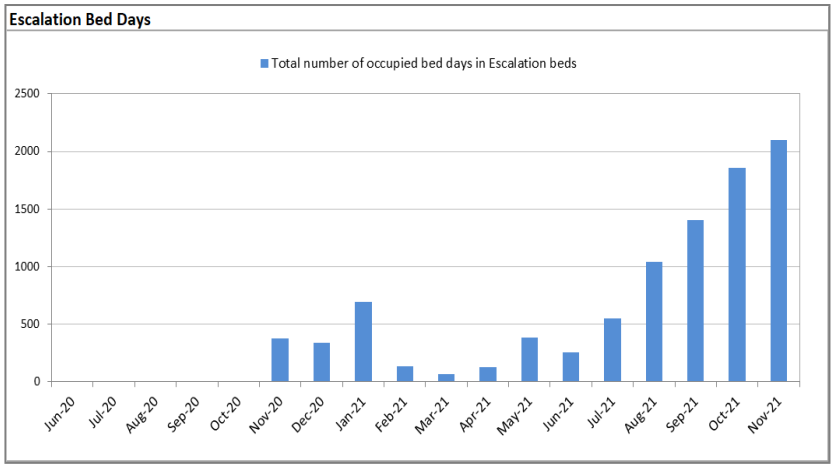
Patient Experience

Are We Safe?

Last 12 months	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Bed Occupancy %	92.4	89.4	86.8	87.6	90.8	91.2	90.8	90.0	93.9	93.0	94.6	95.0

Data Quality Rating:





November continued to be challenging in terms of bed and ward moves, and the use of escalation beds increased. This data demonstrates the operational demands on the Trust and the constant efforts of teams to facilitate high standards of care in the right place at the right time within the confines of safe capacity limited by staffing. To access clinical specialty beds and COVID positive, suspect and contact capacity it is necessary to continually risk assess, consider the safety and impact of decision making and is central to the practice of clinical teams and the clinical site team.

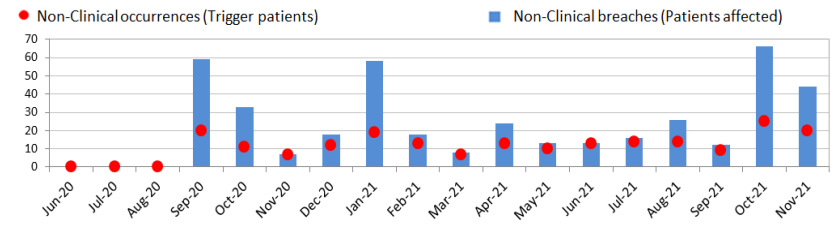
Efforts continue both within the Trust and with external partners to release acute capacity for patients requiring treatment which should support the reduction of patient moves, however it is recognised that the Trust is part of a challenging national picture across health and social care.

Patient Experience

Are We Safe?

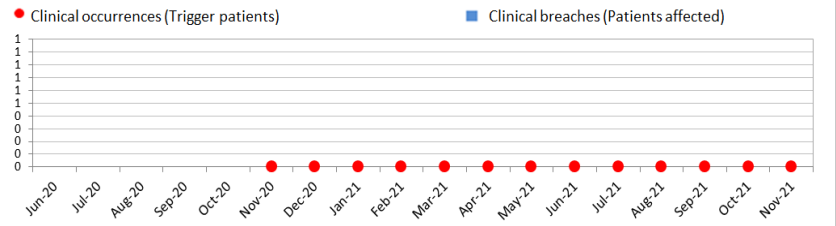
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Jun-20	Jul-20	Aug-20	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
■	0	0	0	59	33	7	18	58	18	8	24	13	13	16	26	12	66	44
●	0	0	0	20	11	7	12	19	13	7	13	10	13	14	14	9	25	20

Delivering Same Sex Accommodation - Clinical



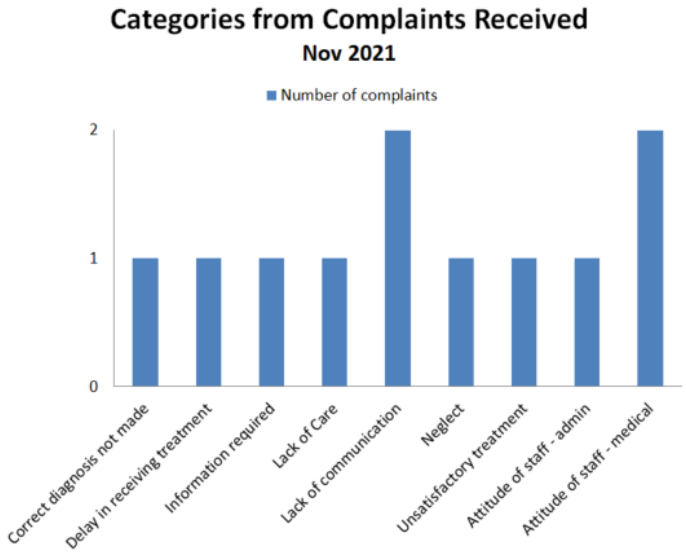
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

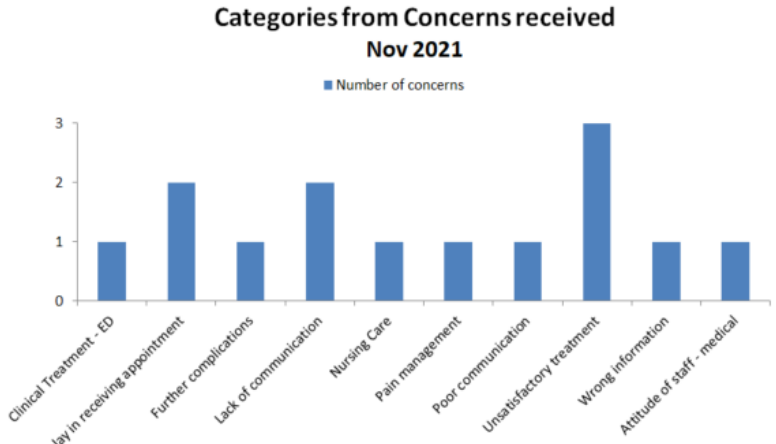
- There were 12 breaches affecting 12 patients which occurred on Radnor. These were all pts who were unable to be moved off the department within 4 hours of being declared fit to move. Nine breaches were resolved within 24 hrs. There were 3 patients who had a breach time of over 1 day while awaiting a speciality bed. Privacy and dignity was maintained at all times within the patients bed space.
- There were 5 breaches affecting 22 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. All breaches were resolved within 24hrs.
- There was 1 breach affecting 4 patients on Chilmark. Privacy and dignity was maintained at all times within the patients bed space. The breach was resolved within 24 hours.
- There were 2 breaches affecting 6 patients on RCU. Privacy and dignity was maintained at all times within the patients bed space. 1 breach was resolved within 24 hours . The other was resolved within 48 hours.

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



Data Quality Rating:



Summary and Actions:

Themes from complaints:

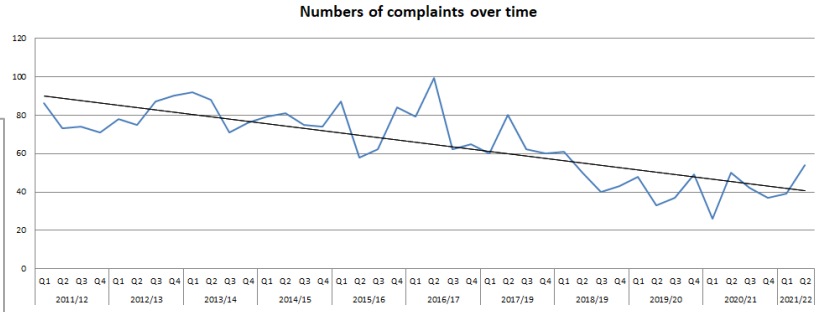
There were 11 complaints raised in November 2021. As can be seen from the graph above there are a wide range of categories used when logging complaints on Datix. No particular themes are noted.

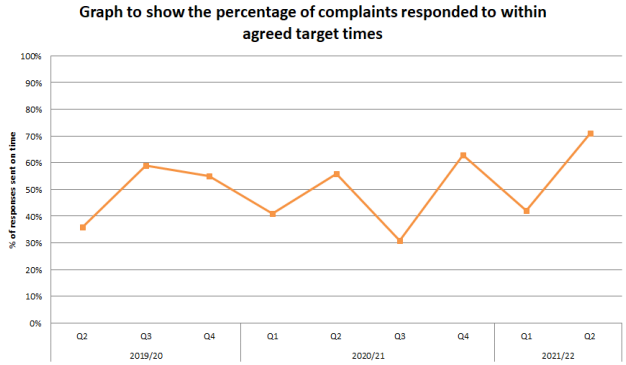
Themes from concerns:

There were 14 concerns raised in November 2021 (none were logged for CSFS).

As can be seen from the graph above there are a wide range of categories used when logging concerns on Datix. No particular themes are noted.

PALS continue to receive a large volume of calls in respect of outpatient appointments. This reflects national concerns regarding waiting list lengths and similar increases in PALS contacts are seen across the NHS.





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.

Turnover for month 8 has continued to be above the Trust target (12.00%). There were 35 leavers and 43 starters by headcount. The most common reasons, where recorded, for leaving were the Voluntary Resignation reasons of – Relocation, Work/Life Balance, and Retirement Age". Together these formed 40% of all reasons for leaving, where a reason was given.

The reason of 'other/not known' remains the most common reason for resignation, this prevents a challenge in understanding what the true reason is for those staff leaving, and what could be done to mitigate.

BSW Benchmarking year to Sept 2021 – RUH Bath 9.53%, GWH Swindon 13.72%

Theatres, Admin & Clerical and Nursing Assistants turnover are hot spots.

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

Work continues around stay conversations, exit interviews, workforce plans in key areas such as Theatres. There will be a presentation on recruitment and retention at the Admin & Clerical governance meeting, as that professional group have the highest turnover rates.

Focussed work is planned on medical hard to fill posts and the retention of trainees nearing CCT for Trust contracts.

To address redeployments concern from Surgery being a reason for leaving, Radnor are a pilot area with focused redeployment support and a redeployment pack, to ensure staff feel supported.

OD intervention around Theatres culture and retention issues.

Working group exploring incentives for additional work is being established to ensure consistency of pay for extra hours worked. Anticipated feel valued

Work is planned on updating the Retirement policy, 9 leavers in month were retirement age, therefore work is around retire and return contracts.

Risks to delivery and mitigation

Capacity for a number of the interventions e.g. Theatres OD pieces, operational pressures – incentives piece

Impact of central policy on mandatory vaccinations for 'frontline workers' on retention and turnover. Ensuring staff are well-informed

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

Nov 21	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	443.41	462.71	(19.3)
Nursing	1,030.79	1,076.65	(45.9)
HCAs	540.72	557.46	(16.7)
Other Clinical Staff	632.11	654.23	(22.1)
Infrastructure staff	1,266.38	1,314.37	(48.0)
TOTAL	**3,913.41**	**4,065.42**	**(152.0)**

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

Vacancy rate in month was 4.06%, compared to 5.65% in September. The Division with the highest vacancy rate was Surgery at 7.07%. The staff group with the highest number of vacancies Trust wide was Registered Nurses at 96.26 FTE (9.5%).

BSW benchmarking Sept 2021 – RUH Bath : 5.37%, GWH Swindon 5.18%

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

Recruitment drive to recruit Maternity HCA's held during month, 10 offers made. Individuals scheduled to start 17.01.2022.

Facilities recruitment event held on 19.11.2021. 36 attendees with 16 offers made on the day. Attendees benefitted from it being held as a 1 stop shop which included interview and offers on the day followed by ID checks and completion of pre-employment forms. 2nd event booked for 28 January 2022.

HCA recruitment event held on 27.11.2021. 11 offers made on the day. All currently going through pre-employment check exercise.

Locum Respiratory Consultant post offered and accepted. Anticipated start date Feb/March 2022.

9 international nurses arrived in month.

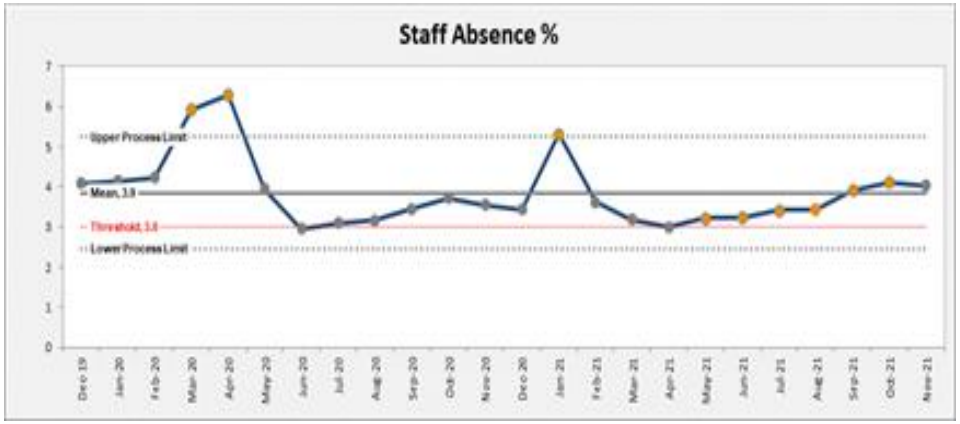
Bid submitted to NHSEI for 2022 RN International Recruitment funding. Outcome due around 15.12.

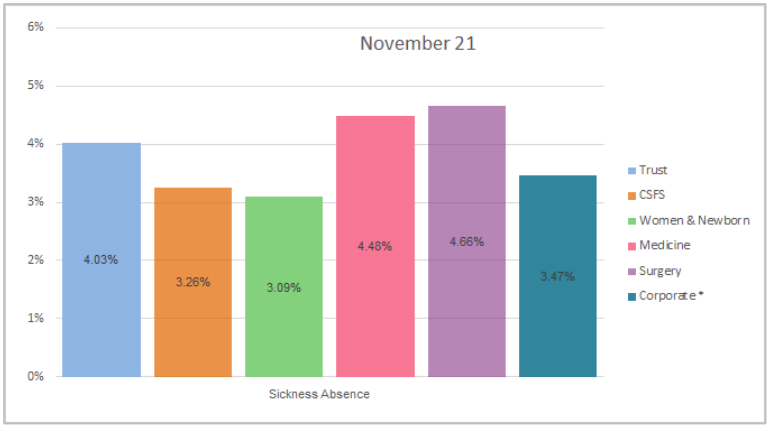
Risks to delivery and mitigation.

Current COVID variant, Omicron may impact further international nurse arrivals due to travel restrictions. Additional arrival date being scoped for the month of January.

Workforce - Sickness

Use of Resources





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

Sickness in month 8 saw a decrease to 4.03%, sickness for the rolling year was at 3.71%. All Divisions are above the Trust target. Anxiety, stress and depression remains the top cause of sickness across all Divisions.

BSW Benchmarking data for Sept 2021 : RUH Bath 4.37%, GWH Swindon : 5.13%

Benchmarking data : NHS Absence rates in July 2021 (Latest month available). The overall sickness absence rate for Acute Trusts in England was 4.96%. This is higher than Salisbury for the same month (3.42%) and higher than July 2020 (3.90%).

Across the NHS, Anxiety/stress/ depression/other psychiatric illnesses is consistently the most reported reason for sickness absence, accounting for over 556,000 full time equivalent days lost and 27.8% of all sickness absence in July 2021, compared to 29.77% in Salisbury in the same month.

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

Work continuing to focus on the management of short term sickness. Continuation of dedicated resource for elective recovery.

Divisions taking responsibility for managing low level COVID queries using SOP to free up OH time for case conference and health appointments.

Working with Manual Handing advisor to identify root causes of MSK injuries and ensure sufficient manual handling support.

Promotion of flu vaccination

People Advisors continue with 1:1 line management support, deep dive sickness work has given both assurance around proactive case management and long term focus

Medical sickness process map to help medical staff with reporting and recording of sickness. Divisional engagement increased. Therefore, anticipate to see improvements next month.

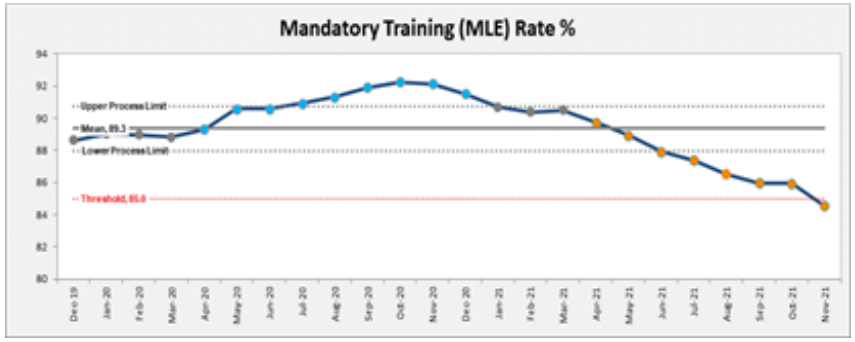
Continuation of Advisors 1:1 line by line sickness meetings with managers, where operational pressures allow.

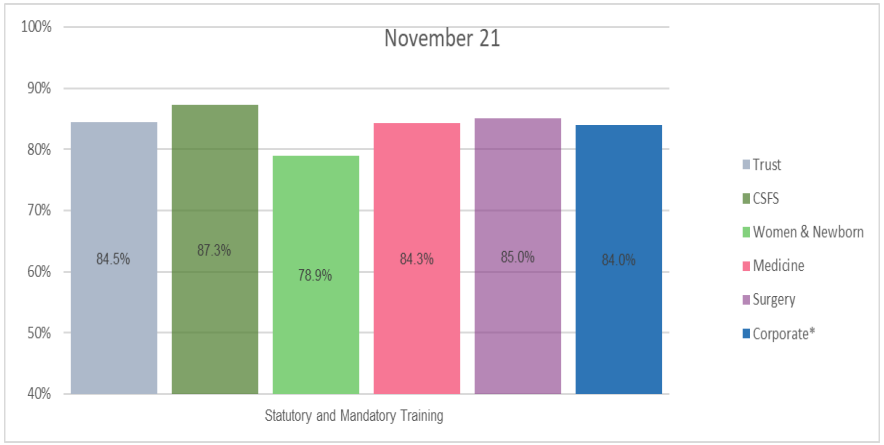
Risks to delivery and mitigation.

Capacity and operational pressures. Other work will be de-prioritised to create scope to continue this focus.

Workforce – Staff Training

Use of Resources





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

The Trust's mandatory training compliance rate was 84.5% for month 8. This is slightly below the previous month and significantly below the same time last year. All 5 Divisions are below target.

BSW Benchmarking Sept 2021 - RUH Bath : 84.5%, GWH Swindon 87.18%

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

Project initiation document to be signed but to include:

Data cleansing to ensure up to date records are kept enabling accurate recording. Manual and Handling and Basic Life Support have commenced already.

Alignment of Core Mandatory Skills with the Core Skills Framework. This will ensure that refresher periods match national recommendations.

Focused activity by Department and Subject Area

Access to computers in Estates and Theatres to undertake the online training.

Continuation of directive communications to Divisions of core topics needing immediate improvement, such as Information Governance.

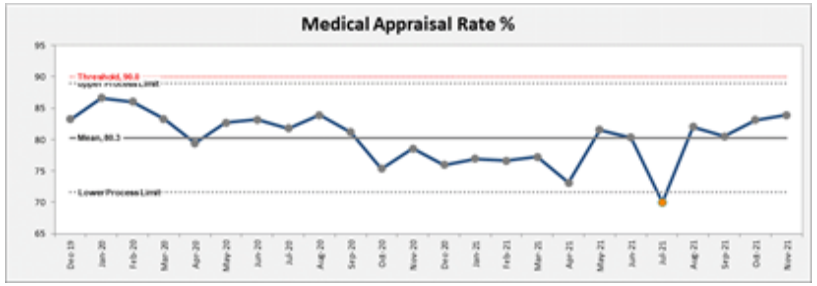
Risks to delivery and mitigation.

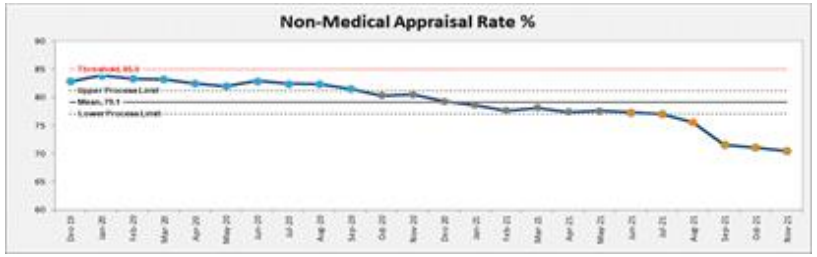
No dedicated resource for the data cleansing activity.

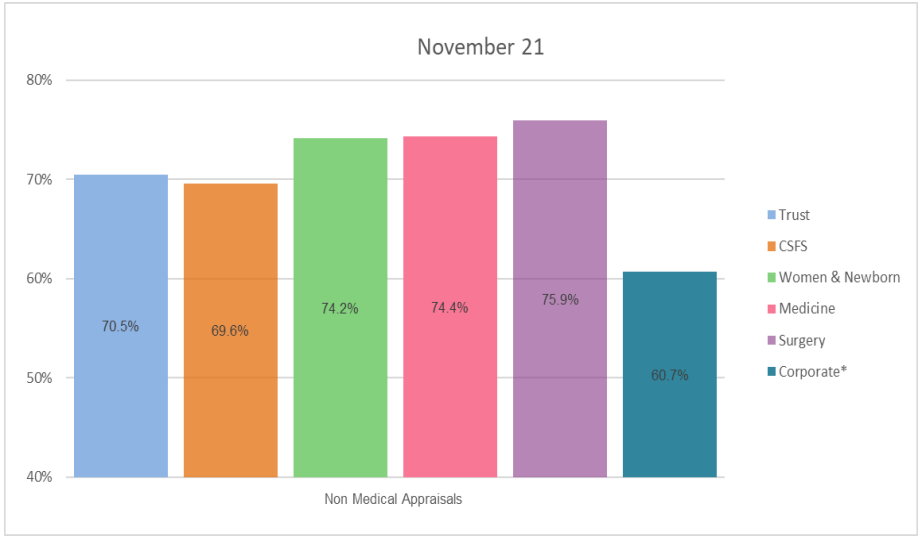
Staff not able to attend training due to operational pressures (specifically Manual Handling and Resus). Mitigation: to enable staff to be paid for attending training on-top of working hours, however this is not possible for all staff.

Workforce – Appraisals

Use of Resources







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

Non Medical Appraisals remain under target at 70.5%, this is a decrease on the previous month position (71.1%). Hotspot areas are Corporate (60.7%) and CSFS (69.6%)

BSW Benchmarking Sept 2021 - RUH Bath : 64.1%, GWH Swindon 71.9%

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

Work will continue with the Divisions around appraisal conversations. As operational pressures continue there is a desire for all staff is to have access to a wellbeing conversation by March 2022. Work is ongoing within OD & People around the implementation of this.

Medical appraisals work is underway with the new Associate Medical Director to improve the appraisal system and process. As part of this work we are exploring all grades of doctors being recorded on the same system. In addition training Appraisers for these conversations.

Risks to delivery and mitigation.

Operational pressures impacting ability to undertake appraisals. The use of the wellbeing conversation could mitigate against the operational pressures impacting appraisals.

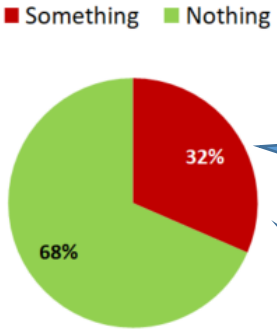
Feedback from Friends and Family test – Q2

Are We Responsive?

What was good about your experience? Nov 2021

"Excellent! First time at a hospital in 81yrs! The staff were so kind, helpful and reassuring. team in the NHS in my 62years" *Endoscopy*

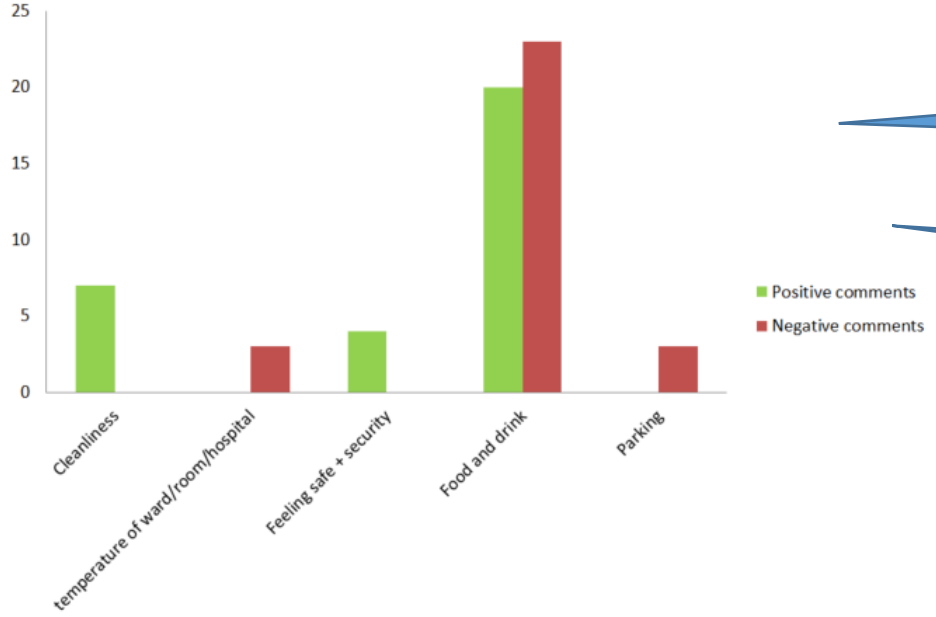
What could we do better? Nov 2021



I know all nurses have to wear masks but in future if any deaf patient is staying, please ensure all staff write on paper instead of trying to talk with masks on. ." *Chilmark*

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

Hospital environment and facilities - positive and negative comments



"The Chilmark suite was very cold on frosty nights. I was non-stop shivering and teeth chattering in spite of piling on blankets."

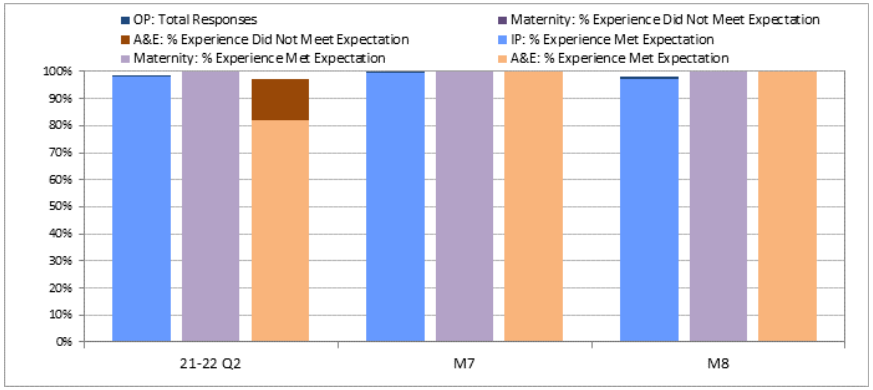
"Parking. Machine not working and I didn't have cash. "

"Efficient care by cheerful staff, both nursing and ancillaries. Superb hygiene standards. Wide choice of food and tasty. " Pembroke Suite"

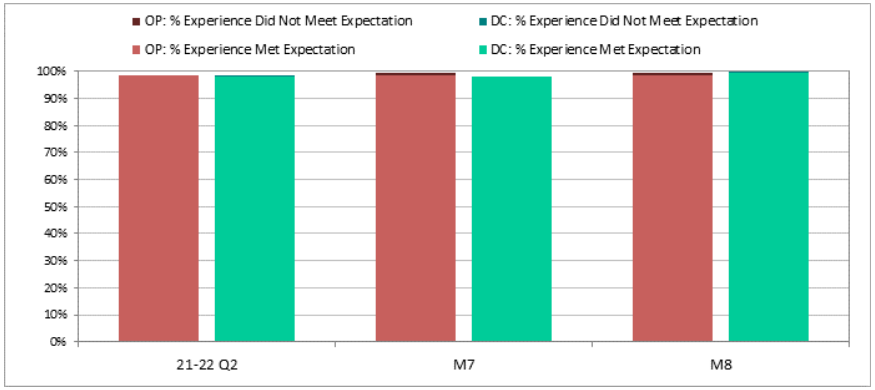
Friends and Family Test – Patients and Staff

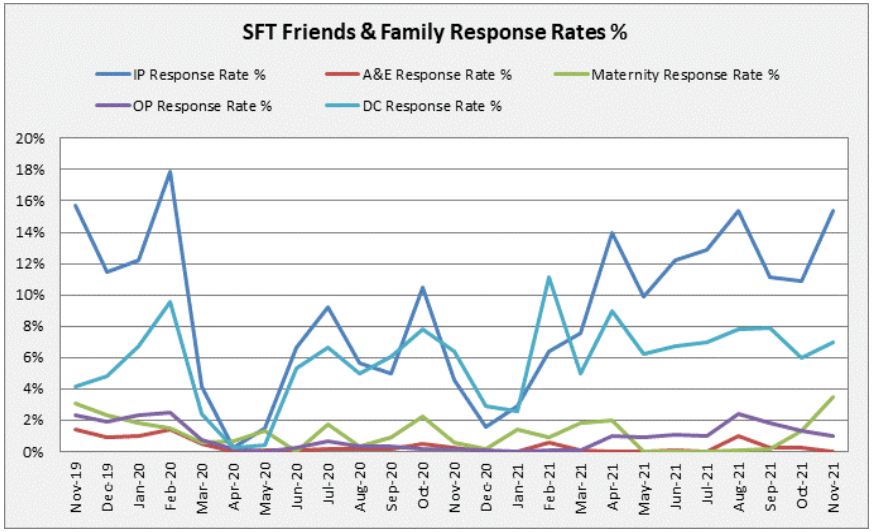
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





We are continuing to encourage use of Friends and family feedback forms in all areas.

Postnatal received feedback from over 20% of patients this month.

Some more great figures on wards:

- Chilmark received feedback from over 60% of patients
- Amesbury received feedback from 45% of patients
- Pembroke received feedback from over 40% of patients

Part 4: Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

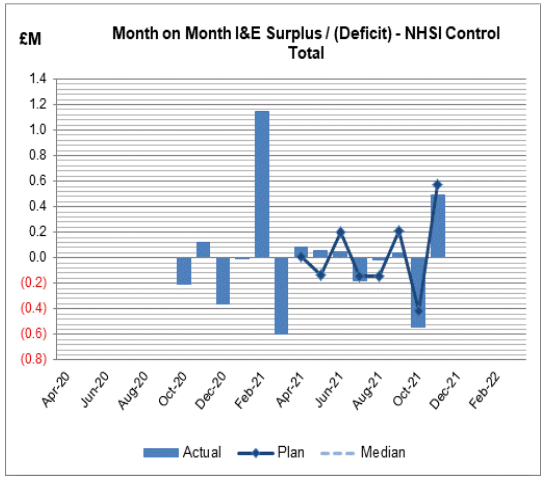
Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	Nov '21 In Mth			Nov '21 YTD			2020/21
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	21,796	22,317	521	166,630	171,995	5,365	251,603
Other Clinical Income	1,146	1,166	20	7,129	5,899	(1,230)	12,085
Other Income (excl Donations)	2,698	3,073	375	20,739	22,454	1,715	31,532
Total income	**25,640**	**26,556**	**915**	**194,498**	**200,348**	**5,850**	**295,220**
Operating Expenditure							
Pay	(15,659)	(15,859)	(200)	(119,924)	(124,241)	(4,317)	(182,474)
Non Pay	(7,834)	(8,499)	(664)	(62,007)	(63,708)	(1,702)	(93,896)
Total Expenditure	**(23,493)**	**(24,357)**	**(864)**	**(181,931)**	**(187,950)**	**(6,019)**	**(276,370)**
EBITDA	**2,147**	**2,198**	**51**	**12,567**	**12,399**	**(169)**	**18,850**
Financing Costs (incl Depreciation)	(1,575)	(1,707)	(132)	(12,414)	(12,404)	10	(18,850)
NHSI Control Total	**572**	**491**	**(81)**	**153**	**(6)**	**(159)**	**0**
Add: impact of donated assets	*(46)*	*(68)*	*(22)*	*(460)*	*(333)*	*127*	*(644)*
Surplus/(Deficit)	***526***	***424***	***(103)***	***(307)***	***(338)***	***(31)***	**(3,959)**



Variation and Action

The final plan for H2 2021/22 was agreed in mid-November, this included an assumption of an allocation of BSW revenue to cover the Trust's initial planned deficit of £3.3m. This revenue is made up of a combination of ERF, ERF+, and discretionary system allocation. The nature of elements of this funding stream include elements of risk (e.g. ERF is contingent on the system delivering the planned level of activity as a whole) but £1.1m has been recognised in line with the underpinning assumptions of the system's H2 operating plan.

With a modest deficit of £6k the Trust remains broadly in line with the H2 plan, however increase staff absence due to Covid and a November spike in the cost of clinical supplies means that the forecast is under pressure. A significant proportion of these pressures will be mitigated in the coming months by the funding awarded for the winter resilience element of the Targeted Investment Fund (TIF).

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.

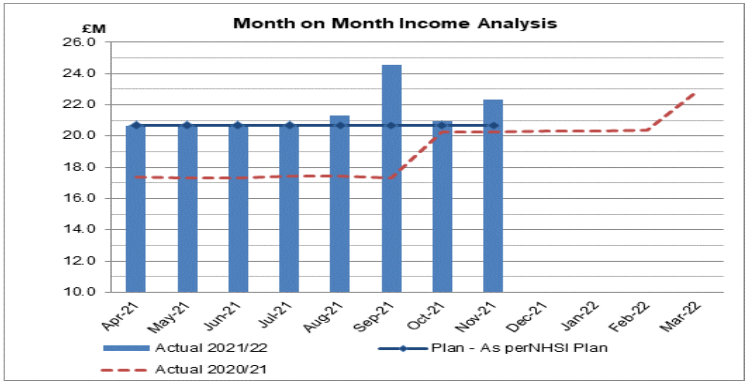
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Nov '21 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	6,104	6,607	503
Day Case	9,995	10,930	935
Elective inpatients	8,628	6,743	(1,885)
Excluded Drugs & Devices (inc Lucentis)	13,855	13,825	(30)
Non Elective inpatients	42,019	43,416	1,397
Other	68,934	69,817	883
Outpatients	17,095	20,657	3,562
TOTAL	**166,630**	**171,995**	**5,365**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	102,620	104,986	2,366
Dorset CCG	16,645	16,859	214
Hampshire, Southampton & IOW CCG	12,527	12,694	167
Specialist Services	22,656	23,410	754
Other	12,182	14,046	1,864
TOTAL	**166,630**	**171,995**	**5,365**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	46,354	46,551	197	35,745	10,806
Day case	13,138	13,887	749	9,300	4,587
Elective	2,385	1,895	(490)	1,445	450
Non Elective	18,766	18,995	229	17,039	1,956
Outpatients	156,523	181,826	25,303	128,645	53,181

Variation and Action

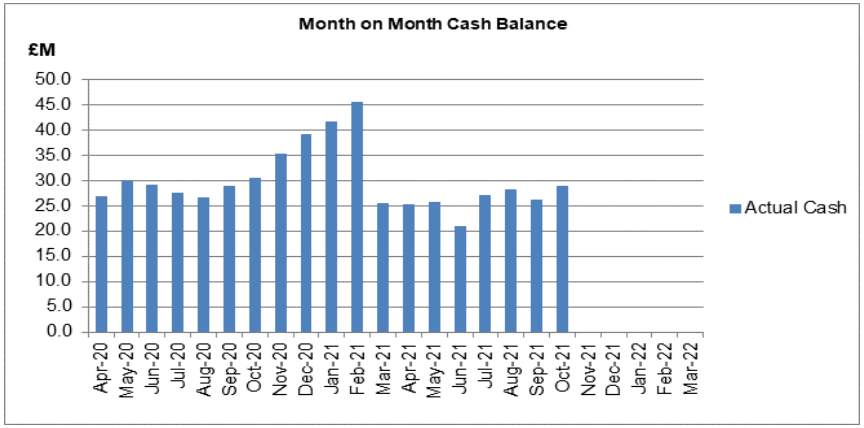
Activity in November in day cases recorded 233 spells more than in October and exceeded the plan for the month. Day case activity has improved against plan in the specialties of General Surgery (40 cases) , Gynaecology (36 cases), Ophthalmology (36 cases) and ENT (34 cases), but activity levels have dipped this month in Gastroenterology and T&O. Activity in elective inpatients was higher than in October with improved performance in T&O/Spinal. Non-Elective spells were slightly higher than in October and remain above plan year to date. Activity pressures continue in Obstetrics and Medicine.. Outpatient activity was higher than last month with more activity this month in Gynaecology, Ophthalmology and Urology,

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. H2 plans are in the process of being reviewed. 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 £1,105k has been included in the position in November, this represents the value agreed as part of the final H2 planning process.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources

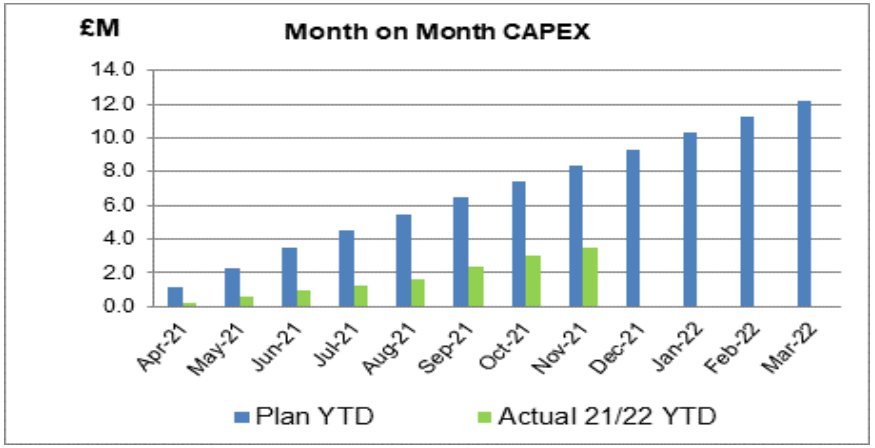


The increase in debtors primarily relates to accrued income for funds due under the Elective Recovery Fund and H2 funding - £2.5m. Prepayments have increased as a result of the requirement to pay NHS Resolution contributions for CNST over the first 10 months instead of the full year and prepayments on the Trust's business rates - £1.7m

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. Work is ongoing to identify where the issues arise and to take steps to improve efficiencies. Purchase order related invoices, where quantities and prices match, are moving smoothly through the system.

Capital Expenditure Position

	Annual	Nov '21 YTD		
	Plan	Plan	Actual	Variance
Schemes	£000s	£000s	£000s	£000s
Building schemes	1,175	984	836	148
Building projects	4,979	3,320	748	2,572
IM&T	3,872	2,584	1,596	988
Medical Equipment	1,728	1,221	346	875
Other	450	294	503	(209)
Additional Funds approved in year	2,778	0	0	0
TOTAL	**14,982**	**8,403**	**4,029**	**4,374**



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.

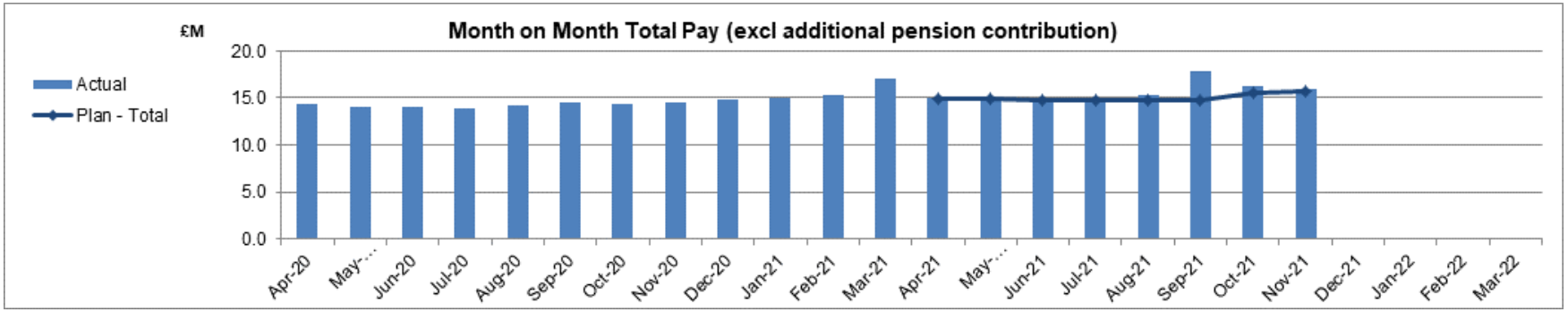
The original capital plan was based on a fairly even distribution of spend throughout the year. However, some building schemes have either been delayed or have been revised. A revised detailed profile plan of how all elements of the programme will be achieved by the end of the year has been developed. 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.

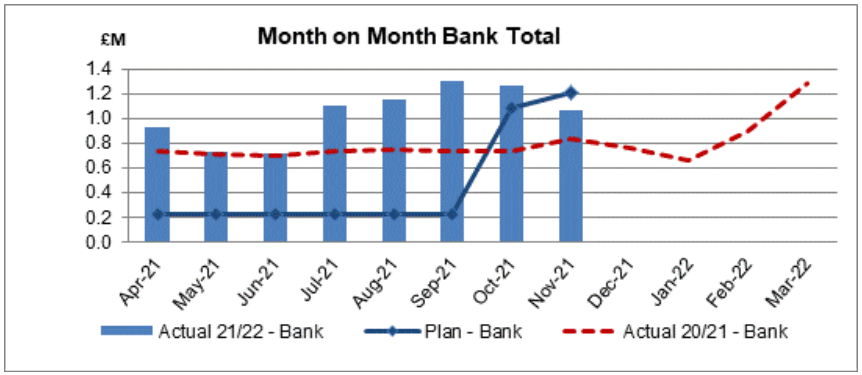
The trust has now been notified that bids for additional capital, including through the Trust Investment Fund, totalling a further £2.9m, have been approved. Plans are now being prepared to procure the equipment and works identified as part of these schemes, whilst continuing to ensure the remaining approved capital programme is delivered.

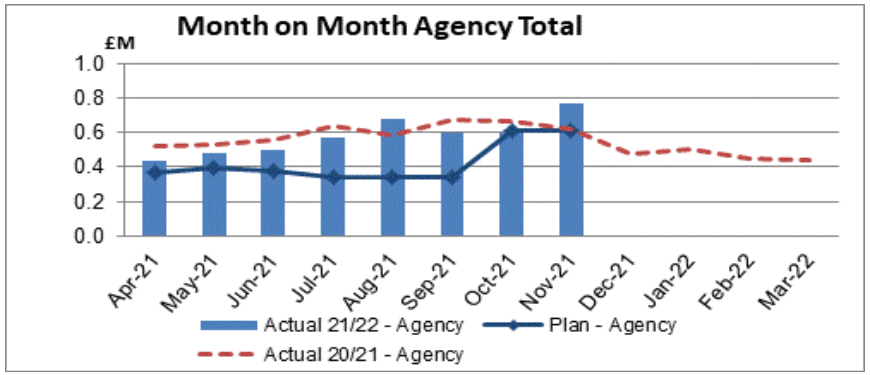
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay costs reduced in Month 8 by 325k (2%). This mainly reflects the nature of the one off increases in month 7 (Salisbury Trading and the TUPE of RUH Procurement team). There was a reduction in both substantive and bank costs, but a significant increase (£175k) in agency - entirely in registered nursing and mainly in the Medicine directorate where short term sickness and absence due to self-isolation continue to increase.

The Trust has welcomed a further 9 overseas nursing recruits in November, bringing the total to 27 this year. A further 23 are expected by the end of the calendar year, as both those delayed due to Covid and the 2021/22 recruitment pipeline begin to arrive. 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 has reported 16.96 WTE infrastructure support staff (cost £50k 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.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	13 January 2022		

Report Title:	Trust Green Plan			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Approval Process (where has this paper been reviewed and approved)	The Green Plan was reviewed by the Operational Management Board on 16/11/21, the Trusts Management Committee approved the Green Plan on 24/11/21 and the Finance and Performance Committee approved the plan on 21st December 2021.			
Prepared by:	Ian Robinson. Head of Facilities			
Executive Sponsor (presenting):	Andy Hyett. Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
The Trust Board is asked to approve the Green Plan (2021-2024).

Executive Summary:
The NHS is responsible for 4-5% of the UK's carbon emissions and 3.5% of all road travel, at the same time climate change is recognised as having a negative impact on health, exacerbating health inequalities. In response the NHS has set a target to achieve carbon net zero by 2040 for direct emissions and 2045 for indirect emissions. Our Integrated Care System (ICS) have set a local target, that 60% of ICS partners will have achieved carbon net zero (for direct emissions), by 2030 and 100% of all NHS organisations will be carbon net zero, for indirect emissions, by 2045. The Trusts Sustainable Development Management Plan (SDMP) was last reviewed in 2019, focusing principally on carbon emissions from gas, electricity and heating oil. Trusts are required to replace SDMP's with a board approved, 3 year 'Green Plan'. Green plans and the Governance behind them are designed to support a reduction in direct and indirect carbon emissions, from across the organisation. Our Green Plan sets out a framework for how we will reduce the impact of climate change, embrace 'green' learning and innovation and support the NHS deliver a carbon net zero healthcare system, by 2045. In November (2021) the NHS Green Team published regional carbon footprint data which identified a 62% reduction in carbon emissions since 1990. In 2022 data will be collected to estimate (for the first time), the carbon footprint at organisational level.

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) -	☐

Green Plan

2021-2024

Foreword

The NHS is responsible for 4-5% of the UK's carbon emissions and 3.5% of all road travel; at the same time, climate change is recognised as having a negative impact on health, exacerbating health inequalities.

We recognise the important role we have in helping to reduce carbon emissions and improve sustainability, to deliver high quality care today without compromising the needs of future generations.

Our Green Plan sets out a framework for how we will reduce the impact of climate change, embrace 'green' learning and innovation and support the NHS deliver a carbon net zero healthcare system, by 2040.

The quality of our environment has a direct impact on our health. Through engagement and partnership working we will transform our environmental impact and make a positive difference on the health and wellbeing of our staff and the population we serve.

The Green Plan is our commitment to reduce our impact on the environment and put us on a path to deliver a cleaner, greener, healthier and more equitable future.

Nick Marsden

Chairman

Stacey Hunter

Chief Executive Officer

Contents

1. Introduction

Salisbury NHS Foundation Trust ('the Trust') is a statutory body, which became a public benefit corporation on 1 June 2006. The Trust provides services at Salisbury District Hospital (SDH) (*see appendix 1*), where 4, 800 staff deliver a broad range of clinical care to approximately 270,000 people in Wiltshire, Dorset and Hampshire, which includes:

- Emergency and elective inpatient services
- Women and newborn
- Day case services
- Outpatient services
- Diagnostic and therapeutic services
- Specialist spinal rehabilitation, plastics and burns Specialist services, such as burns, plastic surgery, cleft lip and palate, rehabilitation and the Wessex Regional Genetics Laboratory extend to a much wider population of more than three million people.

The Trust is located within and aligned to the Bath, Swindon and Wiltshire (BSW) Integrated Care system (ICS). In its long term plan for the next five years, the BSW system describes a vision for the future of supporting and sustaining healthy, independent living.

2. Organisational Vision

As a leading local anchor Institution, we play an important role beyond the boundaries of our Estate, in contributing to a greener, healthier and more prosperous city.

We can further contribute to the local area through: partnership working, health promotion and prevention, employing more local people, supporting local procurement and reducing the environmental impact of our activities.

We are committed to reducing our carbon footprint in line with the NHS target, to reach net zero by 2040 for direct carbon emissions and by 2045, for indirect carbon emissions.

Our aims:

1. Ensure greater engagement with the community, a greater sense of community ownership and involvement with the hospital
2. Contribute to the development of Salisbury as a place
3. Reduce the organisation's carbon footprint and deliver sustainable initiatives that support site development
4. Contribute to a reduction in the causes of ill-health (e.g. air pollution), with an impact on unplanned admissions
5. Improve recruitment and retention
6. Support for local enterprises through procurement.

3. Sustainability Plans and Targets

The health consequences of Climate change were acknowledged at the Paris climate conference (in 2015), resulting in the 'Paris Agreement', a legally binding international treaty on climate change. The NHS contributes 4% of national carbon emissions; the Climate emergency is a health emergency with Climate change and health inextricably linked with consequences for our patients, the public and the NHS.

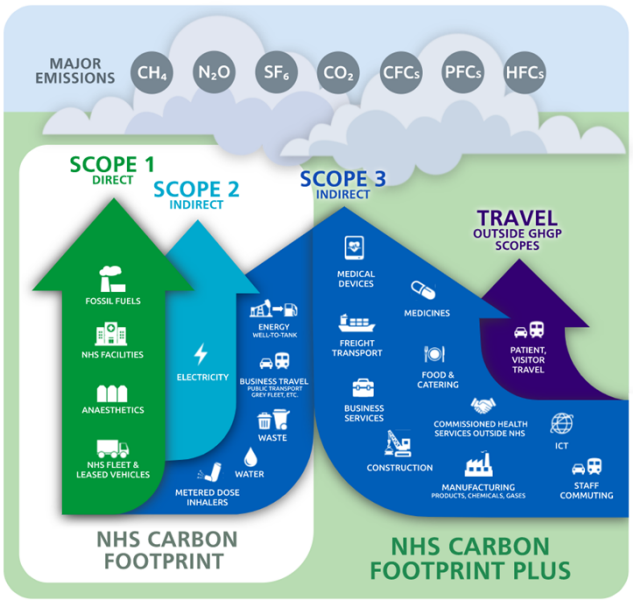
Climate change threatens the foundations of good health; we, therefore, need to take actions that will lead to a reduction in carbon emissions.

All NHS Trusts were required (under the NHS Standard Contract 2017-19) to have a Board approved Sustainable Development Management Plan (SDMP), to support an 80% reduction in carbon emissions by 2050 (Climate Change Act 2008). In the latest SDMP report (2019) the Trust identified that the 2015 target, of a 10% reduction in carbon footprint (from the 2007 baseline), had been achieved.

The carbon reduction target for the NHS was revised when in October 2020; the Greener NHS National Programme published its new strategy, *delivering a net zero National Health Service*. This report highlighted that left unabated climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer.

The report set out trajectories and actions for the NHS to reach net zero carbon emissions by 2040, for the emissions it controls directly (with an ambition to reach an 80% reduction by 2028 to 2032), and 2045 (The NHS Carbon Footprint Plus) for those it can influence (such as those embedded within the supply chain), with an ambition to reach an 80% reduction by 2036 to 2039.

Emissions are broken down into categories identified by the Greenhouse Gas Protocol (GHGP):



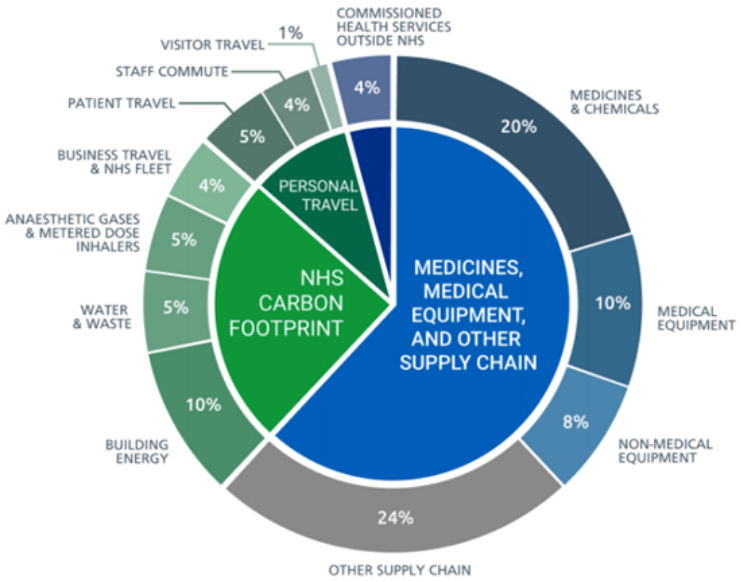
Scope 1 – All Direct Emissions from the activities of an organisation or under their control. Including fossil fuel combustion on site such as gas boilers, NHS fleet & leased vehicles, NHS Facilities and Anaesthetics.

Scope 2 – Indirect Emissions from electricity purchased and used by the organisation. Emissions created during the production of the energy and eventually used by the organisation.

Scope 3 – All Other Indirect Emissions from activities of the organisation, occurring from sources that they do not own or control. These are usually the greatest share of the carbon footprint, covering emissions associated with business travel, freight transport, waste, water, and medicines, medical devices, ICT, staff commuting, construction/building Services, food and catering.

Travel – Outside GHGP Scopes - emissions from patient and visitor travel.

Sources of carbon emissions, in the NHS:



Delivering a 'Net Zero' National Health Service (2020)

The 2021/22 NHS Standard Contract sets out the requirement for Trusts and each ICS to replace Sustainable Development Management Plans with a Board approved Green Plan detailing the approaches to reducing carbon emissions, in line with national trajectories. The Green Plan will not actively consider offsetting; instead will focus on efforts to tangibly reduce Carbon emissions.

In developing this Green Plan we have reviewed our progress on reducing carbon emissions and developed an action plan with a renewed focus, including:

1. Changes in the governance and management arrangements for sustainability
2. Improved monitoring and reporting of progress against action plans and commitments
3. Reviewed our communication strategy around the Green Plan agenda
4. Plans for greater engagement with the local community, Trust staff and ICS colleagues

Priorities for the next three years, as an organisation we will:

1. Embed 'Sustainability' into everything we do, support behaviour change and undertake the actions that will lead to the delivery of Health services within a low or zero carbon NHS.
2. Engage with our community, partners and staff, working collaboratively to embrace the use of technologies, innovation and develop new models of care and new ways of working.
3. Seek to become 'Carbon Literate' raising our staff's awareness of the impact everyday activities have on the climate and know what steps can be taken to reduce emissions, individually, in our teams and as an organisation.
4. Move towards more sustainable low carbon energy sources

5. Develop and promote flexible and remote working, a low or zero carbon commute to work
6. Ensure modern building methods are applied to new building projects
7. Ensure suppliers meet minimum standards expected on net carbon zero and social value
8. Prepare the Estate, develop mitigation and adaptation plans in response to climate change
9. Promote and invest into energy (and water) saving measures, '*make every KWh count*'
10. Increase healthier, more sustainable menu choices and reduce food waste
11. Reduce (or replace) the use of medical gasses and medicines, high in carbon emissions
12. Promote 'active travel' with improved secure storage and e-bike charging facilities
13. *Increase Resource Productivity* – Extend the life of items purchased (repair), increase the volume of recycled waste and repurpose items (e.g. furniture)
14. Reduce the volumes of residual waste through supplier engagement (avoidance), reuse and recycling

4. Green Action Plan

4.1 Workforce and system leadership

Working with the Carbon Literacy Project we aspire to become a 'Carbon Literate' organisation, aware of the impact everyday activities have on the climate and know what steps can be taken to reduce carbon emissions, individually, in our teams and as an organisation.

We will support the Greener NHS Team - *'Healthier Planet, Healthier People',* staff engagement campaign, which seeks to bring to life the link between our health and that of our environment, empowering staff to create a greener sustainable health service, in a way that is meaningful to them.

We plan to better engage with our local community and Staff to develop a Green Forum with Green Champions, empowered to lead a programme of employee led Green initiatives.

Staff Led Actions may include:

- Using a refillable bottle for a year saving 64kg of CO2 compared with single use plastic bottles.
- Turning off equipment and lights and controlling temperatures can lead to great savings, and significant reductions in CO2.

  *TLC – **T**urn off equipment, **L**ights out, **C**lose doors.*

- Saving one car journey a week of 16.7 miles (average daily commute) reduces the equivalent of 230kg of CO2e per person over a year.

- Using the right bin: In 2017, the NHS sent 15% of its waste to landfill, a total of 47,000 tonnes, a weight equal to 650 times the Space Shuttle.

Our actions, we will:

1. Become Carbon Literate, with training and support for staff
2. Support and engage with the '*Healthier Planet, Healthier People'* staff engagement campaign and establish a network of 'Green Champions'
3. Embed our Green Plan objectives within our leadership teams and promote sustainability in our approach to quality and service improvement.
4. Establish and maintain a multi-disciplinary Sustainability Group to develop and deliver the sustainability agenda
5. Develop internal and external engagement and communications to highlight and promote the sustainability agenda
6. Encourage and recognise our staff that embrace sustainability and support us with the 'climate change' challenge

4.2 Sustainable models of care

During the Pandemic significant progress has been made in delivering virtual outpatient appointments, resulting in positive patient feedback. Investment is in place to further develop this work and increase the number of non-face to face appointments, and establish virtual appointments (where clinically appropriate).

We have been running a number of paper lite projects (e.g. E outcome forms for out-patients) and have reduced the number of printers on site. We will seek to develop further opportunities to adopt paper lite strategies in the delivery of care.

We will embed sustainable practices within our models or care, challenge and review the use of 'single use' items and seek alternatives.

Our Actions, we will;

1. Increase the number of non-face to face outpatient appointments
2. Establish and promote further paper lite models of care
3. Challenge and review the reliance upon 'single use' items and seek credible alternatives
4. Support the ongoing development and expansion of online clinical discussions aimed at reducing Hospital admissions e.g. the Virtual Ward project.

4.3 Digital transformation

Our IT team have achieved savings in power consumption and storage capacity by moving to a centralised data centre (The Cloud). We have expanded the use of "Attend anywhere" to ensure outpatient consultations can take place virtually and expanded the use of Video conferencing for multi-disciplinary meetings. Advice and guidance software has been purchased for clinicians (including GP's) to communicate with each other via an app.

The use of virtual meetings and webinars has become 'business as usual' and are routinely used throughout the Trust, resulting in a reduced demand for meeting room space and 'off site' travel.

Our actions, we will;

1. Further develop our electronic patient records system to reduce the use of paper and enable mobile access to information.
2. Work to develop a clear case for change including benefits such as improved virtual collaborative working, and seamless information sharing that could be enabled by a shared electronic patient record across the three Acute Hospitals in the ICS.
3. Implement electronic personal held records to reduce the use of paper with people and they are able to own their care and effectively engage virtually with clinicians.
4. Commit to Digital transformation with reference to the NHSX's 'What Good looks like' framework.
5. Investigate the introduction of a room/desk booking solution to improve the utilisation of office/meeting space.

4.4 Travel and transport

The Trust has established a multi-agency, Transport Strategy Steering Group (TSSG). Through this route we will continue to promote and deliver low carbon strategies to support Green Plan objectives.

Working with a leading provider we have established a platform to support 'car sharing' in the commute to and from work.

In 2020 we installed 14, 7kw Electric Vehicle chargers, available to patients, staff and visitors. We plan to further expand this network and make the Estate 'EV' ready.

To promote the use of public transport we have agreed discounts in place with the local bus company.

The Non-Emergency Patient Transport service was successfully tendered in 2020 requiring the provider to evidence their progress towards an ultra-low (or zero) emission fleet.

Support for 'active travel' has included:

- Improved signage on cycle routes, to and from the Hospital
- Promotion of a 'cycle to work' scheme, linked to salary sacrifice
- Provided access to lockers and showers through 'Active Travel' membership of our Leisure Centre
- Increase the threshold in our cycle to work scheme, supporting the purchase of e-bikes

Our Actions, we will:

1. Develop and gain support for a Travel to Work strategy that contributes to a reduction in carbon emissions, for the commute to work.
2. Further improve facilities to support and promote 'active travel', including secure cycle storage, a bike-Dr Service, dedicated shower and changing facilities.
3. Promote the use of public transport through the development of personal Travel Plans and better engagement with local transport providers
4. Further develop and promote formal car-sharing and a reduction in single occupancy car travel, in the commute to work
5. Support the move to zero emission vehicles, including the addition of further Electric Vehicle (EV) charging infrastructure on site
6. Work towards moving the Trust vehicle fleet to ultra-low (or zero) emission, vehicles
7. Ensure a greater focus on providing staff with travel information combined with the development of Personalised Travel Plans.
8. Continue to promote the use of delivery vehicles with ultra-low (or zero) emissions.
9. Identify the opportunities to improve air quality using the cleaner air hospital framework.

4.5 Estates and Site Redevelopment

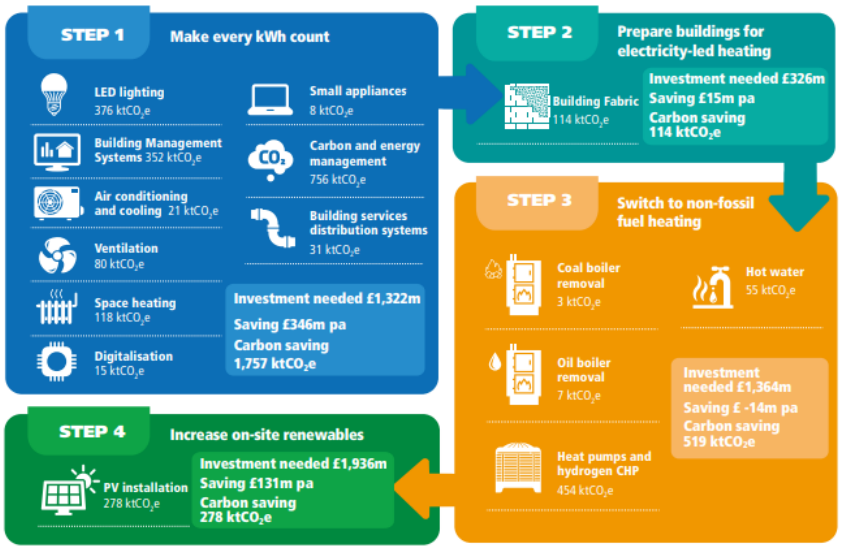
4.5.1 Our Estate

We are committed to reducing our carbon footprint and our Estates team have made significant progress with actions across a range of initiatives, which includes:

- Following an Estates Review (in 2020), we appointed an Energy Conservation Manager
- In 2014 we invested in photovoltaic 'Solar' Panels, generating 4% of our electricity
- 40% of our electricity demand is generated onsite via a Combined Heat and Power (CHP) generator.
- In 2021 we invested £100k in LED lighting systems
- All waste is disposed of through contracts which ensure that opportunities are maximised for recycling, with no waste going to landfill. Our clinical waste is incinerated and the heat generated supplies hot water to Bournemouth Hospital.

- We have developed a recycling centre, which has been the subject of national interest. Volunteers work with procurement and staff to recycle, repair and repurpose as much furniture, mobility aids and other items, as possible.
- The grounds team have been marking and conserving areas of wildflowers since 2018, a Nature Guide has been produced, funded by League of Friends.

Despite the progress made, many challenges remain, including the thermal efficiency of older buildings still in use and the need to decarbonise the estate.



Four step approach to decarbonise the NHS Estate

NHS Estates 'Net Zero' Carbon Delivery Plan (October 2021)

Our actions, we will:

1. Adopt the 4 stage approach to decarbonise our estate:
   - *Make every kWh count,*
   - *Prepare buildings for electricity-led heating,*
   - *Switch to non-fossil fuel heating and*
   - *Increase on-site renewables.*
2. Seek opportunities to further increase the use of renewable energy
3. Promote Energy Conservation and waste recycling initiatives
4. Develop plans for the transition to more efficient lighting and prepare our buildings for electricity-led heating
5. Review and seek to further reduce the amount of exterior night time lighting
6. Reduce water loss (leaks) and investigate the opportunity to recycle water in our swimming pools
7. Develop plans to replace our Combined Heat and Power (CHP) generator, by 2024

8. Develop a coherent energy strategy that supports our low carbon objectives
9. Through our Estates strategy, seek to develop our estate replacing inefficient infrastructure and buildings, adopting low carbon strategies and prepare our estate for severe weather events
10. Ensure construction and capital spend supports modern building methods and low carbon strategies
11. Upskill our Estates staff to be more 'energy aware', and conscious of their contribution to our Green Plan
12. Further promote and facilitate recycling, repurpose and repair, supporting a low/zero waste culture
13. Working with our staff and local community, develop our 'green' spaces to support the health and wellbeing of our staff, patients and visitors, scope out options for onsite tree planting, supporting the 'NHS Forest' movement.

4.5.2 The Elective Care Centre and Site Redevelopment.

Achieving NHS carbon reduction targets will require new hospitals and buildings to be, at the very least, net zero carbon compatible (Net Zero Carbon Hospital Standard, 2021). We are committed to the delivery of NHS Carbon net zero objectives and our 'campus development' programme will make a significant contribution to achieving this commitment. It will enable us to move out of old, inefficient buildings and facilitate the construction of new buildings that meet modern building standards and use technologies that are highly energy efficient.

Underpinning the campus development are some key guiding principles:

- Avoid carbon emissions by designing buildings that require fewer materials and construction activities to build and less energy to run.
- Minimise carbon emissions by using materials and construction activities that result in fewer carbon emissions and ensuring efficient use of energy.
- Replace higher carbon energy sources with low or zero carbon energy sources, both in construction and operation.
- Offset residual carbon emissions that cannot be avoided through quantifiable and verifiable carbon offsetting measures

In order to make a positive contribution to the Trust's net zero carbon objectives through the Elective Care Centre, key requirements will be:

- Developing a carbon emissions model to enable assessment of design procurement and construction options
- Facilitate non-carbon based delivery systems
- Use of modern methods of construction to reduce carbon impact of construction

- Replace higher carbon energy sources with low or zero carbon energy sources, both in construction and operation.
- Offset residual carbon emissions that cannot be avoided through quantifiable and verifiable carbon offsetting measures

Measures such as the BREEAM excellent score and net zero carbon assessment will be used to monitor progress.

The Elective Care Centre is the first major opportunity the Trust will have to establish the key principles of building design which will then influence further developments.

4.6 Medicines/Medical gasses.

Through our Medical Gas Committee we have ceased using Desflurane, a medical gas responsible for a significant amount of carbon emissions, replacing it with Sevoflurane.

We have made progress on recycling foil packaging/blister strips, with collections in place to ensure products are recycled.

We need to focus on ways in which the use of Nitrous Oxide can be reduced. Nitrous Oxide is a major component of Entonox and whilst a very effective analgesic for labouring women, Entonox is a greenhouse gas that accounts for over 2% of the NHS carbon footprint *(Sulbaek et al, 2012; Sustainable Development Unit, 2013).*

Many inhalers used within the Trust are aerosol based and as such, release carbon emissions. Alternatives to current commonly used inhalers may be more expensive and not as effective. Our Pharmacy team are working closely with healthcare colleagues in Primary Care to achieve the transition to more environmentally friendly products.

There is significant wastage of Medicines that could otherwise be avoided; our Pharmacy team are working to reduce this.

Our actions, we will:

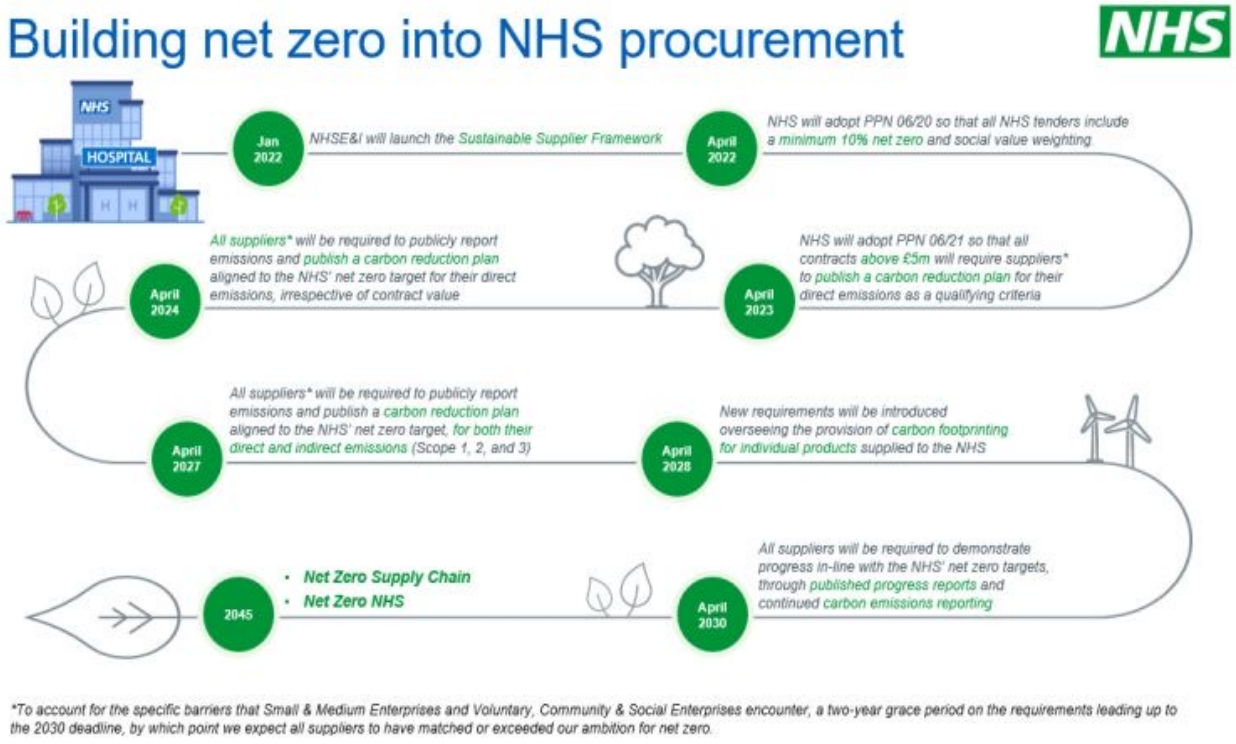
1. Aim to eliminate the use of Nitrous Oxide in the theatre setting within 3 years.
2. Explore more sustainable alternatives to the use of Entonox
3. Work closely with the Primary Care network across BSW to ensure that there are environmentally friendly and affordable options to enable us to move away from reliance on aerosol inhalers
4. Undertake a review of medicines that generate high levels of carbon emissions and explore alternatives
5. Continue to reduce Pharmacy waste.

4.7 Supply chain and procurement

Our Procurement team work closely with all NHS supply chain partners to achieve a sustainable procurement route for the goods and services used across the Trust and the wider ICS.

The Procurement team are committed to the principles of sustainable procurement and was one of the first teams within the Trust to develop a strategy to deliver sustainable objectives.

To demonstrate effective environmental management suppliers to the Trust will be requested to have (or to be working towards), Environmental Management System certification (ISO14001, EMAS, BS8555 or equivalent).



Net Zero Supplier Roadmap

- **From April 2023:** the NHS will adopt the Government's 'Taking Account of Carbon Reduction Plans' (PPN 06/21), requiring all suppliers with new contracts for goods, services, and/or works with an anticipated contract value above £5 million per annum, to publish a carbon reduction plan for their direct emissions. From April 2024, the NHS will expand this requirement for all new contracts, irrespective of value.
- **From April 2027**: all suppliers with contracts for goods, services, and/or works for any value, will be expected to publish a carbon reduction plan that takes into account the suppliers' direct and indirect emissions.
- **From April 2028:** new requirements will be introduced overseeing the provision of carbon foot-printing for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.
- **From 2030**: suppliers will only be able to qualify for NHS contracts if they can demonstrate their progress through published progress reports and continued carbon emissions reporting through the supplier framework.

Supply Chain Challenges include:

- Reduction of the use of plastics. During 2019 / 2020 alone, the NHS purchased 184 tonnes of plastic catering consumables.
- To ensure 'sustainability' is a crucial consideration in all procurement decisions;
- The Public Sector has a vital role to play in furthering sustainable development though the procurement of goods, supplies, and services works and utilities.
- Procurement will raise the profile of sustainable procurement practices, working with suppliers to help achieve this
- Protecting biodiversity
- Training and develop our staff in the principles of sustainability and sustainable procurement
- Supporting innovation that provides sustainable solutions and reduces the consumption of resources, working with commissioners within the Trust and our supply chain
- Reduce transactional costs by supporting eProcurement, eTendering and eCatalogues
- Ensuring procurement activity is compliant with current and future government and public procurement legislation
- Supporting the Trust's sustainability action plan, working with stakeholders to deliver the NHS Carbon Reduction Strategy for England.
- Ensuring all tendering documentation outlines the Trust sustainable policies and requirements.
- Specifying and evaluating sustainability requirements in all tenders and contracts.
- Building sustainable outcomes into procurement staff appraisals

- Ensuring consideration of the waste hierarchy principles (reduce, reuse, recycle, recover)

Our actions, we will:

1. Develop a robust process for managing 'continuous improvement' and Net Zero commitments.
2. Reduce the amount of material that is disposed of by assessing the requirements for goods and encouraging the use of recycled goods where possible
3. Where waste material needs to be disposed of, we are committed to sourcing solutions to recycle in line with legislative requirements and duty of care
4. As an Anchor Institution, make a positive contribution to the local economy and its ambitions to develop sustainable working practices. Our Procurement processes will add social value by supporting local business opportunities recirculating wealth and bringing community benefits.
5. Act upon available national guidance and adopt a Social Value Policy which will build social value into most, or all contract specifications and award and award a significant proportion of tender scoring based on this.
6. Support the NHS Supply Chain in its commitment to reduce the use of single use items in its supply chain and aim to reduce plastic catering consumables used by the NHS by 50 tonnes during 2021 / 2022.
7. Actively seek to increase the utilisation of national contracts where it is clear that sustainability issues have been addressed
8. Undertake whole-life costing when purchasing equipment to include training, implementation, and disposal of goods, consumables, utilities and energy efficiency.
9. Encourage suppliers to propose innovations which improve the sustainability of their tender offering and reflect this in tender evaluation criteria.
10. Include a statement to all suppliers of goods and services that the Trust is committed to leading on sustainability and expects all members of the supply chain to actively support us in this aim
11. Seek the adoption of the Evergreen Supplier Framework as a mechanism to benchmark suppliers and shift to those that actively support the NHS sustainability principles.
12. Ensure the nomination of an ICS lead for sustainable supply chain and procurement to incorporate sustainability into foundations of ICS delivery
13. Work towards ensuring that all paper purchased for use by the organisation, contains recycled content.

4.8 Food and nutrition

In 2018 our Catering Team achieved the 'Food for life' bronze award, awarded to recognise the use of locally sourced, fresh produce and the use of seasonal menus.

The catering team support animal welfare and sustainable methods used in the supply of food and actively work to reduce food miles, with the sourcing of goods and services locally, whenever possible.

Meat and dairy items contribute to our carbon footprint; in response we have promoted plant based diet choices for staff and visitors and developed a bespoke vegan menu for our patients. Additionally, we have increased the number of plant based menu options onto our standard hospital menu.

We have ceased using single use plastic cups, replaced polystyrene products and have replaced all 'take-a-way' plastic cutlery with wooden items. Plastic straws have been changed to a more eco-friendly biodegradable product. Disposable plastic cups used by patients (for water) have been replaced with re-usable beakers.

Our actions, we will:

1. Work to significantly reduce the volume of 'single use' items used in food service e.g. coffee cups, take a way containers
2. We will review our recipes and working with Dietitians, reduce the volume of meat and dairy from our menus
3. Working with our Estates team we will seek further improve our energy efficiencies and reduce energy consumption, in the food service process *'Make Every KWh Count'*
4. With an increase in the use of organic products, we will seek to achieve the Food for Life Silver award'
5. We will investigate alternative methods for waste food disposal, removing the food macerator
6. We will seek to increase the volume of food consumed by our patients, supporting a reduction in food waste e.g. reintroduce the '*course by course'* initiative
7. We plan to introduce an electronic patient meal ordering system, reducing paper and supporting a reduction in food waste
8. We will work with our Procurement team to increase the percentage of locally sourced foods.

4.9 Adaptation

Adaption is the process of adjusting our systems and infrastructure to continue to operate effectively, while the climate changes. We will develop plans to mitigate the risks and effects of climate change including severe weather conditions such as flooding and heatwaves.

Using the Climate Adaptation Risk Assessment template, we will monitor the significant risks facing our organisation and set out the adaptation and mitigation actions required.

Our actions, we will

1. Identify a named Adaptation lead by April 2022
2. Complete the Climate Adaptation Risk Assessment and manage these risks through the Trusts Business Assurance Framework.
3. Develop longer term plans through our site development work, to militate against these risks.

5. Green Plan Governance

The Chief Operating Officer is the Trust Board nominated Executive Director and net zero lead, with responsibility for sustainability and the delivery and implementation of this Green Plan.

The Head of Facilities is the Trust lead for sustainability and will provide the Trust Management Committee (TMC) with progress reports, against Green Plan objectives.

We will work collaboratively with our ICS partners, staff and our community, to further develop our response to the climate emergency and plans for carbon reduction, evolving and updating our Green Plan to meet this challenge.

Our Green Plan will support the development of a system wide Green Plan (in 2022), for the BSW ICS.

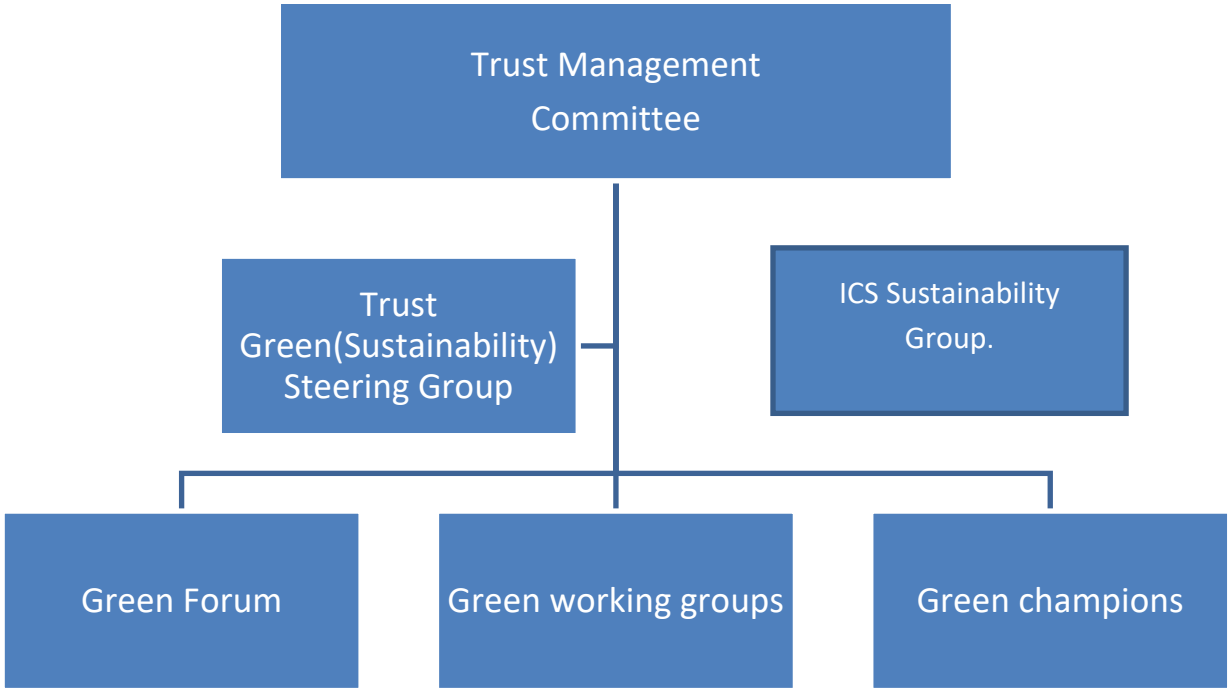


Figure 1: Green Governance Structure

5.1 Reporting Progress

Progress against the Green Plan will be formally reported to the Trust Management Committee (TMC) and will consider:

1. The progress made and the ability to increase or accelerate agreed actions
2. New initiatives generated by the community we serve, our staff, ICS colleagues or partner organisations
3. Advancements in technology or other enablers
4. The likely increase in ambition and breadth of national carbon reduction initiatives and targets.

A detailed action log will be developed and monitored by the reconfigured Sustainability Steering Group. The action log will be consistent with the themes and aims identified in this Green Plan and will provide a level of detail that will ensure accountability for the delivery of objectives.

6. Appendices

6.1 Salisbury NHS Foundation Trust Overview and Dimensions

Salisbury NHS Foundation Trust (SFT) is a statutory body, which became a public benefit corporation on 1 June 2006. The Trust provides services at Salisbury District Hospital (SDH) which is located a mile south of the city centre. We deliver a broad range of clinical care to approximately 270,000 people in Wiltshire, Dorset and Hampshire which includes:

- Emergency and elective inpatient services
- Women and newborn
- Day case services
- Outpatient services
- Diagnostic and therapeutic services
- Specialist spinal rehabilitation, plastics and burns Specialist services, such as burns, plastic surgery, cleft lip and palate, rehabilitation and the Wessex Regional Genetics Laboratory extend to a much wider population of more than three million people.

Salisbury District Hospital includes the Duke of Cornwall Spinal Treatment Centre. This is a purpose built, 45 bed unit which specialises in caring for people who have spinal cord injury and serves a population of 11 million covering an area across most of southern England. Our services are delivered by 4,800 staff.

SFT is located within and aligned to the Bath, Swindon and Wiltshire (BSW) Integrated Care system (ICS). BSW has a population of approximately 920,000 people. There is a combined health and care workforce of approximately 40,000 staff. All the hospital trusts within the ICS are located on the fringes of its boundary and patients are referred to specialist centres outside of the BSW footprint for expert support and treatment, e.g. cancer services in teaching hospitals in Oxford, Bristol and Southampton.

Bath, Swindon and Wiltshire all have growing populations and have local communities with very different health and care needs. BSW achieved an ICS status in December 2020. In its long term plan for the next five years the BSW system describes a vision for the future of supporting and sustaining healthy, independent living.

The local population which SFT covers is predicted to grow by about 14% between now and 2030 and overall by about 11% by 2041. This is largely driven by an increase in housebuilding across the area and by the military rebasing project which has seen large numbers of army personnel and their dependents settling in Wiltshire following the closure of military bases in Germany.

Whilst the overall population is increasing about the same level as for the rest of England, in the Wiltshire ICS area the proportion of people in older cohorts is increasing more than in the rest of the country. In particular the over 80's is forecast to increase by 120% (England

91%) and the over 64's by 45%. At the same time, the number of younger people is reducing, as is the number of working age residents – this puts Wiltshire at odds with the national picture.

This presents a future demographic challenge for the system – growing demand associated with an ageing population with an increasing number of life limiting long term conditions and at the same time a potentially reduced workforce to care for those needs. There is a clear link between age and increased levels of long term conditions.

Our Estate covers some twenty one hectares, of which a substantial element comprises accommodation which is single-storey and originally built in the early 1940s and which are still being used for clinical services. The site is large, but is sprawling and inefficient to run and has some areas of extremely old accommodation, and even the more recent facilities are approaching thirty years old.

A large proportion of the hospital site is housed in older accommodation. Instead of new buildings, the Trust has sought to use its resources most effectively by moving out non-clinical services from the newer parts of the hospital to the north of the site and converting these areas into clinical space. There is now relatively limited non-clinical functions accommodated in the newer parts of the site - the opportunities for this approach are now exhausted. Yet there remain clinical services provided out of 1940's accommodation (maternity, neonatal intensive care) and in buildings that have exceeded their economic life (day surgery) or in accommodation where the clinical model and therefore the accommodation requirements have changed substantially.

6.2 Key Contributors to the Salisbury NHS Green Plan

We wish to acknowledge the contribution of the following to our Green Plan:

Name	Title/Department	Chapter/section
Laurence Arnold	Programme lead	All
Jon Burwell	Chief Information Officer	4.3
Emma Cox	Head of Quality Improvement	4.2
Yvonne Banton	Occupational Therapist Older Person's Therapy and OPAL Team	4.2
Duncan Murray	Consultant anaesthetist	4.2,4.6
James Brewin	Consultant urologist	4.2
Natasha Grover	Pharmacy	4.6
Peter Davies	Pharmacy	4.6
Paul Straughir	Catering Manager	4.8
Justine Baker	HQ Manager, Facilities	4.4
Paul Freeman	General Manager, Facilities	4.4
Tom Sneddon	Compliance/Energy Conservation Manager 4.5	4.5
Rob Webb	Associate Director and Procurement	4.7
Jean Scrase	Education	4.1
Nicola Summeril	Education	4.1
Claire Wilkinson	OD/people	4.1
Nicky Wilde	OD/People	4.1
Jane Websdale	Waste and Environment Manager	4.5
Dave Roberts	Head of Communications	All
Transport Strategy Steering Group	Multi agency Group	4.4
Caroline Railston-Brown	Sustainability Manager GWH	All

Table 1 Key Contributors to SFT's Green Plan

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	13 January 2022		

Report Title:	**Q2 Patient Experience Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Patient Experience Steering Group			
Prepared by:	Katrina Glaister, Head of Patient Experience			
Executive Sponsor (presenting):	Judy Dyos, Chief Nurse			
Appendices (list if applicable):	FFT themes – balance of positive and negative responses			

Recommendation:

The Board is asked to note this report.

Executive Summary:

This report provides a report of activity for Q2 2021/22 in relation to complaints and the opportunities for learning and service improvement.

- An increased percentage of complaint responses were sent out within the agreed timeframe in Q2
- Complaints that are significantly past their response time are noted in the divisional reports (there is one complaint from May 2021 that has not been closed)
- 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)
- 'Attitude of medical staff', 'unsatisfactory treatment' and 'further complications' are the main theme from complaints and concerns combined.
- In Q2 we saw an increase in re-opened complaints. In all cases complainants were unhappy with the response they had received.
- 98% of patients who completed their FFT questions in Q2 felt their experience was good or very good
- The new Patient Experience Steering Group (PEG) commenced in October 2021. Terms of Reference have been agreed and were ratified at CMB in November 2021. A patient story will be shared at every PEG meeting

This report provides assurance that the Trust is responding and acting appropriately to patient feedback and assurance of patient and public involvement in service co-design and improvement.

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) -	☐

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.

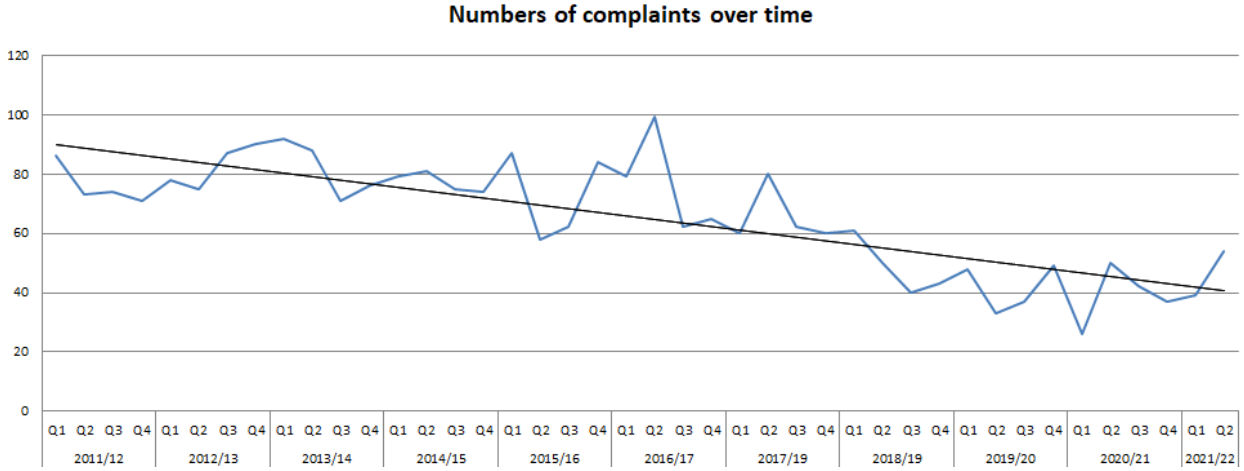
The PALS team (and patient representatives going forward) review all the SOX nominations and choose a selection to go forward to the Trust Board where recipients receive a certificate.

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

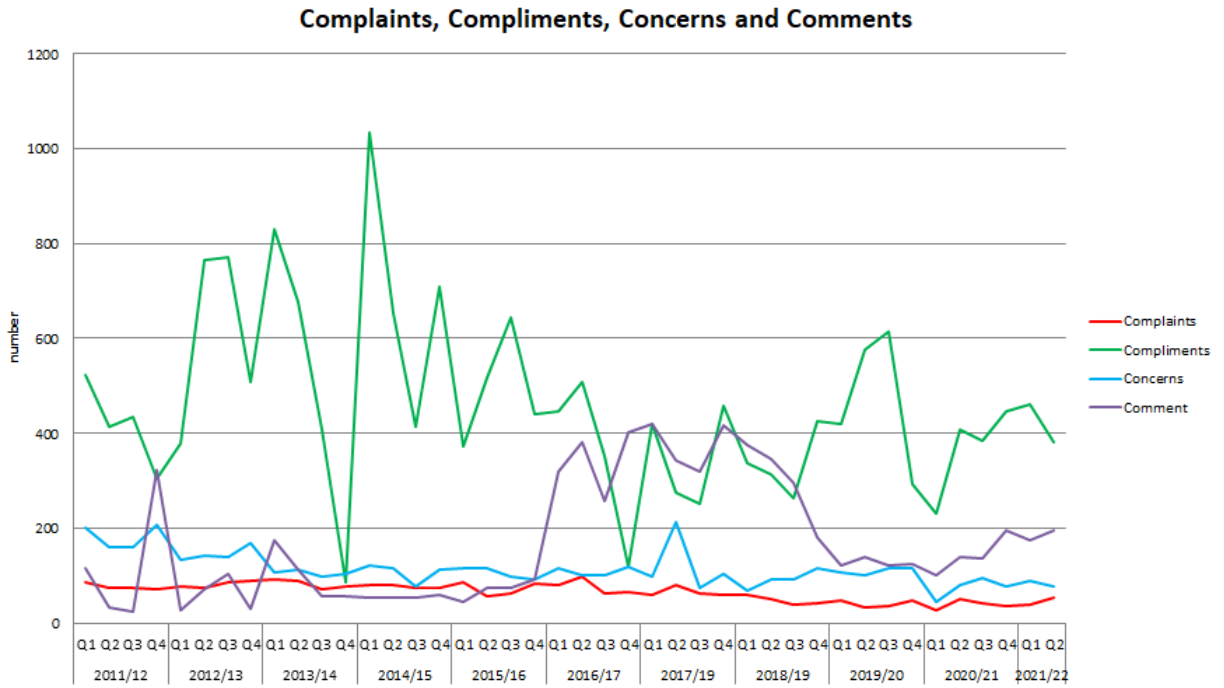
- I just had to write a note to say a heartfelt thank you to the team of wonderful staff in ED yesterday evening. My husband and I were given the devastating news that we had lost our unborn baby. The care I was given for the physical impact of this and the caring nature of the staff dealing with both of our emotional needs was incredibly kind… to all of the super heroes who have worked continuously through the pandemic, thank you.
- I just wanted to say thank you to some staff that saw me when I came in Sunday-Wednesday when I fell off my bike. This was my first ever hospital visit/stay, even though it had its initial frustrations, the staff were brilliant.

2. Complaints, compliments, concerns and comments

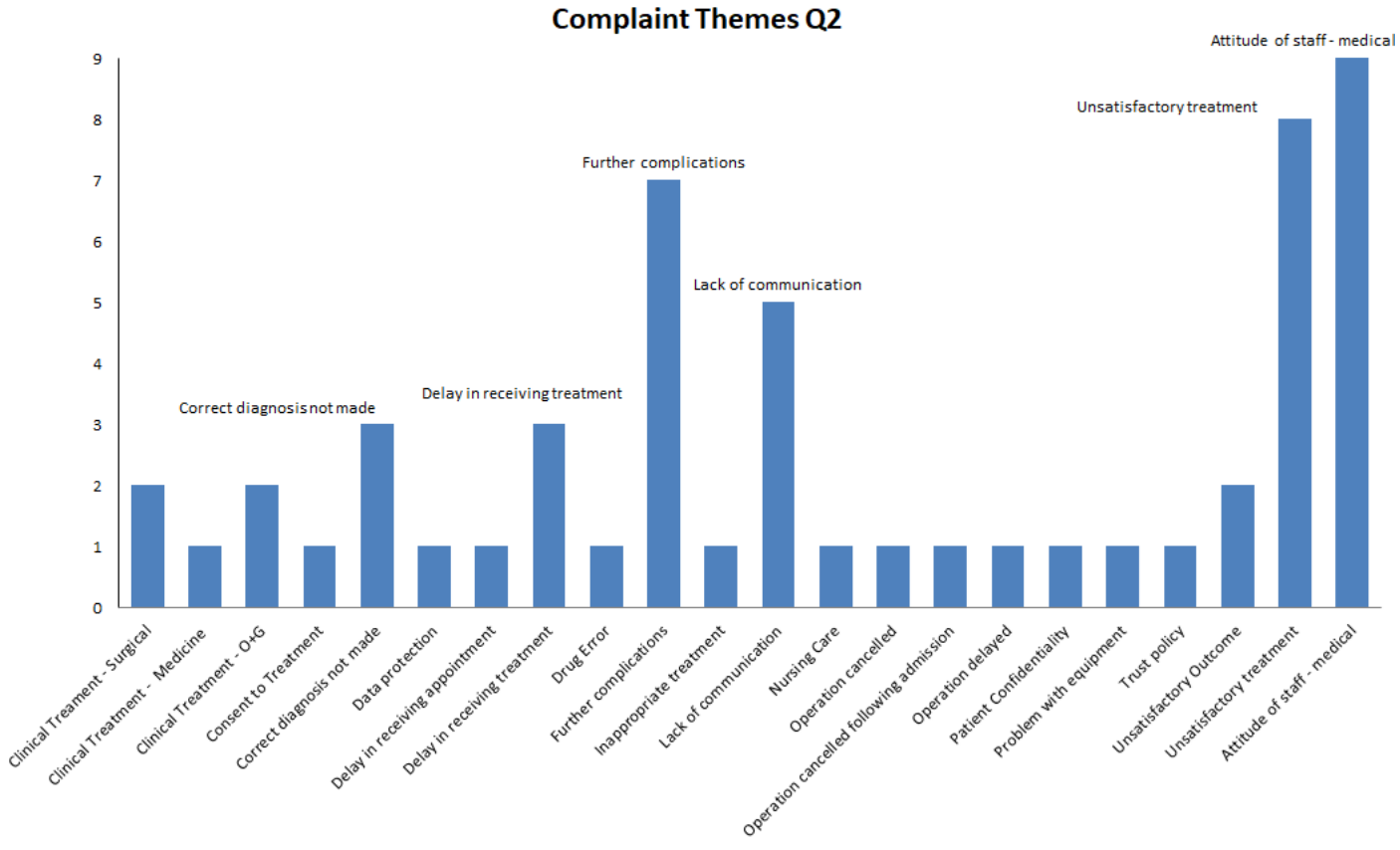
The graph below shows that complaints continue to show a downward trend.

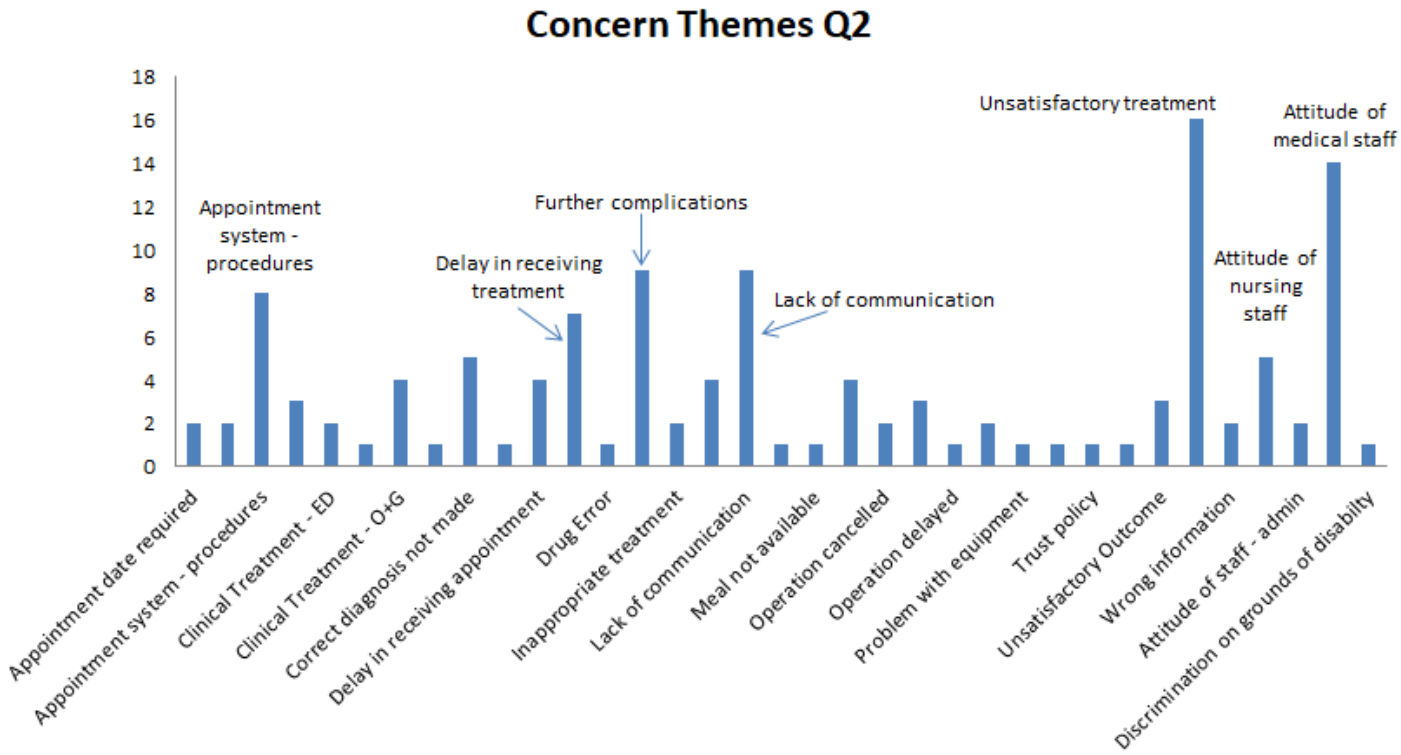


Graph to show complaints, compliments, concerns and comments overtime



As can be seen in the graph below, 'Attitude of medical staff', 'unsatisfactory treatment' and 'further complications' are the main theme from complaints and concerns combined. Where there has been a theme surrounding an individual this has been escalated to the relevant Divisional Clinical Director. A 'deeper dive' into this theme is currently underway.





Themes from Q2 complaints and concerns (clinical divisions)

	CSFS	Medicine	WaND	Surgery	Total
Appointment date required	0	0	0	2	2
Appointment postponed	0	1	0	1	2
Appointment system - procedures	0	1	0	7	8
Clinical Treatment - Surgical	0	0	0	3	3
Clinical Treatment - ED	0	2	0	0	2
Clinical Treatment - Medicine	0	1	0	0	1
Clinical Treatment - O+G	0	0	4	0	4
Consent to Treatment	0	0	0	1	1
Correct diagnosis not made	0	3	0	2	5
Delay in discharge	1	0	0	0	1
Delay in receiving appointment	1	0	1	2	4
Delay in receiving treatment	2	1	0	4	7
Drug Error	0	1	0	0	1
Further complications	0	1	3	5	9
Inappropriate treatment	1	0	0	1	2
Insensitive communication	0	1	0	3	4
Lack of communication	0	4	1	4	9
Lost Property	1	0	0	0	1
Meal not available	0	1	0	0	1
Nursing Care	1	2	0	1	4
Operation cancelled	0	0	0	2	2
Operation cancelled following admission	0	0	1	2	3
Operation delayed	0	0	0	1	1
Poor facilities/environment	0	1	0	1	2
Problem with equipment	0	0	0	1	1
Treatment unavailable	0	1	0	0	1
Trust policy	0	0	1	0	1

Unsatisfactory arrangements	1	0	0	0	1
Unsatisfactory Outcome	1	0	0	2	3
Unsatisfactory treatment	3	8	1	4	16
Wrong information	0	0	1	1	2
Attitude of nursing staff	0	1	2	2	5
Attitude of staff - admin	0	1	0	1	2
Attitude of staff - medical	2	1	5	6	14
Discrimination on grounds of disability	0	0	0	1	1
Total	14	32	20	60	126

Themes from Q2 complaints and concerns (non-clinical divisions)

	Transformation & IM&T	Facilities	Total
Data protection	2	0	2
Lack of parking spaces	0	1	1
Patient Confidentiality	1	0	1
Total	3	1	4

One IG concern remains open since June 2021

In Q2 the Trust treated 17,249 people as inpatients, day cases, non-elective, and regular day attendees. Another 18,863 people were seen in the Emergency Department and 74,615 as outpatients (this excludes telephone calls). 54 complaints were received which is 0.049% of the number of patients treated.

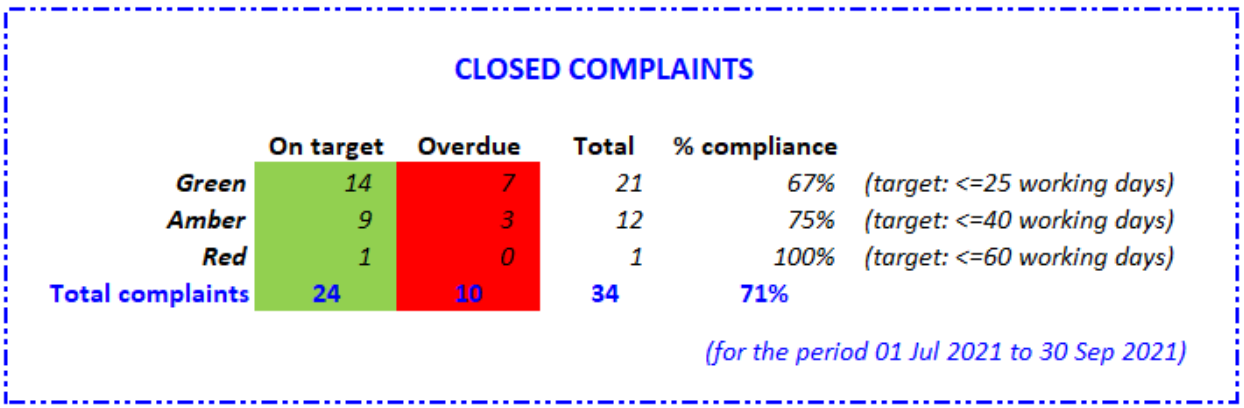
382 compliments were received across the Trust in Q2. Those sent directly to the Chief Executive, PALS or via the SOX inbox are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the individual and their line manager.

Concerns, comments and enquiries

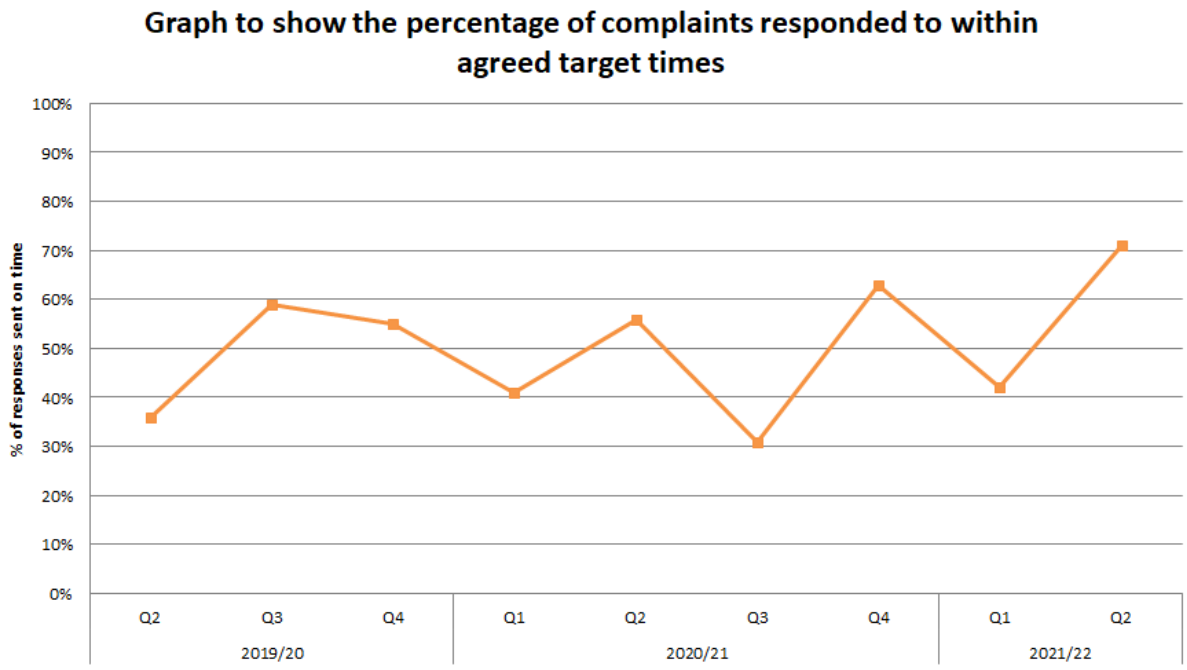
A total of 329 comments, concerns and enquiries were logged by PALS this quarter. Of this number 82% were closed within 10 days.

Concerns, enquiries and comments - closed within 10 working days	No.	%
Not yet closed	11	3
0-10 working days	269	82
11-24 working days	22	7
25+working days	27	8
Total	**329**	

The chart below demonstartes the percentage of complaints closed in Q2 which were responded to within the agreed timescales.

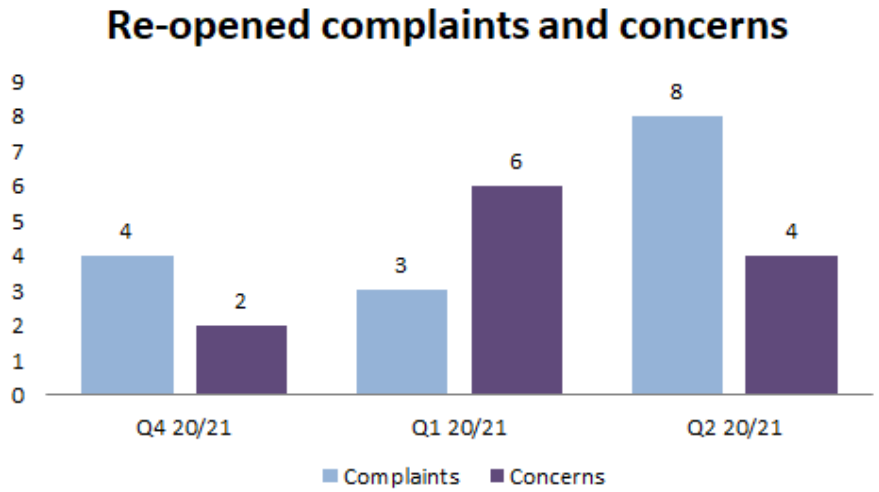


This quarter we have seen an increase in complaints being responded to within the agreed time frames.



Example of actions from Q2 closures:

- Urology Department staff to advise patients to use toilet facilities before they leave the department if they feel this is necessary.
- To ensure discharge summaries and medications are written and requested as soon as possible in order to prevent patient discharge delay. To ensure all team members are aware of the patients discharge dates in advance to facilitate a seamless 'short notice' discharge process. To ensure 'wound' pictures are taken at regular intervals during admission and are uploaded and compared as appropriate. (Medicine)
- Appointment letter to be amended to: “If you have mobility problems, visual impairment or will be travelling to the hospital on public transport, please ring 01722 429282 to make an alternative appointment in the main department”. (CSFS)



In Q2 we saw an increase in reopened complaints. In all cases complainants were unhappy with the response they had received.

3. Complaints by Division

Clinical Support and Family Services

	Q2 2020-21	Q1 2020-21	Q2 2021-22
Complaints	12	13	4
Concerns	7	21	10
Compliments	32	95	53
Re-opened complaints	4	0	0
% closed complaints responded to within agreed timescale	12%	45%	60%
Complaints closed in this quarter	8	11	5
% closed concerns responded to within 25 working days	75%	64%	63%

- There were 4 complaints raised in Q2 with 'attitude of medical staff' as the theme for two of the complaints.
- 5 complaints were closed in Q2; with 60% being responded to within the agreed timescale.
- 10 concerns were raised in Q2. Children's Outpatients and Radiology received 3 concerns each. The main themes being 'unsatisfactory treatment' and 'delay in receiving treatment'.
- The PALS department received 16 comments and enquiries for CSFS in Quarter 2 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 35,886 and of this number 0.01% raised a complaint.
- There is one action plan outstanding from the division (from 1 April 2021).

Themes and actions from concerns and complaints closed in this quarter

Q2 21/22 themes		
Department	**Themes**	**Actions**
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.
Radiology	No themes	Continued review by the Radiology department and the CSFS DMC will review if there is an increase in complaints and themes are identified.
Q1 2021-22 themes and updates		
Gynaecology	Attitude of medical staff	The Clinical lead will share complaints and learning discussed with the wider team at M&M meetings. Concerns will be escalated to DMT.

Compliments

There were 53 compliments for CSFS in Quarter 2:

Sarum Ward = 36, Bowel Screening = 14, SaLT = 2, Radiology = 1

Woman and Newborn Division

	Q2 2020-21
Complaints	10
Concerns	10
Compliments	39
Re-opened complaints	1
% closed complaints responded to within agreed timescale	42%
Complaints closed in this quarter	7
% closed concerns responded to within 25 working days	36%

- This is the first quarter report for the Women and Newborn Division so there is no comparative data for performance.
- There were 10 complaints raised in Q2. The Gynaecology Department received the most (n=6), the main theme being attitude of medical staff.
- 7 complaints were closed in Q2; with 42% being responded to within the agreed timescale. The reason for delay on the others was due to awaiting statements from clinical staff.
- 10 concerns were raised in Q2. Gynaecology received 5 and the Maternity department received 5. There were no particular themes identified by the team.
- The PALS department received 18 comments and enquiries for Women and Newborn in Quarter 2 which were investigated, managed and responded to by the team.

Themes and actions from concerns and complaints closed in this quarter

Q2 21-22 themes		
Department	**Themes**	**Actions**
Gynaecology	Attitude of Medical staff.	Complaints and themes have been discussed at Consultant meeting in August and at the Governance meeting in September. This will be an ongoing action.
Q1 themes and updates		
Maternity Department	Unsatisfactory treatment	• Additional community midwifery support offered; Midwife escorted woman to her ANC appointments. Plan of care to be agreed with the woman. • Cascade to staff on DAU of the importance of undertaking pre discharge checks; this has particular significance when women have been transfer to Maternity DAU from other departments within the Trust. • Improved access to formula feeds, for those women who choose to artificially feed their babies. **Update Q2** • Cascade to the DAU staff has been sent. • Formula feeds have been made more accessible to women who choose to artificially feed their babies.

Compliments

Labour Unit (5), Maternity Admin (1), NICU (17), and Postnatal (15).

Medicine Division

	Q2 2020-21	Q1 2021-22	Q2 2021-22
Complaints	19	15	14
Concerns	31	30	19
Compliments	126	170	250
Re-opened complaints	4	1	5
% closed complaints responded to within agreed timescale	79%	40%	62%
Complaints closed in this quarter	19	20	8
% closed concerns responded to within 25 working days	88%	69%	58%

- 14 complaints were received in Q2. The Emergency Department received the most (n=4), with no particular theme identified. Pitton ward received 3 complaints with the main theme being lack of communication.
- 8 complaints were closed in Q2 and of these 62% were responded to within the agreed timescale. Delays in responses being sent out on time were due to awaiting statements from clinicians and delays in approval from the DMT.
- 5 complaints were re-opened in Q2, this was due to the complainants not feeling their concerns were appropriately investigated and requiring further clarification.
- There were 19 concerns raised in Quarter 2. The Emergency Department received the most (n=12). The main theme being unsatisfactory treatment and clinical treatment.
- The PALS department received 73 comments and enquiries for Medicine in Quarter 2 which were investigated, managed and responded to by the team.
- One complaint remains open from August 2021.
- Total activity within the directorate was 35,224 and of this number 0.03% raised a complaint.

Themes and actions from concerns and complaints closed in this quarter

Q2 21-22 themes		
Department/Ward	**Topic**	**Actions**
Pitton ward	Lack of communication	• New ward lead and Matron appointed. Increased frequency of documentation audits. Ward lead to provide daily walk around to provide reassurance to patients and relatives. Discussion with medics and Discharge coordinator daily to ensure patients change in condition has been communicated to the family. • Daily visitor record and record of any discussion to be held on record.
Emergency Department	Unsatisfactory treatment and clinical treatment	ED has been under significant pressure with increased attendances and ambulance delays. Staff have raised safety concerns to Directorate. 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. At induction with junior's quality of care stressed along with working in difficult stressful times where human factors can come into play. Comms into nursing diary for regular reminders on professional behaviours in the work place along with regular discussions by admin team. Working with wider hospital system to support streaming / SDEC development and earlier specialty reviews to

		improve patient care and experience.
Q1 21-22 themes and updates		
Department/Ward	**Topic**	**Actions**
Emergency Department	Correct diagnosis not made	• To improve communication with patients about their diagnosis by offering a copy of the ED discharge letter • To code each diagnosis with a qualifier of suspected or confirmed diagnosis to improve clarity for GP / patient • To redesign and improve quality of ED GP discharge letter. • Be more pro-active with safety netting advice • Reassure staff that we won't always have a definitive diagnosis made in ED but our role is to rule out any Emergency Presentations
	Attitude of medical staff	• Identification of specific staff members who struggle with appropriate communication and offer of support / training • Offer regular 1:1's and appraisals with all staff • Direct action for staff who have more than one complaint relating to attitude / communication • Consider putting staff on communication and coaching courses. **Update on actions From Q1** Ongoing appraisal is annual and line managers addressing in advance of that if required. Communication and coaching workshops offered however very difficult to free any nursing staff or medical staff up due to gaps / demand and acuity. GPs don't receive any diagnosis / investigation just free text so not possible to deliver suspected or confirmed. Free text for Doctors to write specific discharge details QR codes in ED for Paeds specific advice.

Compliments

AMU (24), Breamore (26), Durrington (4), ED (7), Farley (31), Hospice (48), Longford (2), Pembroke (17), Pitton (14), Redlynch (20), Tisbury (20), Spire (25), Whiteparish (12)

Surgical Division

	Q2 2020-2021	Q1 2020-21	Q2 2021-22
Complaints	18	11	24
Concerns	37	34	36
Compliments	165	90	79
Re-opened Complaints & Concerns	4	6	5
% closed complaints responded to within agreed timescale	36%	29%	73%
Complaints closed in this quarter	11	7	15
% closed concerns responded to within 25 working days	41%	74%	55%

- There were 24 complaints received this quarter with Orthopaedics having the most (n=8). Ophthalmology had 4 complaints. The main theme is Further Complications (n=4, 2 for Orthopaedics).

The other main themes are Lack of Communication and Attitude of staff – medical with 3 complaints each.

- There were no complaint or concern meetings held this quarter for Surgery.
- There were 36 concerns raised in Q2. Ophthalmology had 7 concerns. Central Booking and Orthopaedics had 5 concerns each. The main theme was for appointments (n=10). Insensitive communication and Attitude of staff – medical was a theme for three concerns each across the Division.
- There were 2 complaints and 3 concerns re-opened in Q2. Two are still open and three are now closed.
- The main theme for the 14 complaints closed in Q2 was Attitude of staff – medical for 7 complaints, 2 in Ophthalmology, 2 in Gastroenterology, 2 in Plastics and 1 in Rheumatology.
- The main themes for the 33 concerns closed in Q2 were; Attitude of staff – medical (4) across 3 specialties and Appointment system – procedures 3 across 2 specialties
- The PALS department received 91 comments and enquiries for Surgery in Quarter 2 which were investigated, managed and responded to by the team which was an increase of 9 to the previous quarter.
- One complaint remains open from May 2021, one from July (waiting for a retired consultant to come in and review the medical records) and three from August 2021.
- Total activity within the Division was 13,540 and of this number 0.18% raised a complaint.
- There is one action plan (8448) outstanding from a closed complaint (1st January 2021) for the Surgery Division. This complaint has been reopened and the action plan will be completed when the case is finalised.

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

Q2 2021/2 themes and updates		
Department/Ward	**Topic**	**Action and update:**
Division-wide, specifically: Ophthalmology Gastroenterology Plastics Rheumatology Urology	Attitude of staff – medical	All cases were raised with the individual Clinicians involved. Paul Stephens, as Clinical Director for the Surgery Division, has emailed all Surgery Division Consultants to highlight the increase in complaints raised about the attitude of staff, remind staff that patients are understandably frustrated with the additional delays caused by the Covid-19 pandemic, and ask staff be more mindful of their attitude to patients.
Central Booking	Appointment system - procedures	44789 –- appointment had to be cancelled, but Central Booking did not send cancellation letter – human error. Raised with team members involved, apologised in complaint response & new appointment made. 44960 – delayed follow up appointment due to Covid-19 pandemic, patient states she didn't get an appointment letter, but this is likely because she moved address without telling us.
Ophthalmology	Appointment system - procedures	44777 – elderly patient cannot attend morning appointments, but we do not have the systems to ensure only afternoon appointments are offered. Explained and apologised in complaint response and gave patient the name and number for the Ophthalmology team leader who will resolve issues for them promptly in future.
Q1 21/22 themes		
Department/Ward	**Topic**	**Action and update:**
Not closed: Plastics	Patients refusing to comply with Covid protocols for	Both cases discussed at Ethics Committee meeting. Vaccination Lead is going to produce an Action Card for Covid Protocols for elective patients who refuse to comply with the Trust's Covid

Closed: Oral & Maxiliofacial	elective/non-emergency surgery	Policy. **Update Q2 2021:** Progress on the pathway is being checked.

Compliments

79 compliments were received in Q2, the breakdown is as follows:

Downton Ward = 34, Radnor Ward = 26, DSU = 8, Breast Team = 6, Britford Ward = 2, Laser Clinic = 1, Plastic O/P = 1, Urology = 1

4. Parliamentary and Health Service Ombudsman (PHSO)

There have been no requests for information or notifications of intention to investigate from the PHSO in Q2.

We have heard back from the PHSO in respect of one complaint that had been investigated by them. The PHSO found that the initial complaint letter was a long narrative about the patient's hospital stay and could understand why it had been difficult to respond to every issue raised. However, they felt that had the complaint investigator spoken to the complainant early on then the issues the patient had raised could have been better explored. They asked the Trust to write to the complainant to apologise that this had not happened. This was done within the time scale suggested by the PHSO.

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

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. We are currently working on a gap analysis against the Standards and these will be reported to the Patient Experience and Patient Safety Steering Groups in due course.

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.

5. Trust wide feedback

Patients surveyed

Almost 1500 provided feedback during the quarter through the Friends and Family Test (FFT). We are encouraging areas to start displaying/handing out the FFT feedback cards.

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	423	384	91%	32	7.5%	6	1%	1	0.5%	-	-	-	-
Emer Dept	39	27	69%	5	13%	1	3%	4	10%	2	5%	0	-
Inpatients	561	458	82%	92	16%	8	1.5%	2	0.5%	0	-	1	-
Maternity	3	3	100%	-	-	-	-	-	-	-	-	-	-
Outpatients	448	394	88%	47	11%	5	1%	1	-	-	-	1	-

Some feedback received this quarter

What was good about your experience?

- Excellent. I got looked after well by everybody. So helpful. They are an awesome bunch of lovely people.
- I had numerous phone calls because of COVID with amazing nurses. I was absolutely terrified after procedures and they got me through it all. My GP surgery did not want to know! Honestly I don't know what I would have done without you
- The nurse led surgery kept me well informed of what was to happen, made sure I was comfortable and dealt with any questions I had. The procedure was explained as it progressed and full after procedure follow-up advice/instruction provided in a friendly, cheerful manner. I felt confident I was being dealt with by experts who were concerned about me and my personal well-being
- Not enough room to say how committed the staff are, working in such hard times, very kind, caring, professional and supportive. Nothing is too much bother. Made me feel really cared for, safe and secure. I will miss the smiles. There is nothing that could have been done better. Circumstances within NHS as so much pressure being short staffed but they all work so hard to not show this. Well done.
- To be cared for by people who care about you. The staff are brilliant. I now also have a better understanding of my condition which will help me to deal with it better in the future.
- The welcoming and care with kindness. The professionalism and explaining of procedure and overall care is perfection itself. And to top it all a cup of tea and a biscuit!! 100% perfect. Thank you all
- I would like to share my gratitude for the wonderful care I received in A&E yesterday
  The lovely Triage Nurse who made me laugh, Rory and Dan were so kind and fast and had great people skills and humour. The staff don't get paid nearly enough for all the hard work that they do and the care they put in to every patient. I hope I don't need to go again any time soon! but I know if I did I would be in safe hands. Much gratitude and appreciation from me.

What could we have done better?

- Some delay in sorting out my regular medication. Should have been done on admission.
- The food - I ate it to aid recovery but it wasn't great. Stews often had very little meat, often cool not warm. Questionable nutritional value.
- No one could help it but the ward was very loud at night. The food wasn't very good either.
- Better communication. Don't say one thing and not deliver. Do not leave someone in pain.
- The NBM time is exaggerated. If there is no chance of going to surgery before lunch can't NBM be started at lunch time! Consultants seem rushed; doctor patient time is very minimal, hard to ask questions.
- Perhaps a visit from volunteers to take load off hardworking staff. Often enough it's small practical problems we don't want to summon help.
- Tell patients to bring a book!

- Mobile signal is very low. It would be more convenient if the signal strength could be improved.
- As always, the discharge process is unreliable. Drugs are nearly always the sticking point. This is true in other wards and hospitals.
- The hours I had to wait was really upsetting. I was phoned and told to come up early and was then put last on the list. Not good.
- Make sure the cries for assistance were answered as one patient clearly couldn't find her alarm or feed herself sometimes. Otherwise all good.

Patient and Public Involvement – national surveys

Urgent and emergency care survey 2020

The report has been published by the CQC and will shortly be presented to the Patient Experience Steering Group, 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 Steering 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

We have received the headline report and are expecting the CQC publication on 9th December 2021.

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.

Actions taken on areas of concern

Wards, the Emergency Department and Maternity, have action plans in place to address the main areas of concern in their location. Progress is monitored via the Trust's Patient Experience Group and is overseen by the Clinical Management Board.

6. 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 Q2.

7. Translation and Interpretation

This quarter's most frequently used languages for face-to-face interpretation (used on 5 occasions):

- Polish (n=6) Romanian (n=1) Hindi (n=1)

This quarter's most frequently used languages for telephone interpretation (used on 15 occasions):

- Nepali (n=4), Bengali (n=3), Polish (n=2), Portuguese (n=2), Romanian (n=2)

British Sign Language was used on 8 occasions this quarter.

We are experiencing considerable difficulty finding BSL interpreters for face-to-face appointments with our current provider and are working with Procurement to resolve this.

8. Patient Stories

Patient stories are taken to every public Board meeting.

9. Patient Experience Steering Group

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

10. 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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11. Social media

NHS Website feedback

There were 4 items of feedback posted on the NHS Website in Q2.

- Negative – 1 (ED waiting time to be seen)
- Positive – 3 (Maternity, Gynaecology and COVID-19 testing team)

All feedback is available here: https://www.nhs.uk/services/hospital/salisbury-district-hospital/P1700/ratings-and-reviews

Appendix 1. Q2 FFT themes from free-text comments

Each comment is read and coded using a consistent coding schema, covering four key topic areas: The Pathway of Care, Care and Treatment, Staff, and the Hospital Environment and Facilities.

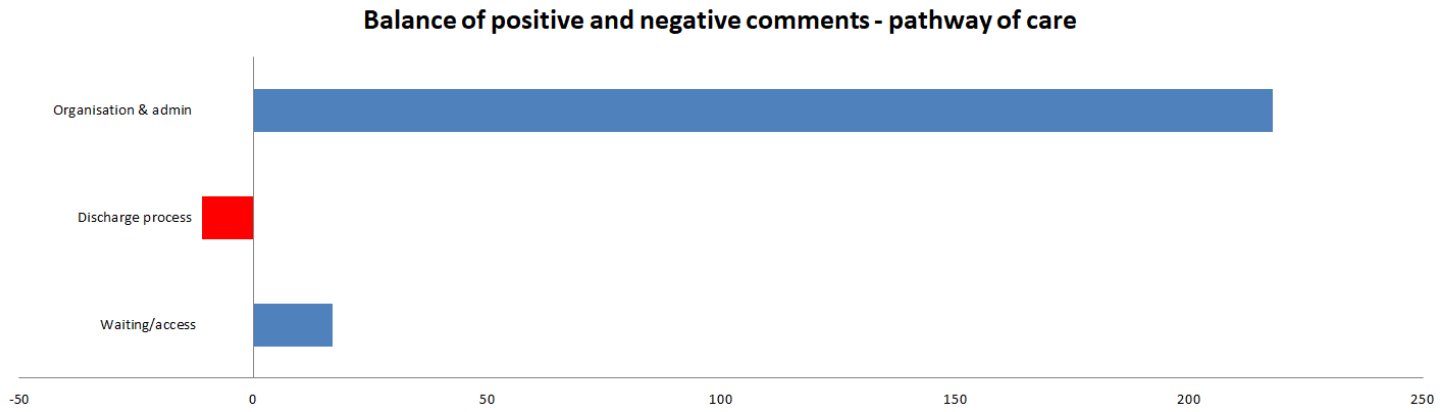
Pathway of care
Waiting/access
Cancelled treatment
ED
Admission to hospital
Hospital/ward stay
Discharge process and/or information
Care after leaving hospital/follow up
Organisation and administration
Moving wards
Transport

Care and treatment
Able to get hold of staff when needed/responsiveness
Care and treatment general
Communication between different staff members
Communication/information giving by staff
Continuity of care
COVID
Involvement of family/carers
Medication
Operations, investigations/procedures
Pain management
Patient's involvement in decisions re care/treatment
Privacy and dignity/respect
Record keeping
Staff took into account patient's medical history
Staff took patient's concerns seriously

Staff
Staff general
Doctors/consultants
Nurses
Therapists
HCAs
Other staff groups
Staff skills and training
Sufficient staff
Attitude of staff
Friendly staff

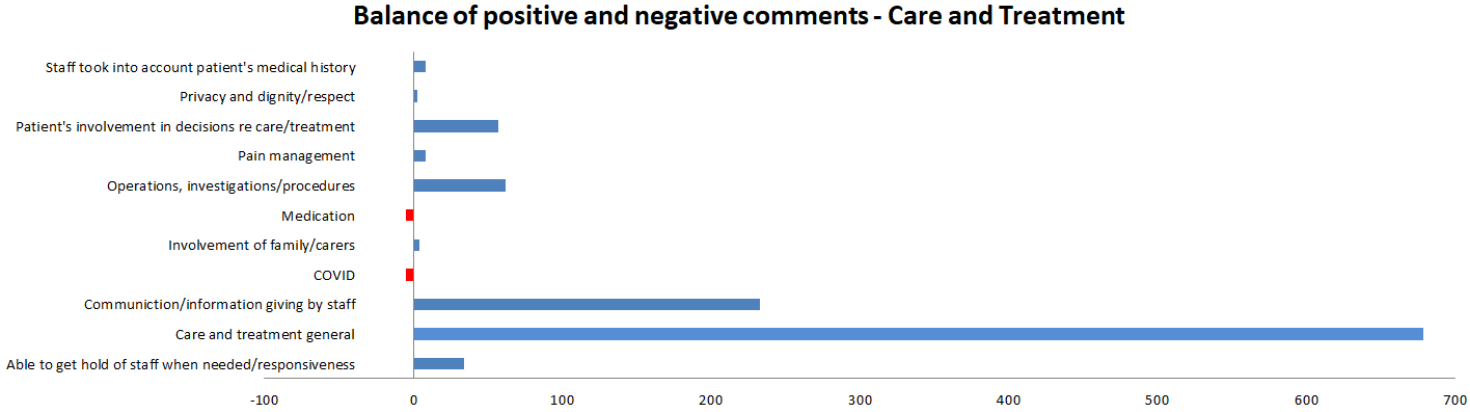
Hospital environment and facilities
Cleanliness
Temperature of ward/room/hospital
Safety + security
Food and drink
Noise
Parking
General environment

Most comments have more than one code allocated to them. Coding was limited to two key themes per category.



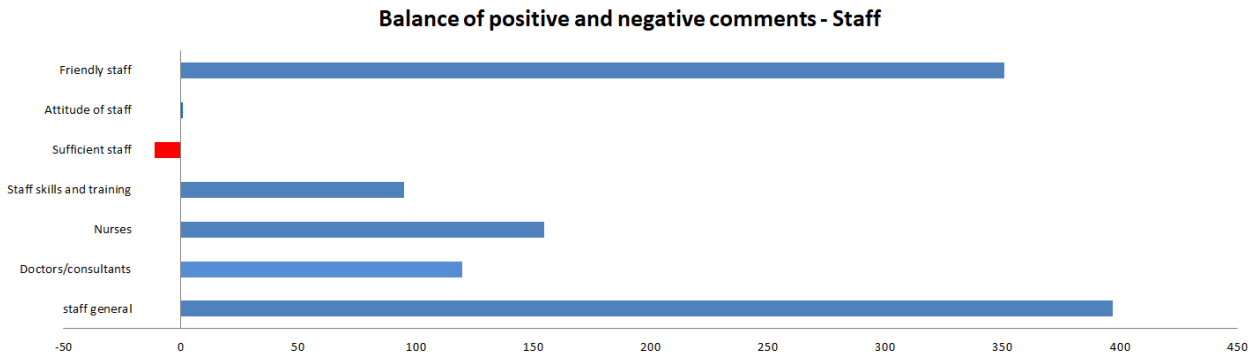
Examples of comments for pathway of care:

- Incredibly slow wait for meds, discharge and updates. Time expectations provided here are not met.
- Sort out the discharge procedure when you don't need drugs. Bureaucracy gone mad!
- Wonderful, friendly, efficient staff. No worries re: hygiene safety. Felt I was in the very best place.
- Quick. Efficient and Reassuring. Very thorough questioning and checks to ensure I was correct patient. Brilliant.
- Everything - on time, very efficient, very clear, very supportive. A credit to your service.
- Straight in, straight out. No fuss. Smiling staff. Easy peasy!



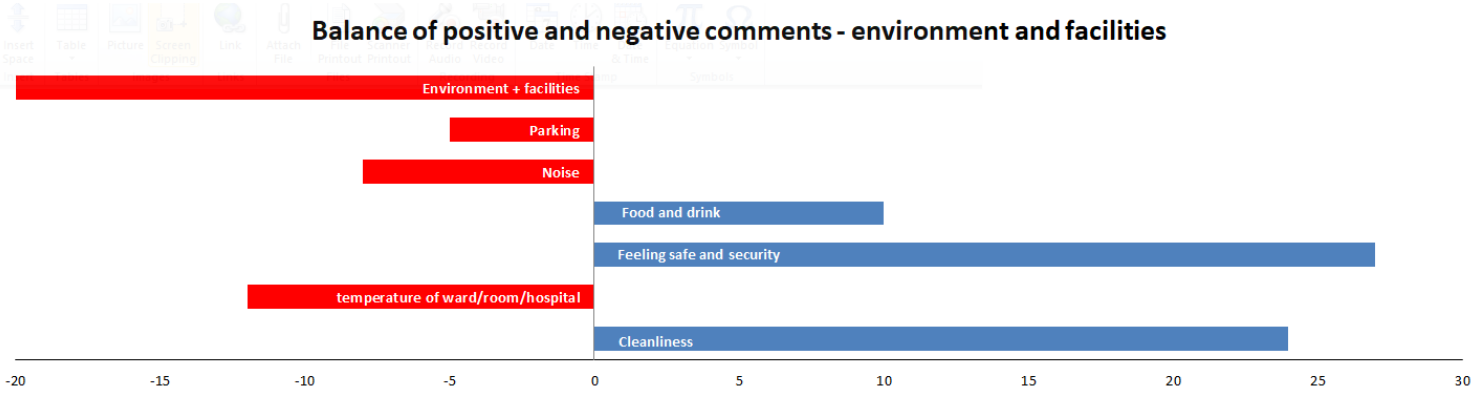
Examples of comments for care and treatment

- All members of staff I came into contact with were excellent. Highly competent, listened, helpful and friendly. They provide care not just doing a job
- The care I received from everybody at the hospital has been incredible. I've felt like I was important and that I was treated like family.
- Dr wrote incorrect prescription after a 4hr wait, took over 2hrs to get it corrected.
- Some delay in sorting out my regular medication. Should have been done on admission.
- Perhaps more clarity given to all staff about COVID test requirement for patients waiting treatment i.e.
- Vulnerable, elderly patients with dementia need someone/a carer with them so there needs to be planning and provision for this - eg invite the carer for a COVID test. LFT/PCR.



Examples of comments for Staff

- I was concerned about the strain on nurses caused by lack of staffing. I could see the impact on mood despite their total dedication.
- Not enough staff especially doctor. Very long delays.
- Really friendly and attentive staff who made me feel calm and reassured. There was always someone available when needed which is hugely appreciated.
- Calm and efficient team. Also professional and friendly



Examples of comments for environment and facilities

- Ward clean and fresh air, lovely.
- Need better washing facilities.
- Loo roll needs to be replenished more often in toilets.
- Too hot at night.
- 1hr wait too long in the heat and little air con. Although I understand NHS shortages.
- I was in the waiting room after checking in, quite a long time and quite chilly.
- Not slamming doors overnight in hallway on our door.
- Bit noisy at night in terms of machine and other background noises.
- Both loos were very tiny and cramped - difficult after bowel prep.
- TV charges were extortionate when you are in for a few weeks, this facility should be free.

CLASSIFICATION: please select

NHS Salisbury NHS Foundation Trust

Report to:	Clinical Governance Commitee	**Agenda item:**	4.2
Date of Meeting:	30 November 2021		

Report Title:	Q2 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 a total of 202 inpatient deaths in Q2. This included 10 Covid-19 deaths.
- Falls was a key theme identified by the medical examiner system.
- There were 2 SII's commissioned related to deaths in Q2. There were no complaints or concerns received by PALS related to end of life care or death in Q2.
- Whilst fewer 'Yours Views Matter' surveys were returned in Q2, the overall percentage of respondents' rating care as either good or very good has increased (81% Vs 76% in Q1).
- The HSMR for the twelve month period ending in June 2021 was 106.4, and has reduced from 113.6. Weekday HSMR 104.5 and weekend HSMR 110.5 (within expected ranges).
- The SHMI for the twelve month period ending in May 2021 is 105.28. When comparing SHMI by site, Salisbury District Hospital is 100.17 and Salisbury Hospice is 264.21.
- Three diagnosis groups have generated 1 negative CUSUM alert (each within Q1) and

there has been one new diagnosis group alert.

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) -	☐

Quarter 2 2021/22 Learning from Deaths report

November 2021

1.0 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.

2.0 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.

3.0 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.

4.0 Summary of Learning

The MSG met on 14th September in Q2, where learning, improvement themes, and actions around in-hospital deaths are discussed.

SJRs

- Themes identified from SJRs has included concerns about documentation, unacceptable delays for reviews, treatment, and procedures e.g. waiting for an MDT, biopsy of scan/ ward based procedure. Plans to try and expand the pool of people undertaking mortality reviews was discussed. Regular meetings between the Medical Examining Officers (MEOs), mortality lead, and head of clinical effectiveness have re-commenced to discuss and identify learning themes from reviews.

Formal Alerts and Reports

- SHIMI data to the year ending April '21 was reviewed. There was one alerting group using the SHIMI data which was the cancer of bronchus, lung. Assurance was provided that this was a hospice driven alert. The non-infectious gastroenteritis CUSUM alert generated in Mar-21 was discussed (as per Q1 report), and it was agreed that no further action was required as the diagnosis changed (to a malignant neoplasm) during the course of the patient's care.

Serious Incidents Requiring Investigation (SIIs)

- A case of a child with multiple seizures who had a cardiac arrest was discussed. Key findings were that hourly neurological observations had not been adequately performed and GCS not monitored appropriately. The ambulance care and resuscitation care peri-arrest on the ward was indentified to be areas of good care. Key actions: Improving learning about hourly neuro observations, completion of the PEWs chart, assessing GCS & considering a full range of differential diagnoses in children presenting with seizures.

Bereavement

- Mostly positive feedback has been received by families. Themes of complaints include communication with families, lack of privacy for difficult conversations, and concerns about pain relief. Further learning has been outlined in section 7.3.

5.0 Summary of Mortality Data for Q2

- **202 deaths occurred in the Trust in Q2 (2021/22).** This figure is inclusive of patients who died in either the Emergency Department or the Hospice. This compares to 204 deaths occurring in Q1 (2021/22).
- There were **10 inpatient deaths from COVID in Q2**. (death within 28 days of a positive swab result / diagnosis on death certificate).
- There was **1 stillbirth and 1 neonatal death in Q2.**
- There were **no maternal deaths in Q2.**
- There were **2 deaths reported for patients with learning disability in Q2.**
- There were **2 deaths identified in patients with serious mental illness**

2021/22	Q1	Q2	YTD TOTAL
Covid Deaths	2	10	12
Stillbirth	2	1	3
Neonatal Deaths	1	1	2
Maternal Deaths	0	0	0
Learning Disability Deaths	0	2	2
Serious Mental Illness	2	2	4
TOTAL DEATHS	204	202	406

6.0 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.

- **There were 16 Structured Judgement Reviews requested by the medical examiner system in Q2. This includes reviews requested where concerns about the quality of care had been identified. This included two patients with a serious mental illness, two patients with learning disabilities, and three 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 2, 2021-22

Accumulative requests for the year 2021/22 (Q2 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)	*4(1)*	*4(3)*			*1*	*3(3)*	***12***
Problem with medication / IV fluids / electrolytes / oxygen		*2*					***2***
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)		*1(1)*		*1*			***2***
Problem with infection control							***0***
Problem related to operation/invasive procedure (other than infection control)			*2(1)*	*1*			***3***
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)		*4*		*1*		*1*	***6***
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							***0***
Problem of any other type not fitting the categories above		*1*				*3*	***4***
TOTAL	***4***	***12***	***2***	***3***	***1***	***7***	

Key Findings – (Main themes for Q2 were related to falls)

A missed fracture
Death following a fall
Fracture neck of femur following a fall
Fall documented on Datix not in patient notes
Multiple falls and family concerns
Management of hyperkalaemia (Commissioned as an SII)
Desaturation during a procedure

7.0 Incidents, Complaints and Concerns

7.1 Serious Incidents and learning relating to patient deaths

- **There were 2 SIIs commissioned related to deaths in Q2 –** These were in relation to the management of a patient with hyperkalaemia and an intra-uterine death occuring at 37+4 weeks.

7.2 PALS Complaints and Concerns in Q2

Family concerns are often addressed by the medical examiner in the first instance through discussion and/or encouraging families to complete a bereavement survey, which is sent out on behalf of the end of life care team. If the family still have concerns then these are referred to PALs.

- **There were no complaints or concerns received by PALS relating to end of life care or death in Q2**.

7.3 **Your Views Matter Survey**

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 Q2, 77 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 26 completed surveys were returned (compared to 101 and 42 respectively in Q1).
- 88% of respondents were able to visit their loved one in hospital.
- 81% of respondents rated the overall end of life care as good or very good (up from 76% in Q1).
- Three surveys rated the care as poor or very poor. Attempts were made to contact all of these respondents by the lead nurse for end of life care.

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

Concerns in Q2 related to phones not working and engineers being unable to visit high risk areas, lack of awareness of the chaplaincy service, privacy when breaking bad news and enquring about tissue donation. As a result, phone issues have subsequently been resolved and every bed now has a working phone at the time of publishing. The end of life and chaplaincy teams have plans to promote their services to wards. Stars appeal are keen to consider funding a relative support room to provide additional privacy if a suitable space can be identified.

8.0 Mortality Benchmarking

8.1 HSMR rolling 12 month trend to June 21

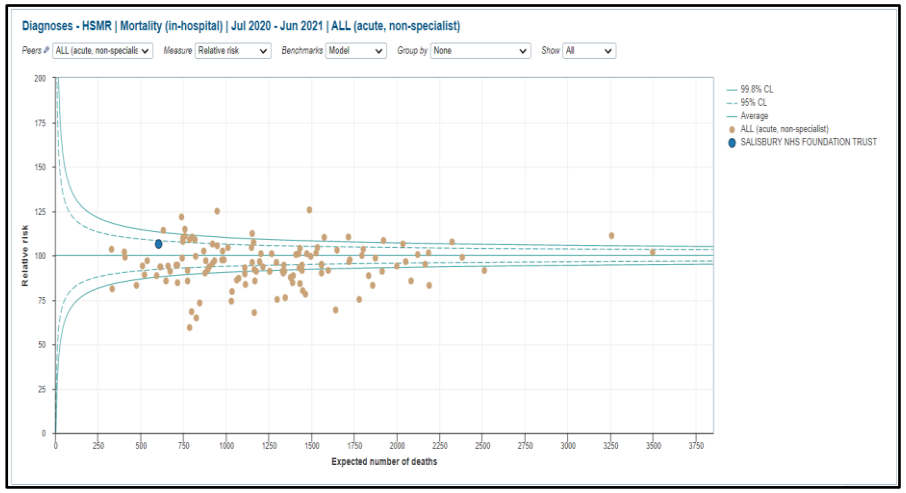
A note from our partner, Telstra Health UK:

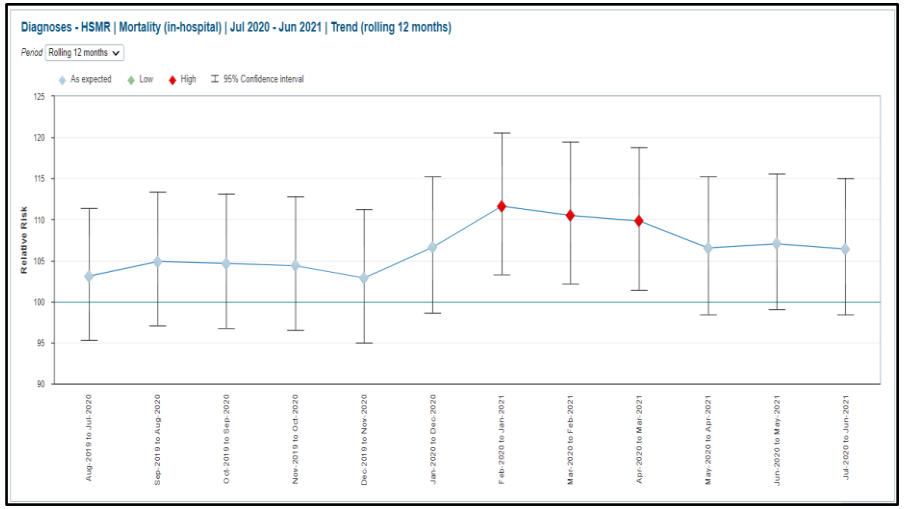
'Telstra Health UK are now receiving HES data directly from NHS Digital rather than via the former Imperial College Unit. This is a richer data set as it now includes patients who have registered a national data opt-out. We have also made significant improvements to our data processing and have reduced the volume of records that are excluded from our risk models (e.g. those with an invalid age). Both these changes mean that overall volumes have increased as a result and this will impact on risk adjusted and crude rate metrics. Our benchmarks now include 10 years of national data up to and including March 2021, as a result, there is now a full year of COVID-19 activity included in the model and risk scores are becoming increasingly adjusted for the changes we have seen over the pandemic.'

- **The HSMR for the twelve month period ending in June 2021 was 106.4 (within the expected range).** This has reduced from 113.6 (for the twelve month period ending in March 2021), which was anticipated as national benchmarks catch up to take account of Covid-19. Some changes to data processing and methodolgoies may have also accounted for this reduction too (as per comments from *Telstra Health UK*, above).

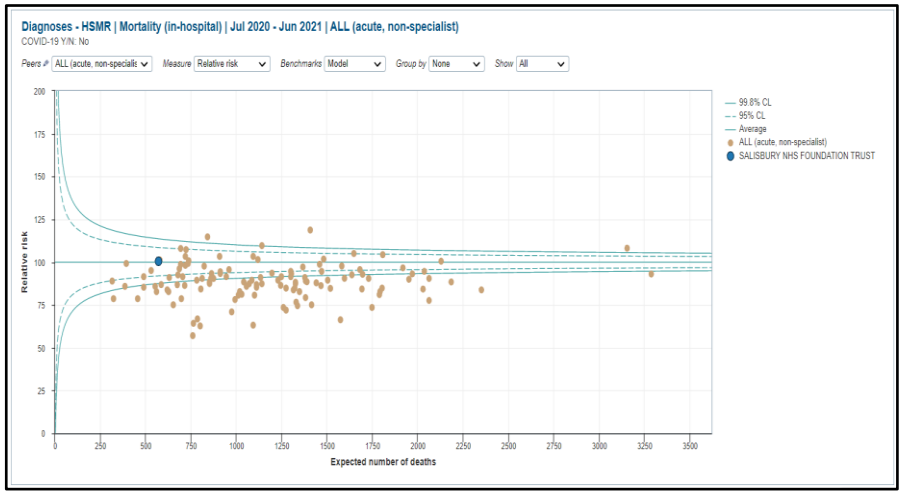
- **Weekday HSMR is 104.5 and weekend HSMR is 110.5 (both within their expected ranges respectively).**

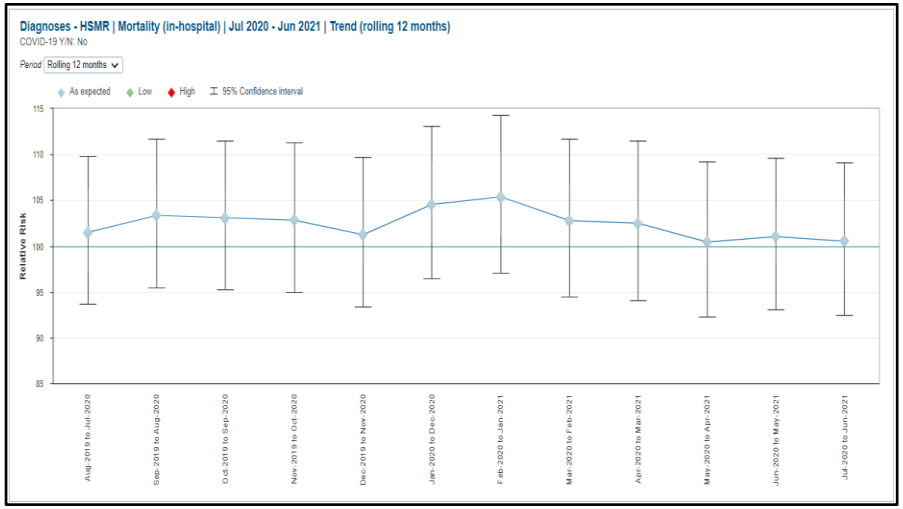
Comparative HSMR including COVID (year end June 2021)





Comparative HSMR excluding COVID (year end June 2021)





8.2 Summary Hospital-Level Mortality Indicator (SHMI) for June 2020 – May 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 105.28 for the twelve month period ending in May 2021 for SFT. When comparing SHMI by site, Salisbury District Hospital is 100.17 and Salisbury Hospice is 264.21.** 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. **SHMI for cancer of the bronchus is the only category statistically higher than expected, and this is likely attributable to the on-site hospice.**

8.3 New Alerts

All new alerts are discussed at the MSG meeting, where a further review or investigation into these deaths may be requested. Three diagnosis groups generated one negative CUSUM alert each within Q1 21/22 (April-June '21):

- **Cancer of bronchus, lung**

- **Cancer of ovary**

- **Residual codes, unclassified**

The two cancer groups appear to relate to hospice activity and do not present when focusing only on the acute hospital site. An initial review of the *residual codes* category suggests that this alert may have been generated due to a delay in coding of discharges at the time of the data submission.

- There has been one new diagnosis group alert for COPD and Bronchiectasis (see supplementary data pack).

9.0 Recommendations

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

Dr Ben Browne,
Head of Clinical Effectiveness

Reviewed by Dr Peter Collins November 2021.

10.0 SUPPLEMENTARY DATA PACK

SHMI Data for the 12 Month Period Ending May 2021

SHMI - Summary Hospital Mortality Indicator

Period: Jun 20 - May 21

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

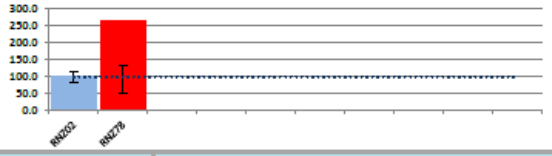
☐ Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

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

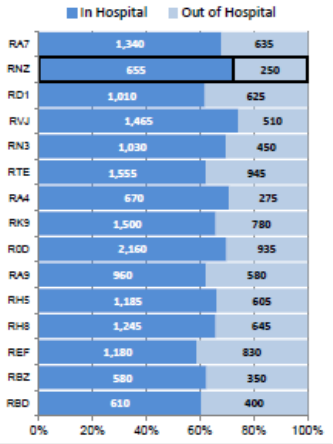
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RBD	Dorset County Hospital NHS Foundation Trust	24,295	1,010	855	155	117.99	88.47	113.03
RBZ	Northern Devon Healthcare NHS Trust	25,120	935	850	85	109.56	88.47	113.03
REF	Royal Cornwall Hospitals NHS Trust	36,045	2,010	2,000	10	100.56	89.46	111.79
RH8	Royal Devon And Exeter NHS Foundation Trust	53,925	1,890	1,990	-100	94.85	89.45	111.79
RH5	Somerset NHS Foundation Trust	47,345	1,790	1,800	-10	99.55	89.37	111.90
RA9	Torbay And South Devon NHS Foundation Trust	42,080	1,540	1,495	45	102.84	89.20	112.11
R0D	University Hospitals Dorset NHS Foundation Trust	86,370	3,095	3,310	-215	93.53	89.77	111.40
RK9	University Hospitals Plymouth NHS Trust	64,460	2,280	1,965	315	116.11	89.44	111.81
RA4	Yeovil District Hospital NHS Foundation Trust	26,685	950	1,000	-50	94.88	88.71	112.72
RTE	Gloucestershire Hospitals NHS Foundation Trust	95,875	2,500	2,510	-10	99.55	89.61	111.59
RN3	Great Western Hospitals NHS Foundation Trust	52,085	1,480	1,645	-165	89.95	89.29	111.99
RVJ	North Bristol NHS Trust	82,135	1,980	2,115	-135	93.50	89.50	111.74
RD1	Royal United Hospitals Bath NHS Foundation Trust	53,885	1,640	1,545	95	106.04	89.23	112.07
RNZ	Salisbury NHS Foundation Trust	32,570	910	860	50	105.28	88.49	113.01
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	81,545	1,975	2,065	-90	95.70	89.48	111.76
Group		824,420	25,985	26,005	-20	99.92		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	32,470	835	835	100.17	85.79	116.56
SALISBURY HOSPICE	100	70	25	264.21	66.88	149.52

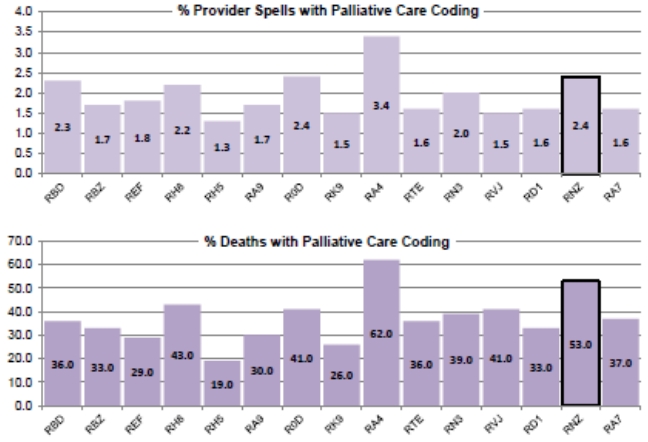


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	60	60.00	102.49	79.39 132.64
Cancer of bronchus, lung	30	20.00	159.03	63.68 157.03
Secondary malignancies	35	30.00	111.96	69.70 143.48
Fluid and electrolyte disorders	10	10.00	92.52	52.63 190.02
Acute myocardial infarction	20	25.00	93.21	66.17 151.12
Pneumonia	90	90.00	101.97	80.40 124.37
Acute bronchitis	10	15.00	92.91	57.96 172.52
Gastrointestinal haemorrhage	15	15.00	112.73	59.44 168.25
Urinary tract infections	20	20.00	96.63	60.12 166.32
Fracture of neck of femur (hip)	15	20.00	88.37	63.96 156.34

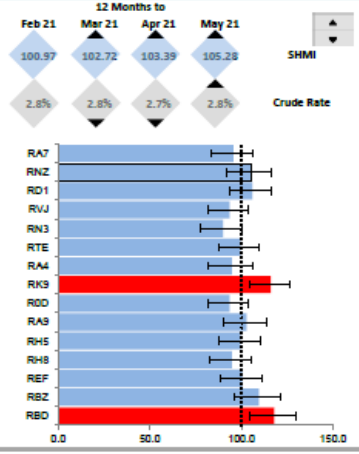
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

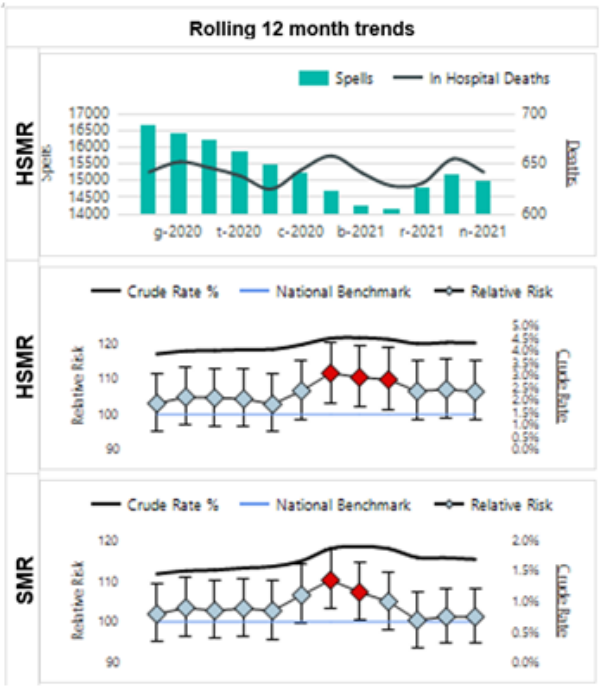
SHMI Group	Obs	Exp	SHMI	Low / High
(98) Other gastrointestinal disorders	15	10	150.00	83.89 247.42
(89) Intestinal obstruction without hernia	15	10	150.00	83.89 247.42
(124) Intracranial injury	20	15	133.33	81.41 205.93
(75) Chronic obstructive pulmonary disease and bronchiectasis	20	15	133.33	81.41 205.93
(65) Congestive heart failure, nonhypertensive	35	30	116.67	81.25 162.26
(66) Acute cerebrovascular disease	50	55	90.91	67.47 119.86
(77) Aspiration pneumonitis, food/vomitus	25	25	100.00	64.70 147.63
(31) Cancer of bone and connective tissue, Cancer of thyroid, Malignant neoplasm without specification of	20	20	100.00	61.06 154.45

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

SHMI_June20_May21.xlsm

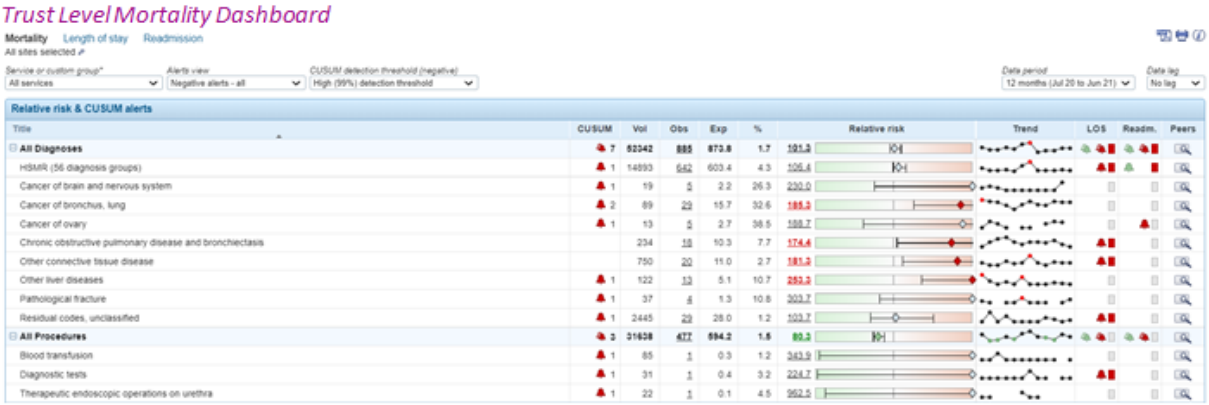
HEALTH | dr foster

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

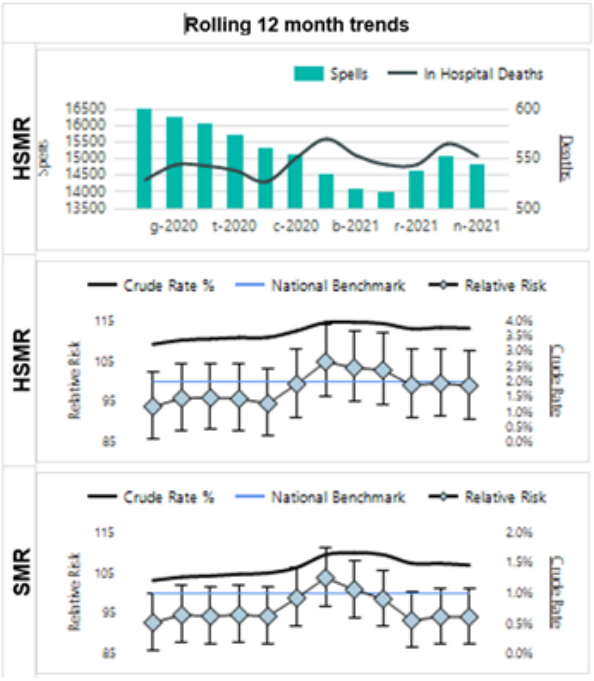


Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		106.4	97.3	95.4
SMR		101.3	96.3	95.7
Non-elective (HSMR)		106.5	97.2	95.2
Weekday, emergency (HSMR)		104.5	95.2	93.5
Weekend, emergency (HSMR)		110.5	103.4	99.9
Saturday, emergency (HSMR)		105.7	100.4	99.3
Sunday, emergency (HSMR)		114.8	106.0	100.5
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		51.2%	31.4%	32.4%
% Non-elective spells with palliative care (HSMR)		6.6%	3.9%	4.3%
% Spells in Symptoms & Signs chapter		10.0%	8.7%	8.1%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		44.7%	42.4%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		12.7%	13.6%	13.8%
% Non-elective spells in Risk Band (0-10%) (HSMR)		82.5%	82.8%	82.6%



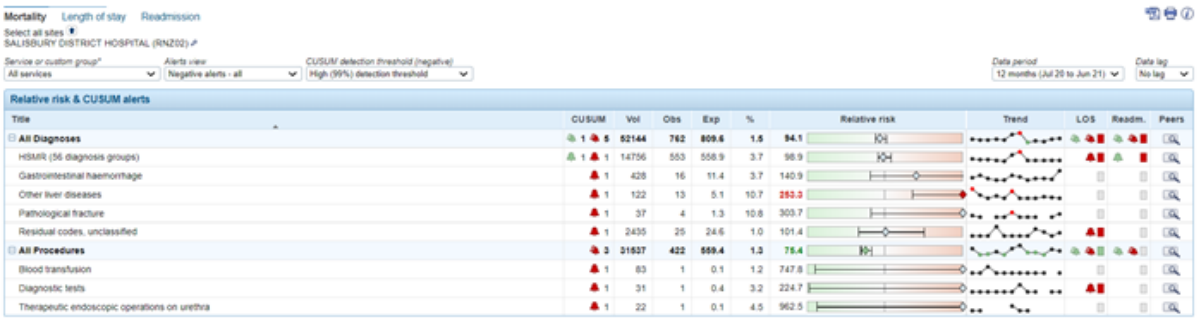
HSMR Data for the 12 month period to June 2021 for SFT (Excluding Hospice Data)



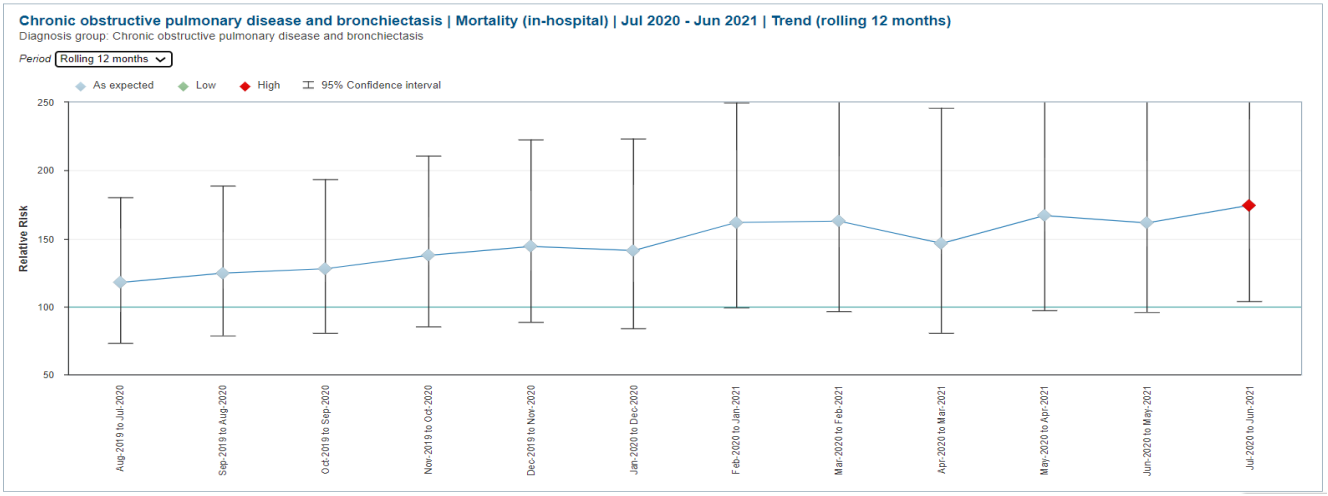
Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	98.9	106.4	97.3	95.4
SMR	94.1	101.3	96.3	95.7
Non-elective (HSMR)	99.0	106.5	97.2	95.2
Weekday, emergency (HSMR)	96.0	104.5	95.2	93.5
Weekend, emergency (HSMR)	106.0	110.5	103.4	99.9
Saturday, emergency (HSMR)	106.3	105.7	100.4	99.3
Sunday, emergency (HSMR)	105.2	114.8	106.0	100.5
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	43.2%	51.2%	31.4%	32.4%
% Non-elective spells with palliative care (HSMR)	5.2%	6.6%	3.9%	4.3%
% Spells in Symptoms & Signs chapter	10.0%	10.0%	8.7%	8.1%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	45.2%	44.7%	42.4%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	12.5%	12.7%	13.6%	13.8%
% Non-elective spells in Risk Band (0-10%) (HSMR)	83.7%	82.5%	82.8%	82.6%

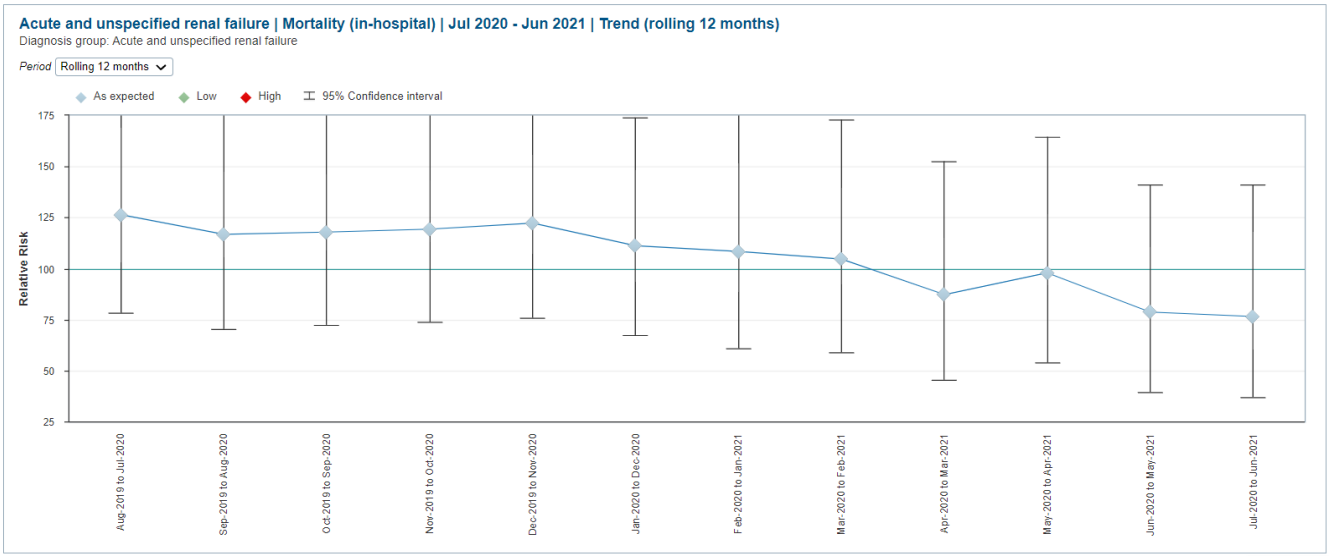
Site Level Mortality Dashboard

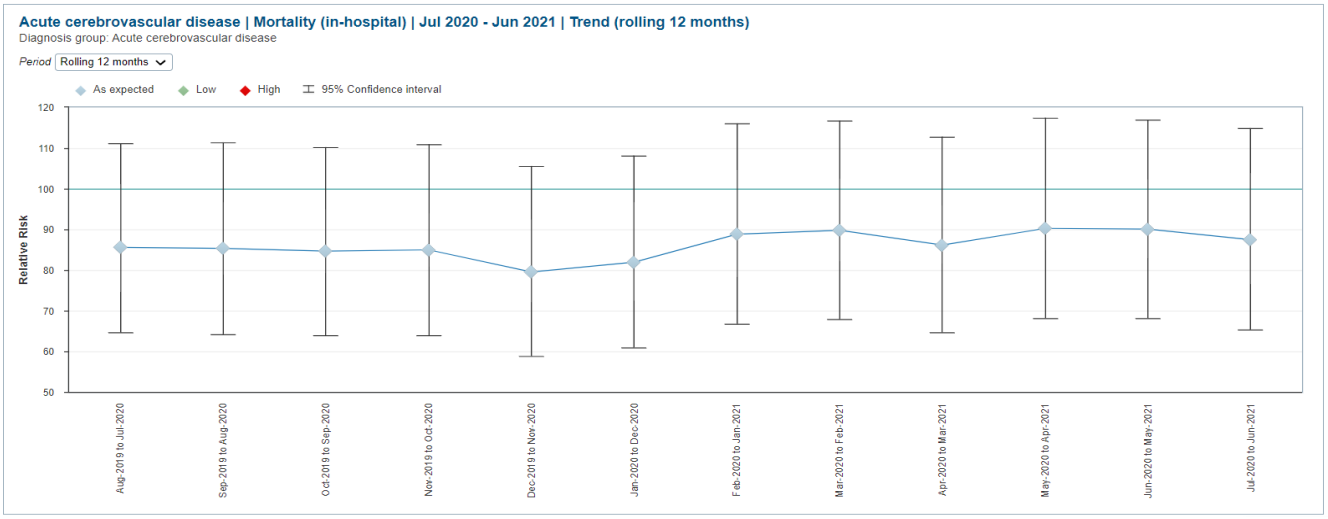


Diagnosis Group Alert



12-Month Trends in Relative Risk for High Risk Groups

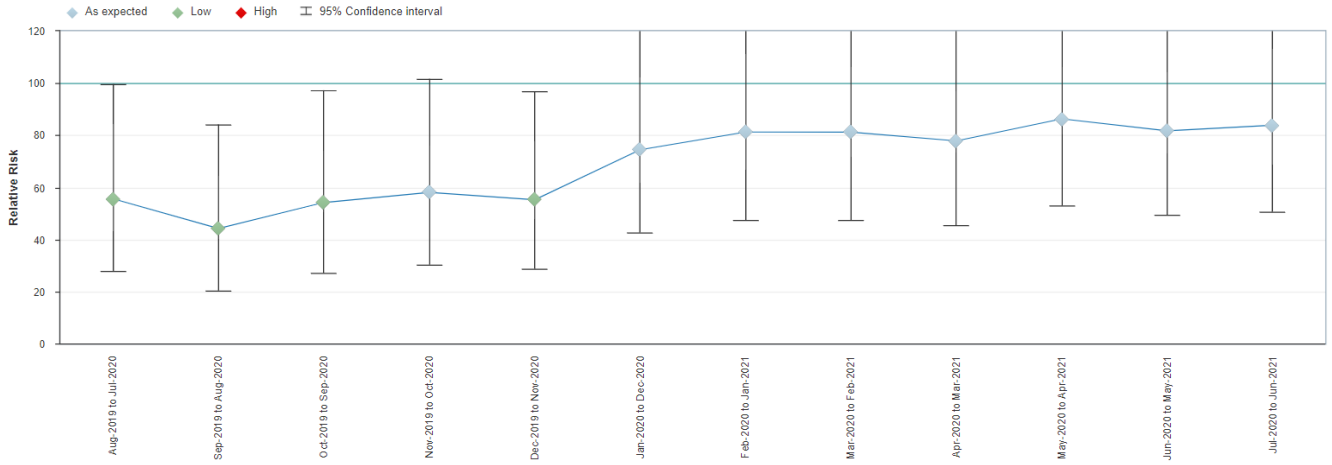




Acute myocardial infarction | Mortality (in-hospital) | Jul 2020 - Jun 2021 | Trend (rolling 12 months)

Diagnosis group: Acute myocardial infarction

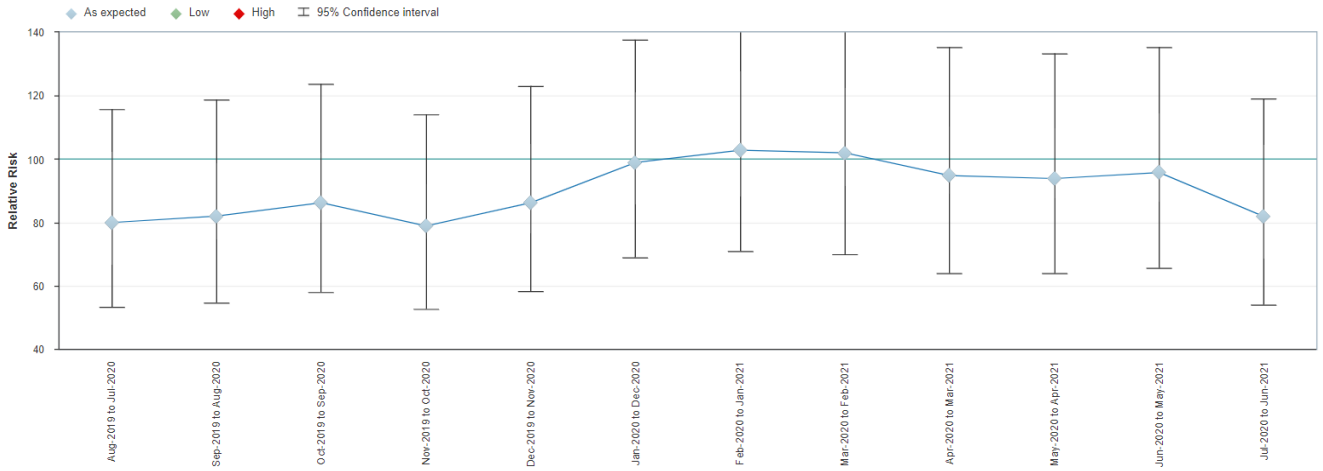
Period Rolling 12 months



Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Jul 2020 - Jun 2021 | Trend (rolling 12 months)

Diagnosis group: Congestive heart failure, nonhypertensive

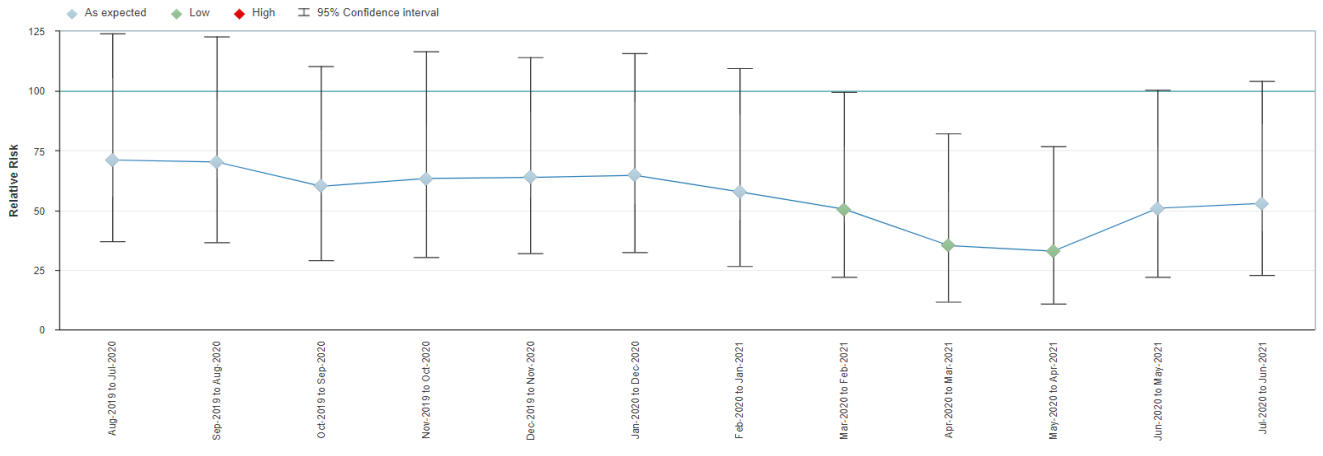
Period Rolling 12 months



Fracture of neck of femur (hip) | Mortality (in-hospital) | Jul 2020 - Jun 2021 | Trend (rolling 12 months)

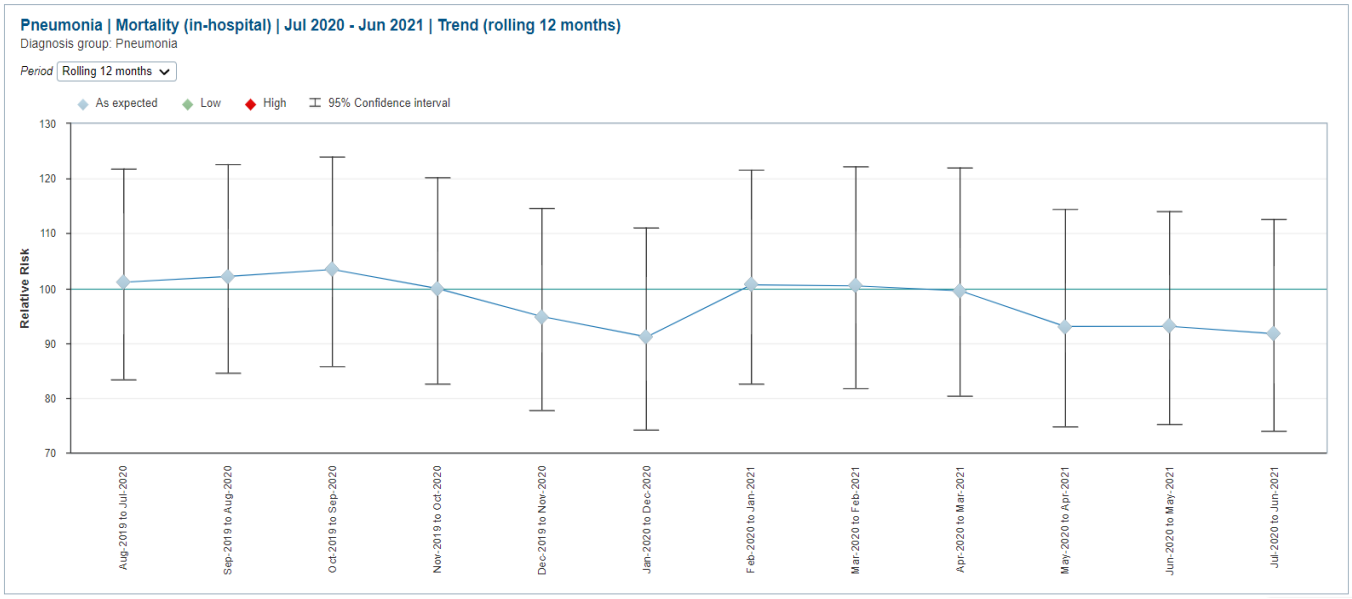
Diagnosis group: Fracture of neck of femur (hip)

Period Rolling 12 months



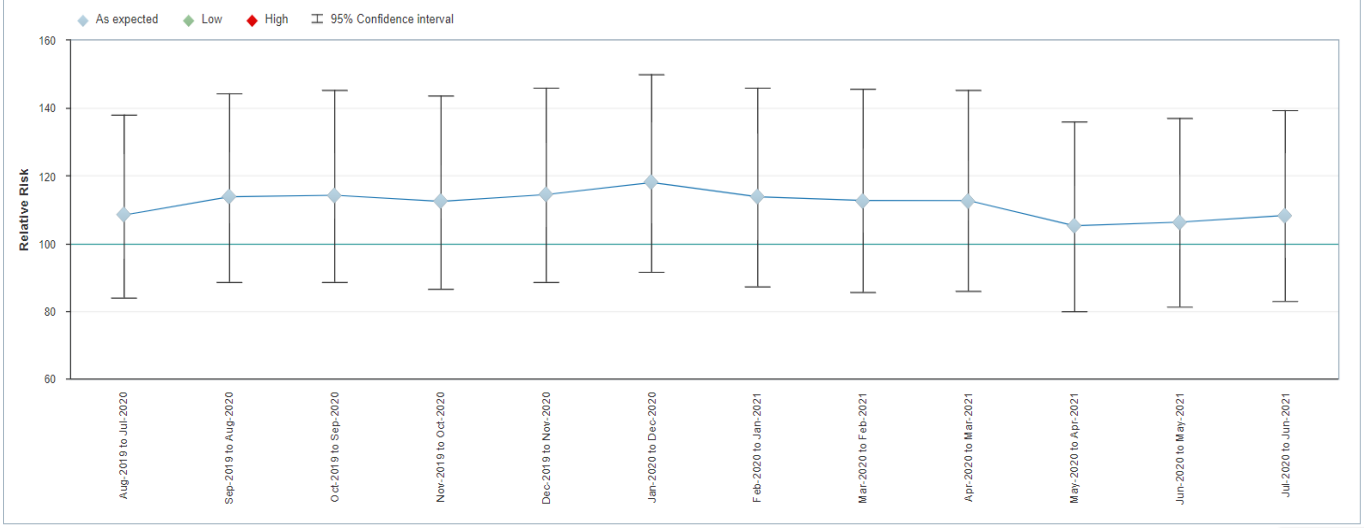
Pneumonia | Mortality (in-hospital) | Jul 2020 - Jun 2021 | Trend (rolling 12 months)

Diagnosis group: Pneumonia



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

Diagnosis group: Septicemia (except in labour)



END

Salisbury NHS Foundation Trust

INFECTION PREVENTION AND CONTROL

DIRECTOR OF INFECTION PREVENTION AND CONTROL

6 MONTHLY UPDATE REPORT

April 2021 – September 2021

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

December 2021 (Final v.1)

CONTENTS **PAGE**

APPENDICES

1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Chief Nursing Officer.

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this six monthly update DIPC Report is to summarise the work undertaken at Salisbury NHS Foundation Trust and inform the Trust Board of the progress made against the 2021/22 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in *'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (revised July 2015),* to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced a challenging six months for infection prevention and control, with the major incident response to the ongoing COVID-19 pandemic.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2021/22 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements.

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control Team (IPCT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks and other clinical activity exceptions.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 4.0 whole time equivalent (w.t.e) ICNs (one of which is a secondment post funded by COVID-19 monies) and secretary (0.6 w.t.e). In addition, there are 3 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG

- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Receive regular reports from the Facilities directorate regarding cleaning programmes.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Clinical Commissioning Group (CCG) and other regulatory bodies, e.g. NHS Improvement (NHSi), within 2 working days, and must undertake an investigation and submit a formal written report within 45 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the *Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, March 2015)*, and the *Public Health England (PHE) HCAI: Operational Guidance & Standards for Health Protection Units (HPUs) (July 2012),* PHE now UK Health Security Agency (UKHSA) from 1st October 2021.

During quarters 1 and 2 of 2021/22, the Trust has had **no** declared internal outbreaks of:

- Viral gastroenteritis (Norovirus)
- *Clostridioides difficile* (*C.difficile*)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the PHE website: https://www.gov.uk/government/organisations/public-health-england

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on bed capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators (CSC), with additional written documentation provided to support staff in the ongoing management of these patients.

5.1 Coronavirus (Wuhan CoV)
On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province in China. On 12th January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. The virus is referred to as SARS-CoV-2, and on 11th February, WHO named the syndrome caused by this novel coronavirus COVID-19. The source of the outbreak has not yet been determined. According to current evidence, it is primarily transmitted between people through respiratory droplets and contact routes. Airborne transmission is possible in specific settings in which procedures or support treatments that generate aerosols are performed. The first cases were confirmed in the United Kingdom (UK) at the end of January 2020 and WHO declared a global pandemic on 11th March 2020.

From January 2020, the Trust initiated emergency planning and resilience response measures utilising significant PHE guidance and updates published as the situation continued to evolve. This included the identification of emergency assessment/triage areas, respiratory assessment zones and care areas, testing programme and personal protective equipment practice management. The Trust has followed established Emergency Preparedness, Resilience and Response (EPRR) protocols which include the instigation of strategy planning and Incident Management Team (IMT) meetings, with key personnel to agree actions and develop iRespond cards across the divisions and disciplines. This work has remained ongoing throughout quarters 1 and 2 of 2021/22.

The IPCT has continued to provide representation within the various identified workstreams, which has included IMT, Clinical Review Group (CRG), Workforce, Recovery, Personal Protective Equipment (PPE) and Virtual Board Round (VBR). (*Of note: in relation to PPE supplies, the Trust continues to work exceptionally hard to ensure adequate stock levels of the required standard are maintained).*

An Infection Prevention and Control (IPC) 'Task and Finish' Group was set up in June 2020 to provide a forum to review and action the continual changes to the IPC guidance published by PHE related to COVID-19. There was representation in the group from all clinical divisions as well as Corporate, Estates and Facilities. Key achievements of the group included providing evidence to populate the IPC Board Assurance Framework (BAF) document versions; Outbreak Management Framework/Policy and process agreement; reviewing and final agreement for use of portable fans in clinical environments Standard Operating Procedure (SOP) and risk assessment document; patient visiting protocol and related risk assessment documentation; review of risk assessments for COVID secure workplaces, with adaptations (where possible) of the environments and feedback of national learning.

The IPC Task and Finish Group was stood down during quarter 3 of 2020/21, with ongoing work feeding into other existing meetings already attended by the IPC Task and Finish members. This included the Ventilation Task and Finish Group, PPE Group, VBR, and IPC update meetings with Matrons in attendance, with appropriate escalation to existing CRG and IMT meetings. As the IPC BAF was updated nationally, the required changes and amendments were completed internally, with the document presented via the IPCWG to the IPCC, and to follow the established governance pathway to Trust Board.

5.2 COVID-19 outbreak prevention and management
During 2020/21, updates to the outbreak management and reporting iRespond card were completed to reflect the changes to external reporting requirements. This included an amended definition of an outbreak for all communicable diseases in addition to COVID-19. The aim of the card continues to ensure that the Trust implements a rapid and well coordinated response to an outbreak of COVID-19 infection, in line with requirements set out in the South West Regional COVID-19 Healthcare Setting Outbreak Framework. The roles and responsibilities of all individuals and departments involved in outbreak management are clearly defined, making efficient use of available resources in order to limit the spread of infection and minimise the disruption of clinical services. It was necessary for the Trust to implement the planned outbreak response process

during quarters 1 and 2 of 2021/22, with the declaration of one COVID-19 outbreak within the medical division:

- Pitton Ward (Acute Frailty Unit) declared on 20th April 2021, with positive results for 4 patients and no staff member linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 24th May 2021.

For this outbreak, the Outbreak Management Group (OMG) was formed with review meetings held throughout. The meetings were well attended by all required individuals and departments within the Trust and by representatives from PHE and Bath and North East Somerset (BANES), Swindon and Wiltshire CCG. The OMG ensured that appropriate arrangements were in place to care for the affected patients and staff, instigating and monitoring the effectiveness of the control measures implemented in containing the spread of infection. The impact on service delivery was constantly reviewed, with communication to all relevant groups, including patients, relatives, carers and staff completed as appropriate. The production and distribution of meeting notes and actions was undertaken by the ICNs. The outbreaks were reported externally to the NHS Outbreak System on the Insights Platform (NHS England & NHS Improvement) within the expected reporting timeframes (within 24 hours of declaration). Updates were reported on the same system when additional cases were identified and/or following an outbreak management review meeting. A further notification was made on the same system at the ending of an outbreak, defined as when there had been no confirmed cases with onset dates in the 28 days since the last positive result.

For the declared COVID-19 outbreak, application of the national COVID-19 case definitions to these 4 cases classifies 2 as hospital onset; definite healthcare associated. The Trust recognises that where any infections are classified as hospital onset healthcare associated then there is clearly scope for learning, and that this is the same for COVID-19 infections. Therefore, this outbreak review was included within the Trust wide Serious Incident Inquiry (SII) undertaken to encompass all of the COVID-19 outbreaks reported from 2020/21. The process identified the Trust response, positive outcomes and actions, in addition to key learning and any recommendations. This SII was completed in quarter 1 of 2021/22, with the outcomes produced into a formal report following the standard Trust SII process.

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by Public Health England (PHE).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During quarters 1 and 2 of 2021/22, there have been no hospital or community onset MRSA bacteraemia cases reported by the Trust. The Trust's MRSA hospital onset case target for 2021/22 is zero.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During quarters 1 and 2 of 2021/22, there have been 6 unrelated hospital onset MSSA bacteraemia cases, where the sources of infection were identified as:

- Skin or soft tissue (1 case)
- Pancreatitis (1 case)
- Endocarditis (1 case)
- Unknown/unclear source (3 cases).

Post infection reviews were completed by the ward teams, with none of these infections associated with vascular access devices. The review highlighted the requirement for ensuring completion of documentation and other practice audits (as appropriate).

Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for reduction targets to be set. PHE are collating data which may act as a baseline for trajectory setting in the future. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset.

6.3 Gram-negative organism bloodstream infections (GNBSIs)
The increase in gram negative organism bacteraemia infections is a national concern and mandatory surveillance of *Escherichia coli (E.coli), Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias continues. This reporting at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work is undertaken by the ICNs.

A national action plan 'Tackling antimicrobial resistance 2019 – 2024' (January 2019) advises that work should continue to reduce healthcare associated GNBSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021/22 with a full 50% reduction by 2023/24.

6.3.1 *Escherichia coli (E.coli)*
Following the identification of a positive blood culture result for *E.coli,* a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the 10 hospital onset cases identified during quarters 1 and 2 of 2021/22, an unknown or no underlying focus of infection was identified for 4 cases, and the remaining 6 cases had a source of infection identified. Of these unrelated 6 cases, the sources of infection were:

- Hepatobiliary (2 cases)
- Lower urinary tract (1 case)
- Gastrointestinal or intra-abdominal collection (1 case)
- Skin/soft tissue (1 case)
- Upper respiratory tract (1 case).

Of note: 1 of these E.coli bacteraemia cases was also identified to be an Amp C producer and a further 1 bacteraemia case had a second organism identified (Pseudomonas aeruginosa).

The Trust will continue to work closely with local community and hospital partners to reduce the incidence of *E.coli* bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection (UTI). In addition, as usual activity levels resume, the ICNs will continue to work collaboratively with the relevant CCGs who are leading on achieving this Quality Premium guidance.

The Trust's *E.coli* case threshold for 2021/22 is no more than 27 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2021/22 document; Version 1, published 12th July 2021).*

6.3.2 *Klebsiella sp.* and *Pseudomonas aeruginosa*
During quarters 1 and 2 of 2021/22, there have been a total of 5 hospital onset *Klebsiella spp.* bacteraemia cases and 4 hospital onset *Pseudomonas aeruginosa* bacteraemia cases.

The Trust's *Klebsiella spp.* case threshold for 2021/22 is no more than 9 healthcare associated cases and for *Pseudomonas aeruginosa,* no more than 7 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2021/22 document; Version 1, published 12th July 2021).*

Further information relating to official statistics and benchmarking of performance can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis

6.4 *Clostridioides difficile (C.difficile) Infection*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply Department of Health (DH) guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to PHE. For 2019/20, changes were made to the *C.difficile* reporting algorithm. This included the addition of a prior healthcare exposure element for community onset cases, and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2021/22, the *C.difficile* case threshold objective set for the Trust by NHS England (NHSE) and NHSi is no more than 22 healthcare associated reportable cases. All Trust thresholds are derived from a 2019 calendar year baseline, to avoid capturing changes related to the pandemic and include healthcare associated cases only. Guidance for testing and reporting *C.difficile* cases remained unchanged and the safety and care of patients remains our concern and priority.

During quarters 1 and 2 of 2021/22, the Trust has reported 16 healthcare associated *C.difficile* cases to PHE, of which 7 cases were community onset and 9 cases were hospital onset. Incident investigations are carried out for all hospital onset cases using a 'SWARM' approach. This process is facilitated by the ICNs with the relevant Clinical Leader and divisional Matron to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs undertake a case review for the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

Due to lapses in care identified from the incident reviews, no healthcare associated *C.difficile* cases have been identified for submission to the relevant CCGs for the Appeals Process Panel. From the completed incident investigations for the hospital onset cases, lapses in care were identified. Key learning has included improvements required for the use of the Diarrhoea Pathway, timeliness of sampling symptomatic patients, and timeliness of clinical reviews for these patients.

In addition, the ICNs have completed extra investigations for the *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

Representatives from the Trust have been involved in the South West Regional HCAI *C.difficile* infection improvement collaborative event held during quarter 2 of 2021/22. The aim is to reduce harm to the population of the South West Region from *C.difficile* infection and share wider learning, with outcomes fedback to the DIPC and IPCWG.

6.4.1 Periods of increased incidence (PII) of *C.difficile*

During quarter 1 of 2021/22, two unrelated PIIs of *C.difficile* were declared within the medical division for two separate wards (Redlynch and Spire Wards). The required incident investigations were completed for the positive cases with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits and monitoring of practices, overseen by the relevant senior staff including the Head of Nursing (HoN) and Matrons.

At the request of the IPCWG, ribotyping results were reviewed by the ICD with final reporting to the DIPC, with no outbreak declared retrospectively.

During quarter 2 of 2021/22, the PII was extended for Spire Ward following the identification of two further hospital onset reportable cases of *C.difficile.* To date, the ribotyping results have all been different. However, it has been acknowledged by the Consultant Microbiologists that not all

samples identified to be sent for ribotyping were retained by the Laboratory. This was investigated by the Laboratory Manager and processes reviewed and updated.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' of 2021/22 for further detail of HCAI data.

(Of note: we are unable to provide any Model Hospital Benchmarking Data as the NHS England Model Health System metrics have not been updated since March 2019).

6.5 Surgical Site Infection Surveillance (SSIS)
The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. For the mandatory surveillance of SSI following orthopaedic surgery, Trusts must participate in a minimum of one surveillance period in at least one category of orthopaedic procedures during a financial year. The Trust complies with this annual requirement to undertake SSIS.

Final data collection for quarter 4 of 2020/21 was reconciled within the required timeframe set by PHE. There were a total of 47 cases entered onto the national database, with one deep infection identified. This was followed up with the Consultant for the patient, who reviewed the case identifying nothing unexpected and with no clear trends. Active data collection for the category of repair of fractured neck of femur (NOF) surgery has continued from quarter 4 of 2020/21 into quarter 1 of 2021/22, to ensure than an extended cohort number of cases is attained.

From the data collected during quarter 1 of 2021/22, a total of 63 cases were entered onto the national database and reconciled within the required time frame set by PHE, with one deep infection identified. This was followed up with the Consultant for the patient, who reviewed the case identifying nothing unexpected and no clear trends, and fedback to the Mortality and Morbidity meeting for the orthopaedic specialty. This case was also discussed at a Patient Safety Summit meeting at the request of the Lead ICN and Risk Department.

Data collection continued in quarter 2 of 2021/22, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 3 of 2021/22. Formal reports outlining progress with SSIS have been presented at the IPCC meetings and disseminated to relevant Trust personnel.

6.6 MRSA screening
The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Divisional Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For quarters 1 and 2 of 2021/22, the Trust compliance rates for MRSA emergency screening ranged from 91.18% - 95.85%. For MRSA elective screening, the Trust compliance rates ranged from 58.62% - 75%. However, it must be acknowledged that the number of elective patients within one of the elective screening cohorts was exceptionally small.

Outcomes of any follow up of actions undertaken by the clinical divisions are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health guidance published in 2015, and continues following further review by the Trust.

6.7 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of bloodstream infections in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). From the data submitted so far, report updates have been provided by PHE and cascaded to the area leads.

6.8 Private Healthcare Information Network (PHIN)
The Trust continues to complete mandatory reporting externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data provided to the ICNs for review, there have been no externally reportable infection alert organisms identified for this patient group during quarters 1 and 2 of 2021/22.

7. HAND HYGIENE

Fifty two areas (including wards and departments) across the four clinical divisions carry out a monthly audit of hand hygiene compliance in their area against the World Health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the divisions of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the divisions to take the necessary action.

Due to the ongoing COVID-19 pandemic, there have been no audits completed by the external auditor during quarters 1 and 2 of 2021/22. However, the clinical divisions have been continuing to undertake cross auditing within their areas and specialities to further validate the audit process.

Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 5, handwashing after contact with patient surroundings and also following removal of gloves. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed, the overall average compliance rate for quarters 1 and 2 of 2021/22 ranges from 50% - 100%. It should be noted there had been an initial improvement with areas completing these audits, but there has been a higher rate of non-completion/non-return of audits from areas during quarter 2 of 2021/22, which has reduced the overall average compliance score.

The 'Red, Amber and Green' (RAG) rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures being monitored by the IPCWG, DMTs and Patient Led Assessment in the Clinical Environment (PLACE) Steering Group.

8. ANTIBIOTIC STEWARDSHIP

The Antimicrobial Reference Group (ARG) have experienced a number of challenges this year as the Antimicrobial Pharmacist post has been vacant since July 2021. Antimicrobial Stewardship (AMS) ward rounds are still going ahead with Dr Flanagan, Consultant Microbiologist, accompanied by the Antimicrobial Pharmacy Technician, Rebecca Stonell. Regular visiting of all clinical ward areas is positively reinforcing AMS and the multidisciplinary teams (MDTs) appear much more confident in approaching Dr Flanagan for help and advice.

8.1 Commissioning for Quality and Innovations (CQUINs) for 2021/22
All CQUINs continue to be held for the remainder of 2021/22. However, the Antimicrobial/CQUIN Pharmacy Technician continues to collect data as a Quality Improvement Project which also includes catheter associated urinary tract infections (UTIs) for the first time. This has shown an increase in the number of UTI patients treated as per national guidance which will in turn reduce inappropriate antibiotic prescribing and antimicrobial resistance. We have been informed by the Regional Lead that a CQUIN for all UTIs will recommence in April 2022. The work done has now managed to attain 73% compliance for quarter 1.

8.2 Total antibiotic consumption
Reducing total antimicrobial usage has now become part of the NHS contract. Our target is to reduce antimicrobial use by 2% every year. Our in-house 6 monthly figures show a 7% reduction in antimicrobial usage since last year. This significant decrease is thought to be due to the large increase in antibiotic use seen during the peak of the COVID-19 pandemic. When patients were initially admitted it was unclear whether their respiratory symptoms were due to COVID-19 or a bacterial cause. Therefore, patients were given antibiotics until bacterial infection was ruled out. Due to the large number of patients admitted, this in turn led to an increase in antibiotic use.

8.3 Action plan for 2021/22
The CQUINs for 2021/22 are currently on hold. It is anticipated that a new CQUIN will start in April 2022 to include all UTIs in patients over 16 years. The Quality Improvement work that is ongoing is anticipated to put us in a good position to do well.

8.4 Ongoing challenges
We will continue our weekly antimicrobial stewardship ward rounds as these have had a significant impact in ensuring compliance with the Trust's anti-infectives guidelines and reducing inappropriate use of antibiotics. Current plans to audit regularly along with other clinical antimicrobial work is on hold until the Lead Antimicrobial Pharmacist post can be filled.

9. AUDIT
The ICNs have not undertaken any formal policy audit during quarters 1 and 2 of 2021/22, but have been actively involved in supporting identified clinical areas to complete the *'Perfect Ward' Application'* (PWA) infection prevention and control inspections. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. *(Of note: these inspections include policy practice standards as part of audit criteria).*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via the PLACE Steering Group). *(Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas*).

The HoN, Matrons and clinical leaders also complete the additional PWA quick COVID-19 assessment inspections within identified clinical areas. These focus on monitoring and assurance around a number of measures, including signage, provision of hand hygiene opportunities, provision of PPE and observations of PPE practices, and adherence with the relevant COVID-19 pathway in the area. It also includes the questioning of staff around COVID-19 symptoms for patients and staff and the resulting actions indicated, isolation and decontamination practices, and demonstrating awareness of visiting guidance and how to escalate any staffing concerns. When required, the ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections. For quarters 1 and 2 of 2021/22, the overall average compliance scores reported have ranged from 98% – 99%.

Please see Appendix C for further details, the results continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Mean compliance scores for quarters 1 and 2 of 2021/22 were 68% for staff completion of hand hygiene assessments and 91% for staff completion for IPC computer based learning (CBL) package *(MLE data accessed 06.10.21).*

The low hand hygiene assessment compliance may be attributed to the access opportunities for staff due to the COVID-19 pandemic. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising an ultra-violet (UV) light box for rotation through their divisional areas and departments. In addition, the ICNs are working with the Education Department to improve compliance for staff completing these mandatory training modules.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. Several of the core infection prevention and control sessions have been delivered for different staff groups, in addition to specific topic requests. The ICNs have also met with small groups and teams or on a one-to-one basis, to provide guidance and aid improved understanding of policies and practices. There has been a continued focus on promoting learning through the daily clinical visits undertaken by the ICNs.

Formal ‘virtual’ meetings with the Infection Control Link Professionals (ICLPs) group were recommenced during quarter 2 of 2021/22. Communications via e-mail and through discussions with various ICLPs as part of both routine and additional visits undertaken by the ICNs to clinical and non clinical areas have continued. Details of education opportunities provided are available from the ICNs.

11. DECONTAMINATION

11.1 Key Success stories in quarters 1 and 2 of 2021/22

We have concluded the upgrade of our automated cleaning system (Trophon) in Radiology and Obstetrics & Gynaecology Outpatients, with the training and roll out of five new devices. These have been introduced using a managed service contract which ensures software updates or system improvements are included during the lifetime of the contract, without further outlay for the Trust.

All six Dry Storage Cabinets (DSCs) are now fully functional in Endoscopy. This has resulted in a significant increase in storage capacity (from 24 to 60 scopes), longer validated storage times (from three to fourteen days) and the ability to safely store our newer scope range (previously incompatible with the old cabinets) preferred by clinicians for patient treatment.

11.2 Progress on actions during quarters 1 and 2 of 2021/22

Decontamination audits have recommenced in a new format. Areas previously audited were limited to departments which undertook their own local decontamination of specialist equipment. The Decontamination Lead has extended the audit schedule to include general ward areas, enabling identification of aspects previously overlooked. This captures wider evidence of local decontamination processes for general equipment, providing assurance for the IPC Board Assurance Framework, Section 2.15. The new audit format also captures reviews of SOPs at the same visit, rather than a separate schedule, offering a more cohesive approach.

The Authorised Engineer (Decontamination) continues to visit and support the Trust whilst the Authorised Person (Decontamination) post remains vacant. The Estates Team continues to work on appointing to vacant posts.

Work to review High Level Disinfection (HLD) of invasive ultrasound probes Trustwide continues. Whilst the work in Radiology and Obstetrics & Gynaecology is completed, the desire to find a suitable automated solution for Fertility Clinic progresses, though intermittently. An alternative device has been identified for further exploration and potential trial. Depending on the outcome, other clinical areas may also benefit.

11.3 Key challenges for quarters 3 and 4 of 2021/22
Completing the Decontamination Audit Schedule within the year, given the acuity of operational pressures and having increased the number of clinical areas on the schedule, will be a challenge. The Decontamination Lead can undertake the audits alone, but the preferred option is undertaking them accompanied by a member of the clinical or divisional team as it offers valuable opportunities to raise awareness and support learning.

The refurbishment of Sterile Services Limited (SSL) has been further delayed due to a significant increase in costs from the original quote as a result of the current supply situation. The decontamination equipment and supply of services, such as steam, is fragile. Although risks are mitigated where possible, the requirement to repeat the tendering process will result in the ongoing use of the fragile infrastructure which in turn increases the risk of complex breakdowns potentially impacting clinical pathways.

12. CLEANING SERVICES

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities Teams.

12.1 Patient led assessment of the care environment (PLACE) internal audits
The Trust developed (with ward leaders) and implemented a programme of PLACE audits from June 2021 following a suspension of these audits from June 2020. We plan to undertake approximately 60 internal PLACE audits over the coming year.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE Lite tool and discussed with ward leaders at the monthly PLACE Steering Group. To support social distancing and to minimise footfall within clinical areas the number of participants in PLACE inspections will be limited, with no Governors or Volunteers present.

12.2 National PLACE
We have been informed by NHSi that this year's National PLACE inspection has been cancelled due to the COVID pandemic; we await further information regarding the National PLACE for 2022.

12.3 Deep clean programme/rapid response team
The deep clean plan for 2020/2021 was successfully completed. The current deep clean programme commenced in May 2021 and is reported monthly at the PLACE Steering Group, IPCWG and IPCC and is progressing well (a copy of the Deep Clean programme is available from the Housekeeping Department).

12.4 Improvement Work Over the past 6 months
To support the Trust's COVID-19 response the Housekeeping Team is providing a 24 hour service with a small cleaning team on site out of hours. We are currently funding this out of existing Housekeeping Department budgets and will continue to review with a desire to scale this back as hospital activity allows.

Below are tables from the past 2.5 years indicating the increased activity during the pandemic. Headline being a 213% increase in additional 'post infection' cleaning, measured between September 2019 (528 cleans) & September 2021 (1127 cleans).

2021/22 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1076	934	850	1106	1105	1127							**6198**
ENHANCED HRS	67.75	67.50	50	66.5	70.75	70.25							**392.75**
DOUBLE CLEANS HRS	104	84.75	79.5	88.0	93.25	60.50							**510**
BIOQUELL	39	40	38	61	56	49							**283**

(Table 1)

2020/21 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1564	1726	1558	1408	1121	1180	1200	1304	1575	2589	1694	1341	**18260**
ENHANCED HRS	38.5	48.25	47.5	72.25	95	56	53.75	96.5	105.5	102.25	65.25	57	**837.75**
DOUBLE CLEANS HRS	4.5	0	40.25	82.25	60.25	77.5	105	149.5	140.25	0	26.25	27	**712.75**
BIOQUELL	30	29	37	62	36	42	39	30	50	10	58	50	**473**

(Table 2)

2019/20 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	521	720	519	670	589	528	612	650	937	647	604	1189	**8186**
ENHANCED HRS	55	90.75	68.5	91.75	74.25	79.75	87.75	94	122	92.75	95	70	**1021.50**
DOUBLE CLEANS HRS	75	50.25	73	61.75	69	85.5	76.50	39.25	47	60.75	54.75	28.75	**721.50**
BIOQUELL	37	58	53	43	46	42	58	35	66	35	23	30	**526**

(Table 3)

12.5 Successes from the past 6 months

The Housekeeping Department were awarded “Team of the Year (Non-Clinical)”, which was gratefully received and a boost to the morale following a tough 12 months.

Housekeeping have procured an additional hydrogen peroxide vapour (HPV) decontamination machine to help support good infection control measures and patient flow.

12.6 Challenges for the coming 6 months

Housekeeping will continue to review the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements and any cost pressures associated to any changes. A paper is being prepared to scope out the recommendations; changes required and associated costs, to implement the new cleaning standards.

Recruitment remains a challenge due to a significant reduction in applicants and the incentives associated with clinical posts (HCSW). The Housekeeping Team is working with the Trust’s Recruitment Team to further support the recruitment of Housekeeping staff.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over quarters 1 and 2 of 2021/22.

The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Part B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) Pseudomonas (guidance for augmented care units), together with the technical guidance document HSG274 (Part 2).

To assist the management process in respect of the water systems across the site, regular meetings of teams (RP and dRP water) from ETS and FES Ltd (PFI maintenance contractor) are held on a monthly basis, to review progress with PPM's and actions in respect of Water Safety.

13.1 Legionella

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings (see Table 4 below) for Legionella (listing counts reported >1000 cfu/l) and high counts for Pseudomonas (Table 5) have taken place in the Trust as a result of the sample results). The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mails as events occur, and as regular reports to the WSG and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 04.10.2021	
					Pre	Post
1	Sarum Ward	07	4.05.02	Outlet back in use and resampled.	1500	100
2	Breamore Ward	27 + 28	WHB Far end of ward	Outlet back in use, PAL fitted, remedial on systems required.	4600	4800
3	Emergency Department	33	Majors cubicle 11	Outlet left in use, PAL filter fitted. Additional sample to be taken for cubicle 9.	400	1800
4	Block 67	51	WHB 67.21	Outlet removed from use, ETS complete additional flushing and taken samples for showers in the area.	50,000	20
5	L3 public WC's	69	Disabled WC	Works completed on system, 2nd clear sample.	>20	>20
6	Tisbury CCU	112	Bay 2 WHB	Outlet left in use, PAL fitted.	800	1800
7	Tisbury CCU	113	Bay 4 WHB	Outlet left in use, PAL fitted, carry out additional flushing and sample shower in Room 4.01.22.	1000	120

(Table 4)

Legionella						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 04.10.2021	
					Pre	Post
8	Whiteparish Ward	114	Bay 2 WHB	ETS to complete additional flushing of outlet and resample.	1000	20
9	Block 05	119 (IVF)	Room 6 WHB	Replace mixer tap on WHB, ETS to complete additional flushing and resample.	4000	20
10	Block 05	121	Room 1 sink cold	ETS to complete additional flushing of outlet and resample.	<20	80
11	Mortuary	127	Post mortem Room	Additional flushing of the outlet by department and resample.	2000	380
12	Vascular Department	193	3.12.58	Additional flushing of the outlet by department and resample.	140	20
13	Main switchboard		Kitchen	Outlet back in use with PAL fitted, works required on system, fed from Sector 04.	25000	16000

(Table 5)

13.2 Pseudomonas Sampling

Live counts are being managed on Neonatal Unit (NNU), Sarum Ward and Odstock Ward, the latest actions and results from resampling as listed on Table 6 below.

Pseudomonas						
	Ward / Department	PS Ref	Location	Action plan	Test result as of 04.10.2021	
					Pre	Post
1	NNU	01	WHB 77.01	1st clear, resample.	Not detected (ND)	ND
2	NNU	20	Shower 77.17	1st clear, resample.	ND	ND
3	NNU	28	WHB 77.08	Remedial works required, PAL fitted.	21	62
4	Sarum Ward	218	4.06.32	1st clear resample.	ND	ND
5	Odstock Ward	116	4.11.32	PAL filter fitted, remedial works required prior to resample.	>100	>100
6	Odstock Ward	123	4.11.33	PAL filter fitted, remedial works required prior to resample.	>100	>100
7	Odstock Ward	179	4.11.48	PAL filter fitted, remedial works required prior to resample.	>100	>100
8	Sarum Ward	109	4.06.09	Clean, disinfect and resample pre and post.	33	
9	Sarum Ward	113	4.06.11	Clean, disinfect and resample pre and post.	24	
10	Sarum Ward	114	4.06.12	Clean, disinfect and resample pre and post.	48	
11	Sarum Ward	108	4.06.08	Outlet removed from use, clean, disinfect, sample pre and post.	>100	

(Table 6)

13.3 Achievements for quarters 1 and 2 of 2021/22

- Water Safety Audit completed on the 14th of July based on NHS Premises Assurance Model SAQ SH 8. An action plan is being developed from the recommendations from the Audit.
- Completion of routine Legionella and Pseudomonas testing and development of subsequent action plans.
- Maintenance and monitoring of the temperature of the main circulated hot and cold water systems across the SFT Estate.

13.4 Key Focus for quarters 3 and 4 of 2021/22

- Maintaining the temperature of the hot and cold water systems across the Trust.
- Improving the level of flushing compliance from circa 50% to the 70-80%.
- Completion of the site system risk assessment, a contractor has been engaged to complete this work, due to complete by the end of January 2022. The risk assessment will inform the Trust of any system risks which an action plan can be developed.
- Engagement of key members (DIPC, Consultant Microbiologist, ICNs) of the Water Safety Group (WSG) in supporting action plans and quarterly meetings of the WSG.
- Review of the Water Safety Policy.
- Training of the Trusts RP and dRP for Water Safety.

14. CONCLUSION

This six monthly update DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2021/22 in reducing HCAI rates for the Trust.

For quarters 3 and 4 of 2021/22, the key ambitions for the Trust will include:

- Continued response to the impact of the COVID-19 pandemic
- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship
- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

15. ACKNOWLEDGEMENTS

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- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities and Amanda Urch, Head of Housekeeping and Portering (Section 12)
- Terry Cropp, Responsible Person for Water and Senior Estates Officer (Section 13).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2021/22

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	CEO	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	CEO	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	Deputy CNO	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	CEO	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/ICD/ICNs	In place
Active Surveillance & Investigation: Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	IPCT	In place
Review implementation of 'alert organism' & 'alert condition' system	ICD/Microbiologists	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	ICD/Microbiologists	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI.	DIPC/ICD/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/Housekeeping Manager	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/Housekeeping Manager/Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	Head of Estates	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/Decon. Lead	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	Head of Facilities	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings (renamed PLACE Steering Group from quarter 2 of 2020/21).	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents.	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit.	HoNs/Matrons/ IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.	ICD/Microbiologists/ Laboratory Manager	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	ICD	In place
Safe handling and disposal of sharps	H&S Lead	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	H&S & OH Lead	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	IPCT	In place
Disinfection policy	Facilities GM	In place
Antimicrobial prescribing	ICD/Lead Pharmacist	In place
Mandatory reporting HCAIs to Public health England (PHE)	ICD	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IPCT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	ICD/Decon. Lead	In place
Glycopeptide Resistant Enterococcus (GRE)	ICD	Included in
Acinetobacter species	ICD	Isolation
Viral Haemorrhagic fever (VHF)	ICD	Policy
Prevention of spread of Carbapenem resistant organisms	ICD	In place
Diarrhoeal infections	ICD	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	NNU Lead	In place
Infection control measures for ventilated patients	ITU Lead/Matrons	In place
Tuberculosis	ICD	In place
Legionellosis risk management policy and procedures, including pseudomonas	Head of Estates	In place
Strategic Cleaning Plan & Operational Policy	Facilities GM	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	Head of Estates	In place
Waste Management Policy	Waste Manager	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	Decon. Lead	In place

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs		
Ensure all staff can access relevant Occupational Health & Safety Services (OHSS)	Head of OD&P & OH Lead	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	OH Lead	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals.	HoN/Matrons/ICNs	Continuous

APPENDIX B (April 2021 – September 2021)

Clinical Directorates	Inpatient areas/wards	*Clostridioides difficile* - all cases (reportable and not reportable)			Bacteraemias - all cases are reportable to Public Health England (PHE)										Outbreak declared	PII declared	Hand Hygiene (mean %)	IPC PWA (mean %)
		Sample taken			*MRSA*		*MSSA*		*E.coli*		*Pseudomonas aeruginosa*		*Klebsiella sp.*					
		Hospital onset; healthcare associated	Community onset; healthcare associated	**No lapses in care**	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	See main repot for details			
Clinical Support & Family Services	Labour Ward							1									77.94%	N/A
	Neonatal Unit							1									100%	N/A
	Post-natal Ward																100%	N/A
	Sarum Ward (inc. Children DAU)									1			1				66.25%	99.88%
	CS&FS Totals:							**2**		**1**			**1**					
Medicine	AMU		1 + 2					2	1	5		1		2			84.01%	99.23%
	Breamore Ward	1									1						82.91%	99.81%
	Durrington Ward																67.23%	98.18%
	ED (inc. SSEU)							12		37		6		9			59.80%	98.28%
	Farley Ward including RCU	1							1								81.12%	99.72%
	Hospice Unit																100%	99.72%
	Laverstock Ward										1		1				85.18%	98.45%
	Longford Ward	1															98.64%	92.71%
	Pembroke Ward	1							1								99.16%	98.91%
	Pembroke Suite									1							81.48%	N/A
	Pitton Ward		1				1			1					20.04.21		64.44%	97.99%
	Redlynch Ward	2 + 1	1						1				1			04.06.21	86.02%	98.48%
	Spire Ward	3 + 2							1		1					21.06.21	93.65%	99.28%
	Tisbury CCU						1										95.56%	100%
	Whiteparish Ward	1					1						1				96.29%	99.71%
	Medicine Totals:	**8 + 5**	**2 + 3**				**3**	**14**	**5**	**44**	**3**	**7**	**3**	**11**				
Surgery	Amesbury Suite																85.06%	98.48%
	Britford Ward	1							1	1			1				86.79%	96.44%
	Chilmark Suite	1															85.93%	99.11%
	Day Surgery Unit																60%	95.33%
	Downton Ward		1							1							64.63%	100%
	Odstock Ward						2										93.36%	97.45%
	Radnor Ward	1 + 1					1	1	4		1						98.18%	99.84%
	Surgery Totals:	**1 + 3**	**1**				**3**	**1**	**5**	**2**	**1**		**1**					
Additional info: Other samples e.g. GP, Emergency Assessment, SAU, OPD, Mortuary, Private Hospital			**4 + 2**															

All SFT samples including inpatient and outpatient areas, GP and other e.g. Emergency Assessment *C.difficile* **reportable** cases = **red** *C.difficile* **not** reportable cases = **blue**

Perfect Ward scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

Hand hygiene scoring:

	Score above 85%
	Score 61% - 84%
	Score below 60%

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

APPENDIX C

Perfect Ward Application (PWA) Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2021/22

Ward/ Dept	Division	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
Sarum Ward	Clinical Support & Family Services	29.04.2021 (91.7%)	10.05.2021 (100%)	25.06.2021 (100%)	30.07.2021 (95.9%)	30.08.2021 (100%)	
Acute Medical Unit	Medicine		06.05.2021 (98%) 28.05.2021 (76.9%) 31.05.2021 (96.2%)	13.06.2021 (96.2%)	07.07.2021 (98.1%)	04.08.2021 (100%)	03.09.2021 (100%)
Breamore Ward	Medicine	26.04.2021 (100%)	23.05.2021 (100%)	21.06.2021 (100%)	06.07.2021 (78.8%)	28.08.2021 (98.1%)	
Durrington Ward	Medicine		05.05.2021 (88.5%) 07.05.2021 (78.8%)		04.07.2021 (94.1%) 22.07.2021 (78.8%)	10.08.2021 (88.7%)	
Emergency Department				08.06.2021 (93.2%)	05.07.2021 (95.7%)	31.08.2021 (95.6%)	
Farley Ward	Medicine	30.04.2021 (92.5%)	31.05.2021 (82.4%)	30.06.2021 (88.7%)	31.07.2021 (98.1%)	31.08.2021 (90.4%)	
Hospice Unit	Medicine	19.04.2021 (100%)	04.05.2021 (92.3%)	04.06.2021 (88.9%) 22.06.2021 (88.6%)	07.07.2021 (91.1%)	04.08.2021 (95.6%)	
Laverstock Ward	Medicine	24.04.2021 (100%)	17.05.2021 (92.5%)	21.06.2021 (82.4%)	02.07.2021 (88.7%)	11.08.2021 (90.4%)	04.09.2021 (100%)
Longford Ward	Medicine	11.04.2021 (96.2%)	13.05.2021 (86%) 31.05.2021 (98.1%)	06.06.2021 (96.2%)	04.07.2021 (100%)	05.08.2021 (96.2%)	08.09.2021 (98.1%)
Pembroke Ward	Medicine	26.04.2021 (98%)	24.05.2021 (94.2%)	25.06.2021 (94.2%)	20.07.2021 (94.2%)	09.08.2021 (100%)	05.09.2021 (96.2%)
Pitton Ward	Medicine	27.04.2021 (82.7%)	13.05.2021 (96.2%)	10.06.2021 (80.8%)	07.07.2021 (92.5%) 07.07.2021 (96.2%)	11.08.2021 (96.2%)	04.09.2021 (90.4%)
Redlynch Ward	Medicine	12.04.2021 (77.1%) 18.04.2021 (96.1%)	16.05.2021 (98.1%)	04.06.2021 (73.1%) 08.06.2021 (100%) 24.06.2021 (74.5%)	09.07.2021 (96.2%)	31.08.2021 (96.2%)	
Spire Ward	Medicine	03.04.2021 (90.6%)	08.05.2021 (96.2%) 24.05.2021 (92.2%)	20.06.2021 (96.2%) 25.06.2021 (96.2%)	05.07.2021 (94.3%)	09.08.2021 (96.2%)	
Tisbury CCU	Medicine	03.04.2021 (100%)	02.05.2021 (94%) 10.05.2021 (82%)	02.06.2021 (94.1%)	01.07.2021 (98.1%)	04.08.2021 (96.2%)	12.09.2021 (100%)
Whiteparish Ward	Medicine	04.04.2021 (86.5%)	16.05.2021 (98.1%)	03.06.2021 (80.8%) 18.06.2021 (94.3%)	06.07.2021 (96.2%) 23.07.2021 (80.8%)	22.08.2021 (92.5%)	15.09.2021 (78.8%) 28.09.2021 (90.4%)
Amesbury Suite	Surgery	02.04.2021 (96.2%)	12.05.2021 (98%) 19.05.2021 (92.3%)	17.06.2021 (95.7%) 23.06.2021 (74.5%)	23.07.2021 (100%) 23.07.2021 (92.5%)	07.08.2021 (86%) 11.08.2021 (94.3%)	02.09.2021 (96.2%)
Britford Ward	Surgery	14.04.2021 (82.7%)	19.05.2021 (96.2%)	20.06.2021 (98.1%) 22.06.2021 (88%)	05.07.2021 (86.5%)	10.08.2021 (80.8%)	27.09.2021 (96.1%)
Chilmark Suite	Surgery	17.04.2021 (96.1%) 26.04.2021 (86.8%)	16.05.2021 (96.2%) 21.05.2021 (95.7%)	20.06.2021 (89.1%) 22.06.2021 (98.1%)	06.07.2021 (96.1%) 30.07.2021 (86.5%)	12.08.2021 (86.3%)	16.09.2021 (95.7%)
Day Surgery Unit	Surgery	13.04.2021 (100%)	17.05.2021 (100%)	16.06.2021 (100%)	14.07.2021 (100%)	20.08.2021 (93%)	27.09.2021 (100%)
Downton Ward	Surgery	19.04.2021 (98.1%)	13.05.2021 (78.4%) 19.05.2021 (96.1%)	07.06.2021 (98.1%) 14.06.2021 (76.6%) 15.06.2021 (78.3%) 25.06.2021 (90.6%) 29.06.2021 (92.3%)	08.07.2021 (96.2%)	27.08.2021 (80.4%)	27.09.2021 (100%)
Odstock Ward	Surgery	09.04.2021 (98.1%)	09.05.2021 (96.2%)	11.06.2021 (94.1%) 18.06.2021 (97.8%)	23.07.2021 (92.2%)	29.08.2021 (96.2%)	26.09.2021 (98%)
Radnor Ward	Surgery	20.04.2021 (96%)	15.05.2021 (100%) 28.05.2021 (94.2%)	23.06.2021 (95.7%)		01.08.2021 (100%) 30.08.2021 (98%)	30.09.2021 (98.1%)

Publications approval reference:
C1337

Infection prevention and control board assurance framework

June 30th, 2021. V1.6 Updates from
V1.5 highlighted in yellow

Q2 21-22

Section	Red	Amber	Green	Change since Q1 21/22
1	2	4	16	1.4 G↓A
2	0	2	11	0
3	0	2	0	3.1 G↓A
4	0	1	5	0
5	0	2	11	5.7 G↓A
6	0	3	10	6.9 G↓A
7	0	1	4	0
8	0	1	11	0
9	0	0	4	0
10	1	0	15	0

Q1 21-22

Section	Red	Amber	Green	Change since Q4 20/21
1	0	4	14	0
2	2	1	12	0
3	0	0	2	0
4	0	0	5	0
5	0	2	12	0
6	0	2	11	6.7 A↑G
7	0	1	4	7.2 R↑A
8	0	0	11	0
9	0	0	4	0
10	1	0	15	0

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance					
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	Q2 (21/22)	
1.1 Infection risk is assessed at the front door and this is documented in the patient notes.	DIVISIONS	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival. LFT testing in ED , if negative then cepheid rapid test undertaken to identify what pathway the patient follows/	1. Non-elective patients may be categorized as low risk and be transferred into open bay before test result. 2. Patients may become positive after admission either due to being incubation stage on admission or due to hospital acquired covid. 3. No current auditing of documentation for front door assessment.	1. Fast tests used for low risk patients as higher risk are not cohorted on test result alone. 2. All patients with negative test are retested in accordance with the testing action card.						
1.2 There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically inoperative	DIVISIONS	Testing and transfer action card includine LFT for contact oatients. Wards redesienated .	Challenges for capacity vs specialty requirements can result in patient moves.	Continued review of contacts via daily VBR and Outbreak Manaeement Meetines.						
1.3 That on occasions when it is necessary to cohort COVID or nonCOVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	IPC FACILITIES	COVID-19 positive patients cohorted during outbreak and when COVID-19 patients exceeded non-COVID. Contacts of COVID 19 positive also cohorted to reduce risk of transmission. PWA rapid COVID 19 inspection completed daily in areas of outbreak (from January 2021) and weekly for all other in-patient areas. Cleaning agreed between Housekeeping and IPC including additional enhanced cleaning - monitored at Outbreak Management meetings. All areas undergo deep cleaning and HPV disinfection of the environment.	National and local prevalence **continues to remain high. Unpredictable number of admissions.** Compliance with daily and weekly auditing compliance. **1 outbreak in Q1 (pilton)**	**All policy followed for Outbreak Management Group. All cleaning undertaken as required.**						
1.4 Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice a) staff adherence to hand hygiene ~~b) UPEC-based vancomycin fluorescents~~ ~~c) staff social distancing across the workplace~~ d) staff adherence to wearing fluidresistant surgical facemasks (FRSM) in: • a) clinical • b) non-clinical setting	ALL	Hand hygiene and IPC practice inspection and audits in place and monitored at Outbreak Management Meetings, IPCWG. Concerns raised at IMT and PPE Groups if needs. All new guidance monitored via IPCWG and additional forums if required. Quarterly submission of BAF to IPCC and Board. Staff social distancing in place including COVID secure risk assessments, Screens Group and room numbers and all staff wearing of FRSM unless exempt (process in place through Occ Health). Staff individual health risk assessments.	Non-compliance identified in hand hygiene inspections Restrictions in office space to facilitate staff at work	Discussed at IPCWG , Matron's Meeting , Ward Performance Reports. Screens in wards and encouraging natural ventilation in all areas. Ventilation T and F Group in place.						
1.5 Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting consider implementine the role of PPE auardians/safety champions to embed and encourage best practice	IPC DIVISIONS	PPE compliance monitored as per section 1.4 PPE Champions introduced Q1 and Q2 of 2020-21. IPC Link Nurses established for several years.	Role of Champions requires review of trained individuals from wave 1. Some IPC Link Nurses redeployed or no lonaer active	Review role of link nurse in IPC in line with RCN Guidance (Jan 2021) and include appropriateness of non-clinical areas						
1.6 Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	COO	In place since December 2020.	**Reliance on staff to report to the Government website which cannot be tracked fro compliance.**	**Ongoing communications with staffto adhere to twce weekly testing.**						
1.7 Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	DoN IPC	All staff LFT as per 1.6 during increased nosocomial period - additional testing not advised within Outbreak Management Meetings with the exception of first declared outbreak on 20.11.20 when LFT not available routinely.		**Staff testing undertaken in the outbreak period identified in 1.3**						
1.8 Training in IPC standard infection control and transmission-based precautions are provided to all staff.	DIVISIONS	1)PPE champion sessions 2)Targeted training for high risk areas 3)IPC inductions sessions 4) On line skills for health session	Face to face training reduced due to classroom restrictions	1. IPC standard training available on NILE and education and information available via the Trust microsite and the action cards. 2. IPC Team undertake ad-hoc and on demand sessions (as has always existed) **2. Roll out of 'Every Action Counts' commenced in Q1 with IPC Team.**						
1.9 IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training.	IPC	1) IPC training is mandatory in all induction sessions	COVID specific training is not part of induction on-line training.	National resources for IPC Training becoming available in March 2021 and will be used to enhance the existing training.						
1.10 All staff (clinical and non-clinical) are trained in: - putting on and removing PPE; - know what PPE they should wear for each setting and context; -and have access to the PPE that protects them for the appropriate setting and context as per national guidance.	IPC	1. Action cards for all PPE requirements in-line with PHE guidance and accessible via Trust intranet portal. PPE compliance monitored through PWA COVID specific and PWA IPC inspections (in-patient areas). Hand hygiene audits monthly (all clinical departments). 2. PPE group commenced at the beginning of the outbreak with a coordinated response between Procurement, DH&SS, Divisional Management Teams, DDoN, IPC and Executive incidence response leads. 3.Individual and department reviews by IPC as required. 4. Specific discussions with high risk areas (Radnor, RCU, ED/RAZ) when making changes to PPE agreed via the PPE group and documented practices within local SOPs. 5. Training records by IPC.	1. PWA available within in-patient areas. No specific PPE auditing in outpatient departments. 2. Continue to have departments with < 85% compliance with hand hygiene audits and non-submission of audits. 3. Risk in staff knowledge and keeping updated with continued changes to PPE requirements. 5. Ongoing FIT testing requirements due to national supply changes and the removal of 3M. 6. IPC hold records for staff training they have undertaken but not all staff.	1. Use of Matron's rounds to reiterate PPE compliance. 2.IPC team continual rounds and ongoing 'on the spot' education and support. 3. Weekly PPE meeting as part of coordinated Trust COVID tactical response. 4. Less changes to national guidance has resulted in more embedded use of PPE. 5. FIT Testing Team have more robust process and have increased capacity.						
1.11 **There are visual reminders** displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	IPC.	Posters and signage across SFT site and in clinical and non-clinical areas. Included on the intranet. Floor markings for social distancing. **Signage refreshed/updated.**								
1.12 National IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPC.	Monitored by Lead ICN Nurse, DIPC and Deputy DIPC and alerts coordinated by EPRR Lead. Reviewed via IPCWG and additional discussions as required to ensure dissemination is agreed and introduced.								
1.13 Changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	IPC/DIPC	1. Departmental risk assessments on DATIX and escalated via the Trust process to Board. 2. Key risks identified at the IMT incident meeting. 3. Risk assessments for COVID secure areas reviewed at IPC meeting. Additional risks identified via the clinical divisions. **4. IPC BAF recorded at IPCC and Trust Board April 2021.**	1. Revised BAF national document 12.02.2021	1. Key risks escalated as required via Covid meetings and not delayed until existing Trust assurance meetings. 2. IPC BAF to be presented to Board Nov 2021.						
1.14 Risks are reflected in risk registers and the board assurance framework where appropriate	ALL	1. As above. 2. Internal audit of the Trust risk process. 3. Discussion of divisional risk assessment via Governance Meetings.	There are variations in the Divisional Governance and performance meetings agenda. (CSFS definitely have COVID as a standing agenda item). **2. June 2021 updated IPC national guidance - to use hierarchy of controls (HoC) as basis for risk assessments. Currently COVID risks have not been updated to reflect.**	As above Risk assessment in place regarding the potential outbreak risk amongst patients and/or staff - Risk No 6570 Risk assessments in place for Ventilation, Outbreak, BAF Compliance; Social Distancing beds						
1.15 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens.	IPC	1. RCA documents of all reportable HCAIs with robust appeal process in place with the CCGs. 2. National data submission on HCAI's. 3. IPCWG/ICC meetings documented with minutes and action tracker. 4.Trust KQI reporting monthly for reportable HCAIs at CMB 5. Bi-annual DIPC report through Trust governance pathway to TB. 6. Policies and procedures for managing infection and prevention e.g. Outbreak policy. Policy compliance monitored via IPC Team and incorporated into RCA documentation and PWA inspections. 7. PWA inspections. 8. Risk assessments in place for example risk of flu outbreak; risk of increasing C.difficile cases against trajectory in the contract. 9. Monthly review of reportable HCAI cases at 'Share and Learn'. **10. Trust part of BSW collaborative projects to reduce gram neg infections.**	1. Increase in reported C-Diff in comparison with 2019-20 (recognised nationally).	1. New Matrons Round inspection currently being formatted on PWA as an assurance inspection undertaken by Matrons and senior nursing management.						
1.16 That Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial strep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	DoN	Triple review process in place and CEO sign off daily . All positive patients reviewed at Virtual board rounds that are daily in higher period of covid positive cases and three ties weekly in lowered level of prevalence	Annual leave may mean one of the group may not sign this off	COO is also part of the sign off aiming for a triple sign off but one of 4 executives						
1.17 This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	DoN	IPC BAF escalated to Board meetings to provide assurance . Board minutes capture this . DoN regularly updates the Executive Team regarding Outbreak position. SI report to be completed and full update will be within the DIPC report.	**Exit meeting for SI Outbreak review booked for November 2021. Recommendations in progress.**							
1.18 Ensure Trust Board has oversight of ongoing outbreaks and action plans.	DoN	1) Outbreak data presented to private trust board and Clinical Governance committee DoN regularly updates the Executive Team regarding Outbreak position. SI report to be completed and full update will be within the DIPC report.	**Exit meeting for SI Outbreak review booked for November 2021. Recommendations in progress. Outbreak declared on Spire Ward September 2021.**	**All actions undertaken in-line with Outbreak Management Policy**						
1.19 There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	DoN	Executive teams walk about timetables 7 days per week at periods of higher prevalence . Non clinical areas reviewed by service leads . Perfect ward covid audit used daily in ward s with covid position patient and weekly elsewhere by Band 7 and senior nurses review data	Executive and manager do not use a structured template for this but Matrons do Hons review review ward convid data and Peer review							
1.20 local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff.	All	**Currently 1 overarching risk assessment for ventilation.**	**Departmental risk assessments not documented on Datix. Ventilation Working Group to commence in November 2021.**	**Risks associated with operational function considered. Areas with cohorts of COVID-19 patients undertaking enhanced level 1 PPE introduced specifically by the Trust in Q4 2020/21. Staff advice provided regarding PPE as required and frequently with any changes to patient population.**						
1.21 the documented risk assessment includes: a review of the effectiveness of the ventilation in the area operational capacity prevalence of infection/variants of concern in the local area	All	**See 1.20**								
1.22 Iriaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical followine admission across all pathways.	All	**See section 1.1 Screening on admission in place. All patient tracked through VBR. Screening gaps followed up with individual teams.Tastine Cell meets fortnightly.**								
1.23 when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of RPE for patient care in specific situations should be given	All	**See 1.20**								

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	Q2 (21/22)
2.1 Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas.	DIVISIONS	1. Designated unit (RCU) for management of suspected and confirmed COVID-19 patients. 2. RCU management by designated Matron with cohort of senior nursing team who remained on the RCU (6x Band 6, 4 x B6 Staff). 3. Respiratory specialist nurses, education department and CCOT with support from quality directorate , worked through competencies and upskilling to ensure all reached a level of competence and confidence to work with this group of patients. 4.Staffing ratio was supported to allow high numbers of staff with additional support of day and night rota for CPAP and respiratory support. The team were supported by the respiratory consultants and doctors on the ward at all times. 5. ITU/RCU training and induction, use of runners, task teams, theatre SOP. 6. Reference to action card 3.101 standard infection control principles. Action card 3.102 & 3.102A regarding infection control PPE, and donning and doffing of PPE with support provided by IPC Team and use of PPE 'wardens'. 7. High risk areas supported by Chaplaincy, Clinical Psychology and Palliative Care Teams for staff and patients experiencing end of life care. 8. PWA Quick Covid 19 assessment to ensure staff understanding in these areas. 9. Standard judgement review commissioned for Covid 19 related deaths in hospital	1. Ongoing issue with staff sickness and self isolation requirements.	Continued monitoring of national and regional intelligence. Review locally when any national learning identified (such as Trust outbreaks) 2. 'Red line' staffing document produced for nursing to identify minimum staffing levels. 3. Staff redeployment to clinical areas from non-clinical areas as required. Return of volunteers to support clinical areas. **4. Review of staff training ongoing and staff on Laverstock Ward support from ITU.**					
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas.	FACILITIES	1. Housekeeping staff have been Fit tested for level 3 mask, MLE PPE units in date and practical training given by supervisors and shadow training with other experienced housekeepers. No trends within incident reporting regarding practices by housekeeping staff. Designated cleaners to clinical areas.	Overnight cleaning team will have to cross all areas. On risk register (no 6571).	All staff aware of regimes and PPE.					
2.3 Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	FACILITIES	1. Training guides/practical training and shadow training given prior to undertaking an infection clean. Additional training given to under HPV decontamination for specific supervisors and senior housekeeping staff. All cleaning requests are validated, form completed and signed off by ward sister on completion. Discussions with Housekeeping and IPC to agree any additional cleaning including 'double cleans' and reviewed daily and as required.	1. Continued changes in IPC guidance. Not an issue in Q3 and Q4	1. Membership of IPC Group.					
2.4 Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk.	FACILITIES	1. Process in place for signing off terminal cleans. 2. Only 1 outbreak area in Q1.	1. Confidentce in the signing off process between ward lead and housekeeping	1. Minimum daily discussion with IPC and Housekeeping confirming cleaning requirements. 2. PWA inspections discussed at Outbreak Management Meetings.					
2.5 Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	FACILITIES	1. RAZ areas increased cleaning hours and cleaning after every patient transfer, in addition to the "normal" ward cleaning. Implementation of double cleaning required for side rooms, Infection control will inform housekeeping daily Mon - Fri where they require double cleans. Sign off sheet and decontamination sheets are available for review.							
2.6 Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	FACILITIES	1. Our chlorine based products are in use across the site. These products meet the national guidance and have been signed off by Infection Control and Occupational Health. COSHH sheets are available.	A challenge remains that many non-clinical equipment providers are not familiar with providing data/information on this level of cleaning and therefore decisions were made where necessary on standard Trust practice, and any reports of device damage will be monitored.	Wipes are available for non-clinical equipment in clinical areas (e.g. keyboards, photocopiers, phones etc.) which have been agreed with IPCT, Decontamination Lead and IT. External providers have been asked to provide guidance where appropriate.					
2.7 Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products.	FACILITIES	1. Our chlorine based products are not washed off, so appropriate contact time is in place.							
2.8 As per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).	FACILITIES	1. Increased number of cleaners who undertake additional touch point cleaning every day. 2. Non-clinical areas have identified cleaning regimes to provide self cleaning of areas and equipment. 3. Individual users will decontaminate electrical equipment, mobiles and tablets etc. 4. Room cleaning will be undertaken by the departmental staff when PPE is removed. 5. Staff are to wipe all touch point twice daily and hourly in outbreak zones	1. No auditing in place of non clinical areas. 2. Potential challenges of changing supply of wipes. 3. No auditing of cleaning of electronic devices such as tablets, keyboards, phones (including personal phones).	COVID secure risk assessments require confirmation that staff are meeting the requirements. Continued discussion with Procurement re supplies and decision via IPC. Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of electronic devices and technology within clinical areas (see 2.6)					
2.9 Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	FACILITIES	A process is in place for contaminated linen which is returned to the on-site laundry and decontaminated to the appropriate standard in line with BSEN14065 and HTM01-04. Process posters have been circulated to all linen areas.							
2.10 Single use items are used where possible and according to single use policy.	DECON LEAD	Disposable mops and cloths are used in RED zone areas including any side rooms. Single use equipment is used as per Trust policy where possible.	No monitoring of single use items.	For PPE would be monitored and managed via PPE Group. No reported incidents.					
2.11 Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance. Actions in place to mitigate identified risk.	DECON LEAD	Any items left in the room are cleaned. Ward staff undertake the decontamination of equipment and use Clinell "clean" tape to highlight this action has been completed. All reusable equipment to be decontaminated as per Trust Policy. In-patient areas monitored via PWA.	Limited audit evidence.	Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of IT within clinical areas. In addition during the COVID pandemic, additional items have been added to stock availability such as single use blood pressure cuffs and pulse oximeter probes to provide an alternative to our normal re-usable items for areas to order if appropriate. Refreshing of some SOPs to include decontamination of COVID where relevant. No reported incidents.					
2.12 Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	ALL DEPARTMENTS	2)Staff are to wipe all touch point twice daily and hourly in outbreak zones 3) Enhanced cleaning in outbark zones	No specific audit in place.	COVID secure risk assessments require confirmation that staff are meeting the requirements. Continued discussion with Procurement re supplies and decision via IPC. Details for ordering of appropriate wipes circulated trhough comms. No incidents reported of issues with cleaning in non-clinical areas.					
2.13 Ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air.	ETS	Walk-round of all areas completed as part of recovery with capacity and flow reviewed. Space allocation committee reviewing appropriate spaces for specific services. National guidance on ventilation chased through NHSI sacral times.	1. Unknown air exchanges and ventilator levels in many areas. 2. Additional ventilation system ordered for APG zones 3. National update for ventilation HTM updated 30th June 2021. 4. No Ventilation Working Group in place.	Areas undertaking AGPs to be identified and assessment of air exchanges to be completed. 2. Ventilation risk assessment in place 3. Ventilation improvement works in progress (not wards) 4. All areas clinical amd non-clinical encouraged to have windows open and maintain ventilation where possible. 5.Ventilation issues overseen in Space Allocation Committee. **6. Ventilation Working Group to commence November 2021**					
2.14 Monitor adherence environmental decontamination with actions in place to mitigate any identified risk	ALL DEPARTMENTS	Decontamination policies and processes in place. Cleaning protocols in place.	Minimal oversight on all monitoring practices.	1. Decontamination Lead undertakes auditing over 12 month period. 2. PWA inspections include some elements in this standard.					
2.15 Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	ALL DEPARTMENTS	Decontamination policies and processes in place. Cleaning protocols in place.	Minimal oversight on all monitoring practices.						
2.16 A minimum of twice daily cleaning of: a) areas that have higher environmental contamination rates as set out in the PHE and other national guidance b) 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, c) electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards d) rooms/areas where PPE is removed must be decontaminated ideally timed to coincide with periods immediately after PPE removal by groups of staff	**FACILITIES DIVISIONS**	**See section 2.8 a) IC inform Housekeeping of areas that require enhance cleaning which will involve the daily clean and an additional cleaning of touch points later in the day including b) door handles, call bells and frequently touched surfaces. b) Nursing staff carry out the cleaning of over-bed tables before each mealtime and the "user" c) will be required to clean electronic equipment including mobile phones, desk phones, tablets, keyboards etc. d) PPE areas are cleaned at regular intervals during the day.**	**Lower nursing staffing levels may reduce frequency of cleaning**	**PWA inspections continue to monitor environments.**					
2.17 reusable non-invasive care equipment is decontaminated; a) between each use b) after blood and/or body fluid contamination c) at regular predefined intervals as part of an equipment cleaning protocol d) before inspection, servicing or repair equipment	**DECONTAMINATION**	**Decontamination policies and processes in place. Cleaning protocols in place.**	**1. Difficult to evidence cleaning between each use robustly 2. Obvious soiling where decontamination has failed can be captured via Datix (specific category) but likely to be underreported 3. Wards have cleaning protocol 4. MDMS request equipment decontaminated by clinical teams prior to sending to department for**	**Ward areas now included in Decontamination Audit Schedule - raising awareness of importance of right process/product/time/frequency as well as clearly identifying clean/dirty items. Some elements are captured as part of the IPC 'Perfect Ward' and potential to extend these.**					

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2 (21/22)**
3.1 Arrangements around antimicrobial stewardship are maintained.	IPC CONSULTANT	New Microbiologist in post and Antimicrobial pharmacist remains in post.	Only 1 x per week ward round 2. Changes in AP and impact upon AMS rounds	1. Micro staffing levels will now permit the establishment of an antibiotic ward round. This is to start w/b 13/07/20. Currently established for once a week with aspiration for possibly twice weekly dependent on findings/needs . 2. Increased resilience and continuity with pharmacists and fully established microbiology team. 3. Teaching with junior doctors contin. Antibiotic issues issues discussed at M and M meetings. Implemetation of EPMA to address issues in the future.					
3.2 Mandatory reporting requirements are adhered to and boards continue to maintain oversight.	IPC	1. RCA documents of all reportable HCAIs with robust appeal process in place with the CCGs. 2.National data submission on HCAI's. 3.IPCWG/ICC meetings documented with minutes and action tracker. 4.Trust KQI reporting monthly for reportable HCAIs at CMB 5. Bi-annual DIPC report through Trust governance pathway to TB. 6. Policies and procedures for managing infection and prevention e.g. Outbreak policy. Policy compliance monitored via IPC Team and incorporated into RCA documentation and PWA inspections. 7. PWA inspections. 8. Risk assessments in place for example risk of flu outbreak; risk of increasing C.difficile cases against trajectory in the contract.	1. National increase in non-COVID HCAI's reflected within the Trust **2. Case numbertrajectory set in July 2021. Highly likely to exceed.**	1. Exisiting Trust IPC contol measures in place.					

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance					
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2 (21/22)**	
4.1 Implementation of national guidance on visiting patients in a care setting.	DM/KG	1. Action card on patient visiting with restrictions and guide for staff. Specific areas detailed for individual approaches and agreed at IMT. No serious complaints raised regarding visiting restrictions. 2. High risk patients in Spinal Unit subject to separate action card to protect shielding patients. 3. Action card for delivering patient belongings coordinated by PALS. 4. Capacity for relatives/carers to communicate virtually expanded and detailed on Trust external website . 5. Specialties with separate guidance followed national and local requiremetns during suspension.	Evidence of staff undertaking risk assessment with visitors who require PPE. Variation in PWA inspections.	COVID-19 quick assessment completed on PWA. 2. Visiting Action card has been reviewed for both resticted visiting and susequent suspended visiting in wave 2. 3. Visitors logs in place. 4. Ongoing review of visiting access in line with national guidance. Positive feedback from visitors.						
4.2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access.	DR/LA	1. Entry to clinical areas restricted with use of 'SALTO locks' . 2. RCU specific signage regarding designated status (now removed due to reduced numbers).	1. Sudden influx of numbers will require reinstating of signage.	1. Numbers discussed via IMT and actions agreed . Signage can be reinstated quickly. 2. Signage reinstated for these areas as required. **3. Signage updated for** **Laverstock Ward October 2021 as now cohort area.**						
4.3 Information and guidance on COVID-19 is available on all trust websites with easy read versions.	KG/DR	Easy read information available. Additional added and noted by Healthwatch Wiltshire. No complaints or concerns raised regarding information. Links with Mencap and local LD partners. Internal communications - via IMT for general communications to staff and the public. With traditional broadcast and print media being agreed by a combination of CEO, COO and Exec OD&P based on recommendations from Head of Communications (or Deputy).								
4.4 Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved.	DIVISIONS	1. In Surgical division use of SBAR handover process and sticker in patient medical notes on any transfer. Taking in to consideration action card 3.130 & 03.138 management of identified contact patients. 2. In Medical division - wherever clinically appropriate patient with Covid 19 are nursed within the RCU template and not transferred out unless proven negative following the de-escalation policy. Discharges to residential placements are only allowed after negative screens. Any contact are advised as such on discharge.	1. No audited evidence of SBAR or other patient transfer. 2. Key challenges in wave 2 with patient moves to reduce risk of infection spread. 3. Timely swabbing of patients. Swabbing team disbanded.	1. Currently nil identified serious incidents due to harm from lack of infection status . 2. Nil poor outcomes discussed in Virtual Board Round. 3. Descalation action card. 4. No reported incidents on DATIX due to harm from lack of infection status . 5. Introduction of LFT for patients when required.						
4.5 There is clearly displayed and written information available to prompt patients, visitors and staff to comply with hands, face and space advice.	ESTATES	1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc.) 4) Social media campaign about what to do when on site 1. 5. Patients asked to replace face coverings with masks at height of second wave.		1. Patient discharge leaflet outlining contact status and guidance. Included reminders regarding hands, face, space. **(updated October 2021)** 2. Signage around the estate updated to remind visitors and staff that masks still required.						
4.6 Implementation of the supporting excellence in infection prevention and control behaviours implementation toolkit has been considered C116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf(england.nhs.uk)	**IPC Team**	**Principles agreed as workplan for 21/22 with pilot undertaken in orthopaedics during Q1**	**Resource constraints within iPC Team to roll out all aspects of the toolkit over winter period.**	**Exisitng IPC principles, education and training continue. Outbreak practices undertaken in-lin with national guidance. PPE monitoring group continues.**						

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2 (21/22)**
5.1 Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID -19 cases.	IPC	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival. LFT testing in ED , if negative then cepheid rapid test undertaken to identify what pathway they patient follows.	During very busy period some swabs were missed at the intervals required (1,3, 5-7 days and then weekly)	Swabbing team in place to ensure all patients are tested at intervals as per action cards Swabbing process reminded to all staff.Team disbanded in Q1.LFT testing for any contact patients.					
5.2 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimize the risk of cross-infection, as per national guidance.	DIVISIONS	1. Medical division - RAZ and standard Majors process in place as per action card. Any resp symptoms or common complications are directed through RAZ (Reference to action card 3.098A & B ED and clinical response management of Covid 19 patients. ED configuration and service delivery action card). 2. Surgical division - No 3.129. SAU action card and outpatient action cards. 3. CS&FS - Action cards (03.116, 03.136, 03.146), risk register, SOPs. **4. Ward reviews to enable cohorting of patients reviewed as required. COVID escalation criteria in place.**	Designated 'red and green' areas to be approved and signed off by DIPC by September 2020. f	1.All patients swabbed and all staff are wearing PPE appropriate to activity. 2. Screening undertaken in outpatient settings. 3. High, medium and low risk (red, amber green) pathways approved via IMT as per national guidance. 4. LFT introduced into ED on 26.12.20 as per national guidance. Also used in SAU and AMU.					
5.3 Staff are aware of agreed template for triage questions to ask.	DIVISIONS	clinicians establish if there is previuos knowlegde of a positive diagnosis or are there any features to suggest COVID but this is down to clinical judgment..	No agreed template for questions.	1. Triage key questions are asked and documented					
5.4 Triage undertaken by clinical staff trained and competent in the clinical case definition, and patient is allocated to the appropriate pathway as soon as possible.	DIVISIONS	Clear pathways for patients to be triaged into categories A-D etc and ation cards to support this. This with the LFT and ?or Cehеid result leads to alloaction of a bed in a suitable are for that category of patient	1. Occassional risk of patient testing posiitve despite lack of symptoms and negative LFT.	1. action cards for planned pathway detailing requirement of patients in cat A-D. 2. LFT at front door to support risk of non symptomatic positive cases.					
5.5 Face coverings are used by all outpatients and visitors.		1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc) 4) Social media campaign about what to do when on site 5) Leaflet for inpatients detailing mask wearing , hand face and space		1. In wave 2 peak visitors asked to wear a surgical mask rather than a covering.					
5.6 Face masks are available for all patients and they are always advised to wear them	DIVISIONS	1. Masks available at entrances to the Hopsital and in wards and departments 2. PWA COVID 19 inspection data (in-patient areas)		**Matrons advising oversight on ward areas.**					
5.7 Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care **June 2021 Wording changed to: clear advice on the use of face masks is provided to patients and all in-patients *are encouraged* and supported to use surgical facemasks (particularly when moving around the ward)providing it is tolerated and is not detrimental to their (physical or mental) care needs.**	IPC	1. Masks available at entrances to the Hopsital and in wards and departments 2. PWA COVID 19 inspection data (in-patient areas)	**1. Lack of evidence to support that all in-patients are being asked to wear masks.**	**1. Review by Divisions**					
5.8 Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) **June 2021 wording changed: Monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs.**	DIVISIONS	All in-patients advised as per standard.	No current specific audit data for in-patients (but captured for other groups).	**Matrons advising oversight on ward areas.**					
5.9 patients visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	DIVISIONS	1. Screens provided in outpatient areas and/or social distancing floor tape. Waiting areas marked out for maximum usage.	1. Lack of consistency and difficulty for areas to recover with service requirements.	1. Walk rounds of all non-in patient areas undertaken and reported via Recovery Cell. Review of service delivery via Space Allocation Committee. 2. Screens task and finish group in place and reports to IMT. 3. Areas asked to risk assess where staff may be returning from work 4. Screens oversight incorporated into Space Allocation Committee.					
5.10 To ensure 2 metre social & physical distancing in all patient care areas	ALL	1. All areas have posters regarding space. 2. Floor markings in corridors 3. Outpatient areas reviewed in Q1 and seating removed/reviewied. Screens in reception areas installed. 4. Bed spaces reviewed. Curtains in place from January. 5. PWA COVID inspection data for compliance	1. Ward areas have limited space which resticts movement and ability to distance at all times.	**1 Review ongoing regarding staff break areas.**					
5.11 For patients with new-onset symptoms, isolation, testing and instigation of contract tracing is achieved until proven negative.	DIVISIONS	1. Wards and medical staff review all patients with new resp symptoms and all patients are screened on admission and rescreened every 7 days. Reference to action card 03.148 & 03.151 non elective medical and surgical admission pathway and flow of testing. Also reference action card 3.098A regarding clinical response to suspected coronaviruses. 2. Designated person to undertake contract tracing which commences on notification and undertaken by B7 Sister at the weekend. 3. Positive patients reviewed at the Virtual Board Round and correct contact tracing verified.	1. Risk to number of available of side rooms for isolation.	1. Twice daily review of side rooms by IPC. 2.Regular review of covid result and senior decisions made as to appropriateness of cohorting patients to allow isolation capacity. Use of ward area with high number of siderooms. 3. **VBR frequency determined by COVID numbers, weekend oversigt of contact tracing for patients overseen by Dep DIPC/IPC.**					
5.12 Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced.	DIVISIONS	1. Process and SOP in place for cohorting and de-isolating negative patients which includes senior clinical review and is not reliant on test results. Use of whiteboard to trace patients. 2.Virtual Board Round meetings to highlight and discuss. 3.PWA quick covid 19 assessment feedback to remind staff are procedures.	During peak of wave 2 lack of ability to segregate into side rooms.	Cohorting of contacts introduced and cohorted by contact (not mixing of contacts).					
5.13 There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	IPC DIVISIONS	1. Testing action card and patient movement and testingrequiremetns in place. 2.Testing results clarified in VBR review	1. Gaps in testing and risk of outbreak	1. VBR review 2. **Nil incidents in Q1**					
5.14 Patients that attend for routine appointments and who display symptoms of COVID-19 are managed appropriately.	DIVISIONS	1. Patients are contacted regarding symptoms prior to testing and asked again on arrival. Wherever possible patients are seen using "Attend Anywhere". 2. STOP Station SOP for consistency of practice across departments.	1. Lack of audited evidence regarding management.	1. Nil serious incidents raised regarding possible transmission in out patient areas.					
5.15 individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation.	IPC	**1. Risk assessment completed September 2021**	**1. Side room availability within the Trust does not support the isolation of all extremly vulnerable patients.**	**1. Side room access reviewed as required and patients at risk provided with side room or in a non red/high risk area. No current incidents of high risk patients with HCAI.**					

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2 (21/22)**
6.1 Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.	DIVISIONS COMMS	RAZ and standard Majors process in place as per action card. Keep left signs throughout the estate One way system in place in restaurants, OPDs and all areas this is possible Limited access to coffee rooms (1 in 1 out) Maximum numbers on all doors and masks worn in offices unless alone or under numbers with 2 metres distance Visit limited to essential only Restricted access to the site has been in place since Q1	Not possible in all areas but all are have been reviewed and 2. Staffing gaps require continual movement of staff to ensure safety.	1. Areas continue to be reviewed - some layout and geography of areas does not allow one way entrances and exits. Areas provide additonal touch point cleaning. 2. Staff not currently moved if an area in outbreak.					
6.2 All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe.	IPC DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PPE training provided by IPC Team and records kept. 3. IPC Training on MLE and monitored via IPCWG. 4. Following the introduction on 15/06/20 of masks in non-clinical areas a risk assessment to validate COVID -Secure areas introduced and signed off via the IPC Group and then via IMT. 5. Requirements regarding social distancing within working environments identified with maximum occupancy room signage and link to number 4. 6. Staff shielding, redeployment, working from home guidance and associated safety overseen by Trust Workforce Group. 7. Staff well being and direction to OH support identified via daily bulletin and encouraged discussion with line managers.	1. Continued changes to guidance could result in out-of-date practices.	1. Immediate updating of action cards on receipt of new guidance which has been reviewed at IPC Group. 2. Updated guidance to staff via Trust daily comms and intranet. 3. National update to the quick COVID 19 PWA assessment by the PWA organisation. 4. Improvement in FIT testing provision to speed up process of fitting on multiple masks					
6.3 All staff providing patient care within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	IPC	Refer to section 1.6 Level 1 PPE (standard precautions on induction and within existing training package) Areas such as maternity, RCU, ITU (requiring Level 3 PPE) training provided. Regular Comms advising staff, PPE action cards and national training resources available on staff COVID-19 intranet site.	National training package - supporting behaviours to be incorporated in future training. Need to revisit that staff have ongoing understanding of change and training provision.	1. Enhanced level 1 PPE introduced locally in January due to cohorting of COVID positive cases and high staff absence. 2. no major changes to PPE in Q1(21/22). Updates via comms and action cards.Direct advice to areas who have concerns or specific needs. **3. Trust enhanced L1 PPE applied to cohort bays since January 2021.**					
6.4 A record of staff training is maintained.	IPC/DIVISIONS	1. IPC record of training delivered by the IPC Team. 2. FIT Testing register.	1. Continued challenges with the supply of PPE and repetitive FIT testing required. 2. See section 1.10	1. Co-ordinated via the PPE Group. 2. Improvement in FIT testing provision to speed up process of fitting on multiple masks					
6.7 Adherence to PHE national guidance on the use of PPE is regularly audited. with actions in place to mitigate any identified risk	DIVISIONS	1. Surgical division - Covid secure risk assessments-red, green and blue areas. PPE champions and PPE meetings. Reference to action card 5.037, PHE guidance for healthcare workers. 2. PPE champions in CS &FS from 26/06/20. 3. PWA quick COVID-19 inspection and existing PWA inspections.	1. Currently no standardised inspection/audit within non in-patient areas.	1. PPE usage within in-patient areas audited via PWA IPC and COVID audits. 2. IPCWG monitor compliance. 3. Weekly COVID inspections within in patient units.					
6.8 Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: *hand hygiene facilities including instructional posters *good respiratory hygiene measures *maintaining physical distancing of 2meters wherever possible, unless wearing PPE as part of direct care *frequent decontamination of equipment and environment in both clinical and non-clinical areas *clear visually displayed advice on use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas. *staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	IPC	1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc) 4) Social media campaign about what to do when on site 5) leaflet for impatient detailing mask wearing if possible , hands, face, space 6. How to wear and how to remove a face mask posters across the Trust. 7. All regular Comms include 'hands, space, face' message. Daily COVID 19 bulletins remind staff that we are required to follow national restrictions and actions. 8. Monitored via IMT reporting if lack of compliance observed.	**1. Ongoing and sustained**					
6.9 Staff regularly undertake hand hygiene and observe standard infection control precautions.	DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PWA IPC Inspection.	1. Standard precautions are not routinely audited within non in-patient areas.	1. Daily COVID 19 inspection within in-patient areas in outbreak during February and weekly in non-outbreak areas.					
6.10 The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance. Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas.	ETS/IPC	1. Hand driers removed from use on the 13th of July from the following areas:- SDH North public toilets, Spinal Unit, Hedgerows, Block 29 and the Staff Club. Note:- a decision was made to also remove from use the hair driers that are installed in the Staff Club changing areas. 2. Procurement have been informed of the increase in paper towels and they do not believe stock will be a problem. 3. Extra bins are also in place within the facilities.	1. Increased risk of sewage leaks via blockages caused by wipes in the waste system.	Link to RA 6545 - actions completed					
6.11 Staff understand the requirements for uniform laundering where this is not provided for on site.	DIVISIONS/FACILITIES	1. Laundering of uniforms to be completed within existing washing guidelines provided with uniforms. Addition of reinforcement of the requirement to change on-site and courier uniform within a laundry bag or similar. 2. Clinical staff not usually in uniform provided with scrubs in high risk areas and/or required to wear work specific clothing changed into and out of at work.	1. Not formally monitored.	1. Staff made aware of this requirement within own scope of personal responsibility.					
6.12 All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms.	ALL	1. Reference to action card 5.037 PHE guidance for healthcare workers. Staff seeking appropriate and prompt testing for themselves or household. 2. Trust Comms directed to OH services with 7 day cover to provide guidance on testing and isolation requirements.							
6.13 A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	DoN	1) Daily Virtual board review of all positive patients and staff 2) Contact tracing undertaken daily to ensure all positives cases managed effectively and in correct pathways 3) BSW local surveillance data reviewed via IMT and Gold command		Regular Outbreak Meetings held during Q3 and Q4 attended by PHE, BSW and NHSI&E. Review of Site by DoN with NHSI&E IPC Lead. Daily VBR (7 days per week) to monitor for any HCAI and trace contacts where required.					
6.14 Positive cases identified after admission who fit the criteria for investigation, should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	DoN	1) Daily Virtual board review of all positive patients and staff 2) Contact tracing undertaken daily to ensure all positives cases managed effectively and in correct pathways 3) Daily outbreak meeting , all outbreaks traced with gant charts 4) Outbreaks reported Via immarch portal 5) PHE attend outbreak meeting three day per week		1. x1 outbreak in Q1. Actions covered within the SII outbreak reprot.See section 6.13					
6.15 Robust policies and procedures are in place for the identification of, and management of outbreaks of infection.This includes the documented outcome of outbreak meetings.	DoN	Action card detailing management of outbreak, personnel required and reporting responsibilities in place Outbreak status from 24.03.21 - nil COVID Outbreaks within the Trust.		1. Walkround completed with NHSI/E in January 2021 2. Outbreak management card updated in-line with national guidance January 2021. 3. All Outbreak meetings recorded and sgared with PHE/CCG. 4. SII outbreak review meeting completed in June 2021					

7. Provide or secure adequate isolation facilities

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2 (21/22)**
7.1 Restricted access between pathways if possible (depending on size of facility, prevalence, incidence rate high/low) by other patients/individuals, visitors or staff.	DIVISIONS	RAZ and standard Majors process in place as per action card. Keep left signs throughout the estate One way system in place in restaurants, OPDs and all areas this is possible Limited access to coffee rooms (1 in 1 out) Maximum numbers on all doors and masks worn in offices unless alone or under numbers with 2 metres distance Visiting limited to essential only Signage of ward status	1. Movement of staff required during peak 2. Asymptomatic positive cases arising in amber areas. 3. Staffing gaps increasing number of staff moves. **4. Ongoing capacity pressures resulting in changes to bed bases as required.**	1. Patient categorisation continues. Testing regimes in place.Pathways adhered to where possible.					
7.2 Areas/wards are clearly signposted, using physical barriers as appropriate to patients/ individuals, and staff understand the different risk areas.	DIVISIONS IPC	Signage of ward status Hand face space sign at ward entrances	1. Red zones have specific signage but no agreed signage for other areas. **2. RAG posters delayed due to pending changes to guidance that would remove RAG as a signage tool.**	**Areas that have COVID cohorts have specific physical signage.**					
7.3 Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate.	DIVISIONS	1. Patients isolated within the RCU/Radnor template unless specialty requirements denote higher risk and then isolated within a sideroom facility. Use of siderooms,cohorting, signage, red/amber areas etc. Liaison of site management team and IPC team with ward staff to ensure appropriate patient placement within the Trust. Reference to action card 3.130 and 3.101, standard infection control principles and ongoing management of identified contact patients. Discussed	1. Unpredicted positive patients.	1.Moved on positive screening and contact tracing undertaken as required. Actions reviewed at Virtual Board Round. 2. During peak of wave 2 wards redesignated for positive COVID-19 cohort areas to provide a separate space for any green pathways and reduce risk of spread. Full cleaning of areas before returning to specialty provision. **3. COVID**					
7.4 Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance.	DIVISIONS ETS	No positive or negative pressure rooms in use within the Trust. Patients are all in designated ward/clinical specific environments. No non-clinical environments utilised for clinical capacity.	See 2.12 re ventilation						
7.5 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	DIVISIONS IPC	1. Management between clinical teams and Microbiology/IPC Team. All standard policies and processes in place. Trust wise reporting regarding HCAI. Ongoing regular monitoring via PWA.	Policy audits not undertaken over 2019/20. Previous internal audit not identified concerns. Good feedback from CQC framework review July 2020.	Daily monitoring with ward visits by IPC and links with Site and clinical teams regarding practice. Audit plan to be identified.					

8. Secure adequate access to laboratory support as appropriate

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2)21/22)**
8.1Testing is undertaken by competent and trained individuals.	DIVISIONS	Testing revisited with areas with high false negatives and assessment undertaken of all staff	No specific training logged	1. National video available and PR to create in-house info to be circulated by Divisions to staff with check in that staff have watched training info 2. Testing Cell in place for oversight ofchanges.					
8.2 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance.	DIVISIONS OH	Symptomatic staff (days 1-5) are referred for swabbing on the day they report their symptoms to us and are placed on the swabbing list for the next day. Antibody testing in progress. Staff LFT introduced in December 2020	**Challenges with staff having timely access to OH.**	**Risk assessmsent for staff returning to work.**					
8.3Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	DIVISIONS AND LABS	Symptomatic staff (days 1-5) are referred for swabbing on the day they report their symptoms to us and are placed on the swabbing list for the next day. Antibody testing in progress. Staff LFT introduced in December 2020 Positive cases traced through VBR and testing dates discussed	No routine reproting of all swabbing. Missed swabbing could result in inintended HCAI.	Introduction of swabbing team.(discontinued in Q1) Monitoring continues as VBR.					
8.4 Screening for other potential infections takes place.	DIVISONS	As per existing pathways for e.g. MRSA screening and C.difficile. Sepsis pathway in place. **POC Testing planned for introduction in Q3**							
8.5That all emergency patients are tested for COVID-19 on admission.	DIVISONS	Established screening practice in all admission areas in-line with Trust action card which also outlines screening required prior to patient transfer (in-hospital) LFT indtroduced into ED 26.12.20 and AMU/SAU January 2021							
8.6 That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	DIVISONS	Patients all tested routinely on admission then day 3, day 5 and then weekly. Tested on any new symptoms.		1. VBR oversight of positive cases and tracking					
8.7 That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	DIVISONS	See 8.6							
8.8That sites with high nosocomial rates should consider testing COVID negative patients daily.	DIVISONS	Wards that are subject to outbreak tested negative patients daily. All patient contacts also tested daily.		1. All patient contacts test daily with LFT.					
8.9That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	DIVISONS	Action card in place for discharge testing.							
8.10 That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	DIVISONS	As 8.9							
8.11 That all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	DIVISONS	As directed by the action cards for elective care.							
8.12 Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time of result is available.	Testing Cell	**Testing cell meets fortnightly. Labs monitor turnaround times. POC Testing in Q3**	**Lack of compliance in some areas with the testing process. Recruitment underway for POC Testing**	**Testing posters on display**					

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2 (21/22)**
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms.	IPC/DIVISIONS	Refer to section 1.8							
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	IPC/DIVISIONS	Refer to section 1.4; 1.6; 1.6							
9.3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	FACILITIES	All potential COVID 19 waste is placed in orange bags and picked up as per Trust Policy via the waste teams. Waste stream for masks in non-clinical areas is managed at increased level than national guidance (which only requires a black bag) to ensure consistency and risk of incorrect disposal.							
9.4 PPE stock is appropriately stored and accessible to staff who require it.	PROCUREMENT	1. PPE stock and usage closely monitored and discussed at PPE Group. Access processes robust as evidenced by no incidents of PPE unviability for staff. 2. CS &FS Comms directly to heads of service and leads. PPE update given at weekly DMC and disseminated by HoS to teams. Monthly Divisional PPE Champions group. **3. No significan incidents raised in Q1 or Q2 21/22 4. Robustness of FIT Testing service with oversight of all FIT requirements.**							

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance				
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)	**Q2 (21/22)**
10.1 Staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.	DIVISIONS OD and P	1. Undertaking of individual staff risk assessment, use of occupational health, welfare check of redeployed staff, debriefing in all areas of impact. Reference to action card 03.134, 03.153 & 03.144, guidance for Trust employees defined as vulnerable/extremely vulnerable. This would be covered and met within the COVID risk assessment which ensures the correct work task is being offered according to the nature of the risk e.g. pregnancy, BAME, age, health and the risk assessment also has a psychological wellbeing section on that should be completed between manager and employee. Also, when the pandemic first affected the UK, any staff member could ring our COVID OH line for guidance and support. Three telephone lines in our call centre room was attended 12hrs/day, seven days/wk. This support line continues but is 8-6pm Mon-Fri now. On these calls, we would aim to answer any questions or signpost people if we cant and we also would write a letter to the manager to reflect the clinical advice we gave to ensure the advice is communicated thoroughly. Physical and Psychological wellbeing is also supported via the signposting details on the microsite available to all staff. Consistency panel set up to review the Vulnerable staff risk assessments - selection reviewed each week and managers invited to attend meetings to discuss any concerns with scores or actions taken. Staff risk assessment has been initially focused on vulnerable staff including BAME, but have been expanded to all staff. COO and HRD meeting monthly with BAME staff. 2. OH covid line open 8-4 Mon-Fri and 9-1 weekends. Any letetrs goes back to the staff member directly now but clearly states to share the advice given with their line managers. Consistency panel was set up for the first couple 6-8 weeks I would estimate to ensure support to line managers was available and an opportunity for us to randomly check the quality of the RA's.	1. Staff choice to remain at work where advised not.	1. PPE worn at all times and staff offered alternative areas to work. 2. Risk assessment document template reviewed as required and in-line with national guidance. 3. Vaccination available to all staff groups.					
10.2 That risk assessment(s) is(are) undertaken and documented for any staff member in an at risk or shielding group, including Black, Asian and Minority Ethnic (BAME) and pregnant staff.	ALL	100% of staff have been risk assessed 2. All staff continued to be risk assessed and new starters receive RA prior to commencing.							
10.3 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained.	MEDICAL DEVICES	Written information (in line with manufacturer and PHE guidance) is issued with each system to provide step by step instructions on their use and management. It additionally acts as a resource out of hours and is available as part of the COVID response action pack. Decontamination Lead provides briefing on collection and signature sheet in place for tracking systems. Hoods being used for staff who fail fit testing. Fit testing programme in place. Task and finish group established to review and implement 'Southampton hoods'. (This product was not introduced and Versafloo hoods are used). Decontamination process in line with manufacturers guidance and Trust IPC policy. ESR utilised to capture of trained staff. Robust FIT Testing service in place with lead and oversight of FP3 continues at PPE Group. **Before hoods are issued, the procedure is now to be tested on the Portacount Machine first on all available mask.**	No previous record of briefing and staff collecting the hoods are not always the end users. Risk of requiring more hoods than current supply but not currently an issue. **Due to the National Patient Safety Alert with the reduction of valve masks and air fed hoods we are trying to eliminate as much usage as possible on these items. There is a new process in place to account for this change.**	~~1.~~ Decontamination Lead has commenced list to evidence information signposted to staff collecting, also capturing where staff collecting are not end users. 2. Task and Finish Group in place for procurement of new hoods. Additional hoods on order to increase current availability and managed via PPE group. 3. Stabilised FIT Testing Team to support staff education and monitoring of kit.					
10.4 Staff who carry out fit test training are trained and competent to do so	OD and P	External provider brought into for training all fit testers Retraining undertaken and Train the Trainer approach used. Lead person now oversees any training for FIT Testing. **FIT Team are now trained on the new Portacount Machine plus have had up to date training this year from an accredited company. Ris assessment for Train the Trainer closed.**							
10.5 All staff required to wear an FFP respirator have been fit tested for the model being used, and this should be repeated each time a different model is used.	OD and P	Respirators not issued unless testing has been undertaken Those that fail all masks and a Trust Respirator require a permission email to be sent by the line manager requesting hood. Those that have no taste or smell will be issued a hood if deemed necessary by line manager If all else fails, clinician will have a hood if deemed necessary within role **Introduction of porta count means that issue of taste and smell removed.**	1. Increasing instability of types of mask available and subsequent impact on FIT Testing resource 2. Increasing number of FIT Test fails requiring highwe number of respirators. 3. Withdrawal of valved masks for use when undertaking sterile procedures.	Process for respirator hoods in place. Weekly PPE Group to identify any issues of concern/risk FFP3 maintained on ESR and FIT visit clinical areas routinely and challenge where masks are not being worn effectively and further trusting is required. Testing is being undertaken on a range of masks so staff have more than 1 option. All national alerts are followed through PPE Group. **Plenty of masks now, including UK made. Minimal fails due to accuracy of new machine.**					
10.6 A record of the fit test and result is given to, and kept by the trainee, and centrally within the organisation.	OD and P	All results are kept on ESR so staff can be viewed some wards have adopted a colour coding system which is now being rolled across other wards Staff provided with a record of testing (paper).							
10.7 For those who fail a fit test, there is a record given to, and kept by the trainee, and centrally within the organisation of repeated testing on alternative respirators and hoods.	OD and P	Those that fail with Respirator are issued a hood , record via testing teams	**Due to the National Patient Safety Alert managers will still be required to email however the PPE Team need to agree to this also. A Risk Assessment by Health and Safety will need to be performed to cover any ongoing hood use.**	Oversight of hood management with FIT Testing Team. **Anyone that fails a regular Fit Test will be called to complete a Portacount Test. Depending on their job role, PPE group recomendations and Risk Assessment they will be allocated a hood.**					
10.8 For members of staff who fail to be adequately fit tested, a discussion should be had regarding redeployment opportunities and options commensurate with the staff member's skills and experience, and in line with nationally agreed algorithm. A documented record of this discussion should be available for the staff member, and held centrally within the organisation as part of employment record, including Occupational Health.	OD and P	Staff that have failed fit testing and do not have a hood have been redeployed to a suitable are , records Via ESR and testing team There have not been any issues with the supply of hoods. Staff are supplied with a respirtator or hood as required. Copy of their personal testing is given to the staff member.							
10.9 Following consideration of reasonable adjustments e.g. respirator hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm, and a record kept in the staff member's personal record and Occupational Health service record.	OD and P	as above	Record not held by staff member	Review with testing team to ensure staff hold the record Staff now have paper copy of the record and it is added to ESR. Staff not substantive are kept on a spreadsheet sa not on the ESR.					
10.10 Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	OD and P	all results held on ESR	Record not held by staff member and unable to access ESR record currently. Records are not reviewed by the Board - ESR reports not yet run.	Review with testing team to ensure staff hold the record					
10.11 Consistency in staff allocation should be maintained, reducing movement of staff and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	DIVISIONS	Housekeeping staff are allocated to specific wards and remain in that area until the end of their shift. Those staff that undertake post infection cleans do attend different areas, however strict PPE and decontamination processes are followed. Divisional teams have not embraced reducing movement between staff areas. Daily staffing meeting in place, red and green zones not clearly defined. Mitigation - antigen testing on Pembroke and Spinal where patient group vulnerable has not shown any positive results. Virtual Board Round looking at any hotspots of staff absence.	Significant gaps in staffing due to sickness absence and increasing need to isolate.	Link to Risk assessment 6568 for Surgical Division Ongoing established staffing meetings maintain oversight of safe staffing.					
10.12 All staff should adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	ALL	1. COVID secure risk assessments in place with approval process. Trust wide signage for floors and for maximum occupancy with wearing of masks if this is breached. 2. Security teams and allocated staff to provide guidance and reminders to staff regarding social distancing. Social distancing Task and Finish group established, floor signs, posters, rooms labelled. Public areas not deemed as COVID safe.		Risk register of high-risk areas (labs, pharmacy) have had walk rounds with Sue Biddle					
10.13 Health and care settings are COVID-19 secure workplaces as far as practical, that is that any workplace risk(s) are mitigated maximally for everyone.	ALL	Daily comms used for all staff update Signage in place for what is required and room numbers on all doors Risk assessment and QIA in place for enhamced PPE COVID secure risk assessments completed	COVID secure risk assessments not monitored.	All staff wearing masks and room capcity limited. Awaiting updated IPC guidance prior to changes being made.					
10.14 Staff are aware of the need to wear facemasks when moving through COVID-19 secure areas.	ALL	As above							
10.15 Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	OD and P	All staff isolating for 10 days are logged on a spreadsheet in OH and on our OH diary system called EOPAS. 2. Staff LFT twice weekly.							
10.16 Staff who test positive have adequate information and support to aid their recovery and return to work.	OD and P	If staff member not well enough to return to work after their isolation period, they are advised to consult their GP. They are advised they can contact OH if they need any support from us specifically eg workplace welfare support/signposting or workplace adjustments etc.							

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.2
Date of Meeting:	13 January 2022		

Report Title:	Annual Education and Training Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	OD & P Management Board & People and Culture Committee			
Prepared by:	Nicola Summerill: Head of Education and Apprenticeships			
Executive Sponsor (presenting):	Melanie Whitfield: Chief People Officer Jean Scrase: Associate Director of EICE			
Appendices (list if applicable):	Appendix 1: HEE South West 2020-21 CPD Summary Appendix 2: Final Q1 HEE CPD Investment and Assurance Plan 2021- 2022V.4 Appendix 3: NHS Education Contract Appendix 4: Public Sector Apprenticeship Workforce Target for 20/21			

Recommendation:

The board are asked to note the report and progress made to:

- deliver the NHS Education contract
- secure and deliver against the HEE CPD Investment Plan
- reach the Public Sector Apprenticeship Workforce Target.

Executive Summary:

In a challenging year the education team have made significant progress in delivering the NHS Education Contract; manging the HEE CPD spend and improving the Trusts position against the Public Sector Apprenticeship Workforce Target.

Detail of this progress is provided in the body of the report and appendices.

Key successes include:

- **Apprenticeship growth**: our apprentice numbers have increased from 128 to 140 in the last year and seen a decline in the amount of Levy expiring.
- **Learner support**: we have provided support for over 200 pre-registration student nurses, nursing associates, return to practice nurses and operating department practitioners; liaising with Universities and external placement providers, as well as supporting the

clinical staff working with them.

- **Simulation and Practice Team:** designing and delivering new training packages to inform new practices during early stages of Covid 19 with direct impact on staff ability to care for patients.
- **Designing training programmes at pace** to upskill clinical staff to enable them to return to practice and be redeployed during Covid
- **Military Personnel**: Together with the transformation team ensuring 49 military personnel were ward ready in 48 hours
- **HEAT Project**: we have been working with the delivery team to establish Key Higher and Further education partners for our education campus development. Following a webinar for over 400 training providers, we have now shortlisted providers and will make the final selection within the next two months.
- **Integrating the Knowledge and Library Service and Resus team** with the rest of the provision
- **Completing the diagnostic phase of our Best Place to Work programme during the pandemic**. The only Trust to achieve this nationally.

Key Challenges

- **Re-deployment**: like other areas, members of our team were redeployed to support other areas of the Trust including Fit testing; training vaccinators; working in the vaccination hubs and working on the Respiratory Care Unit.
- **Maintaining essential training with dramatically less space and a skeleton team** to comply with social distancing requirements.
- **Supporting the health and wellbeing of our teams**

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) -	☐

Annual Education and Training Report- Sept 2020-Aug 2021

1. Executive Summary

The 12 months from September 2020 to August 2021 has been like no other year before for both the NHS and for Salisbury NHS Foundation Trust (SFT). All areas of delivery within our Education and training provision have been impacted by the Covid 19 pandemic - together with the rest of the organisation.

Despite the pandemic the expectation from Health Education England (HEE) was a continued commitment to Education, Training and Development both for our own staff and for all the students and learners we support. This has not been without challenges. In addition, HEE released a new NHS Education Contract in April 2021 which replaced the previous Learning and Development Agreement (LDA). The new contract was controversial which led to a delay in it being signed until August 2021.

The provision of funding from HEE for Continuous Profession Development (CPD) has been a much needed boost to our Nursing, Midwifery and Allied Health Professional colleagues. Accessing courses, many of which were limited or cancelled by training providers due to their own challenges with Covid 19, and releasing staff to be able to attend training has been a challenge, but we have so far been successful in utilising all of our allocation for the first year (20/21) with approx. 1500 staff accessing the £380k budget and are on track to utilising the full allocation for the second year (21/22). In addition we subscribed to NHS Elect Platform which provides a range of education and development opportunities available to all staff.

Every year a process takes place across the organisation to establish the need for funding for training and development for the subsequent year. In my third year in role with responsibility of overseeing this process it has become clear that the process is not a 'Training Needs Analysis' as it has been titled to date, but is in fact simply a mechanism to request funding. This has raised questions regarding what takes place organisationally in terms of actual training needs analysis. The need for a review of the process has been identified as a priority in the next 12 months.

Our apprenticeship programme has been able to maintain and improve on its position from 128 apprentices in Sept 2020 to 140 in Sept 2021, which in light of the Covid 19 pandemic is a great success. Understandably, releasing and supporting staff on apprenticeship programmes has been difficult and starting new apprenticeships has not been a priority for our staff. We had minimal disruption to our programmes that were running and were still able to start 44 new apprentices on programmes.

We have continued to work closely with our partners in the Bath, Swindon and Wiltshire (BSW) region and our education networks, including apprenticeships have grown stronger in the last year with some great successes noted in this report. The development and planned launch of the BSW Academy is an exciting opportunity for us to develop these networks further in the future.

Whilst dealing with the challenges of rapidly changing training and development requirements, redeployment, staff sickness and absence, the education team have continued to demonstrate the outstanding characteristics that SFT has come to expect of its staff. All of the team have been committed to doing everything possible to support the organisation through this most difficult year. I would like to take this opportunity to thank every member of the Education Team for daily living the values of this organisation.

2. Introduction

This report provides a summary of the Education and Training activity that has taken place over the 12 months from September 2020 to August 2021 and looks in detail at the following areas.

- Overview of in-house training
- Covid 19- Impact on Training and Development
- CPD- HEE Funded
- Training Needs Analysis
- Compliance with the NHS Education Contract
- Covid 19- Recovery
- Apprenticeships
- BSW Partnership Working

2.1 Central Education Team:

The training identified within this report is facilitated by the core education team. In addition, there is a considerable amount of training supported within departments by specialists, for example, our comprehensive support for clinical scientists and trainees in our pharmacy.

In future reports our annual report will include contributions from those specialist areas.

Education and development teams	
Associate Director of Education, Inclusion, Comm's and Engagement	Jean Scrase
Head of Organisational Development and Leadership • Coaching and Mentoring Lead • 3 x (OD & Leadership) interviewing Nov'2021 • Education Business Manager • Resuscitation Manager o Resus trainers • Head of Library Services o Librarians	Nick Beazley (Sept 2021) Colette Martindale 3 x vacant posts Yvonne Donovan Debbie Fishlock Alanna Cole Liz Manterfield Vacant post Helen Clemow Caroline Thomas
Head of Education and Apprenticeships • Simulation Manager o Simulation technician	Nicola Summerill Claire Levi Colin Kuberka

• Lead Practice Educator ○ Practice Education Team (PE Team)(WTE=3.6) • Moving and Handling Advisor ○ Moving and Handling Trainer	Michelle Ricketts Jude O'Neill Dawn Whitmarsh Angie Hanlon Emma Freeman Amanda Docksey Yvonne Newell Jordan Moore
Dementia Lead Nurse ○ Dementia trainer ○ Dementia Advisor	Sandy Woodbridge Julia Burton David Burton
• Education Administration Team (approx.WTE= 5.0)	Lyn Ludiman Sarah Shales Shannon Mahoney Helen Clemow Education Administrator (vacant) Nikki Macey (Resus) Ana Williams (Library), Receptionist (vacant)

3. Overview of In-house Training

In spite of the challenges faced with Covid 19, the education team have continued to deliver essential training and have demonstrated agility and flexibity in responding quickly and efficiently to rapidly changing demands of the organisation. This has been achieved by supporting colleagues with our vaccination programme, re-deploying into front-line services; upskilling clinical staff and military personnel for deployment and redeployment, supporting our fit testing team and recommending changes in practice through simulation to support the care of our patients.

With the support of HEE CPD funds we were able to grow our offer, responding to the Best Place to Work Diagnostic by introducing new leadership programmes which have been well received by all who have attended. In addition to the planned programme, two additional bespoke programmes were developed to meet an identified need within Maternity and Estates.

The table below summarises the training delivered in 2020-21 categorised using the HEE Star

Activity Category (ref HEE Star)	Subject and Programme Length	Numbers trained Sept 2020- Aug 2021	Numbers trained Sept 2019- Aug 2020
Leadership	Coach 2 Lead- 2 days	35	44
Leadership	Estates Leadership and Management Programme- 7 day programme	12	Not started
Leadership	Compassionate Cultures Workshop- ½ day	108	Not started
Leadership	Clinical Service Leaders- 6 days	19	Not started
Leadership	Compassionate Leadership Programme- 6 days	39	Not started
Leadership	Midwifery Leadership Programme- 6 days	16	Not started

Leadership	Appraisal training- 2-4 hours	50	25
New Roles	Practice Supervision (PS) Preparation- 1 day	110	92
New Roles	Practice Assessor (PA) Preparation- 1 day	63	43
New Roles	Mental Health First Aider- 2 days	63	0
Supply	HCA Induction- 2-5 days	104	94
Supply	Trust Induction-	828	244
Supply	OSCE Preparation- 6 days	33	90
Supply	Preceptorship Programme- year long programme of support	152	123
Up-Skilling	Venepuncture and Cannulation- 1 day	85	133
Up-Skilling	Catheterisation- ½ day	12	75
Up-Skilling	Acute Illness Management- 1 day	87	53
Up-Skilling	Dementia- 1 day	112	90
Up-Skilling	Person Centred Coaching- 2 days	60	6
Up-Skilling	PS and PA Updates- 1-2 hours	100	7
Up-Skilling	Conflict Resolution- 1 day	25	59
Up-Skilling	Covid 19 Up-skilling- various	19	259
Up-Skilling	Covid Simulation		470
Up-Skilling	In situ Simulation- 2-4 hours	158	185
Up-Skilling	Multi-Disciplinary Team Simulation- various	22	0
Up-Skilling	Tracheostomy Study Day- 1 day	55	0
Up-Skilling	Medical Education Training- ½ day	103	
Up-Skilling	Theatre Emergency Simulation-	25	0
Up-Skilling	Respiratory Care Unit (RCU) Upskilling- various	24	0
Up-Skilling	Non-Invasive Ventilation and CPAP Training- various	39	33
Up-Skilling	Basic Life Support (BLS)- ½ day	2095	1406
Up-Skilling	Paediatric BLS- ½ day	520	406

4. Covid 19- Impact on Training and Development

4.1 Capacity and capability

The impact that the Covid 19 pandemic has had on the health service as a whole and the delivery of and access to education and training this year has been unprecedented. The impact of increased staff absences; increased numbers of redeployed staff working in unfamiliar areas; changes to the patients in hospital and therefore access to learning environments and changes to the acuity of those patients has effected all aspects of education and training. This has manifested itself in placement provision for pre-registration students, to induction and on-boarding training for new staff and to our current staffs ability to access training for upskilling or for continuous professional development.

The restrictions on room capacity required to ensure we could maintain social distancing resulted the department being able to accommodate 61 people in training at any one time, instead of 271 prior to the pandemic. Our maximum room capacity was in the Lecture Theatre and was set at 24

instead of the 140 normally accommodated. Our next largest room, Room C could only accommodate 10 people, including the trainer, instead of 32 previously.

There have been limitations on staff being released for education and training, being available to support learners in practice, or being available to deliver training themselves as a result of the changes Covid 19 brought to our working practices. Staff were redeployed across the hospital and the Simulation Team and PE Team developed a range of upskilling sessions to support that redeployment, from core skills such as venepuncture and cannulation, catheterisation and drug administration, to advanced skills such as non-invasive ventilation, Continuous Positive Airway Pressure (CPAP), care of an ITU patient and tracheostomy care.

4.2 Support of students

4.2.1 The PE team were involved in training and assessing staff as vaccinators. Members of the Education Team were redeployed to work within the Respiratory Care Unit (RCU), the fit testing team and the vaccination centre.

The PE Team have continued to provide support for over 200 pre-registration student nurses, nursing associates, return to practice nurses and Operating Department Practitioners from Bournemouth University and Winchester University, as well as our first cohort of internationally recruited PGDip Nurses from Nigeria with University of Southampton. In addition they have arranged and supported smaller numbers of students on bespoke placements from other universities such as Southampton, Portsmouth, Plymouth and Solent.

This includes supporting both the students themselves, as well as supporting the clinical areas hosting those students, all of whom have been under significant extra pressure this year. Unfortunately we did postpone a large cohort of first year student nurses due on placement in January and February 2021 as it was felt this would not be appropriate for them. This decision was supported by the University and was replicated by many other Trusts. SFT were the only Trust to be able to continue to support all other students across other professions and years from Bournemouth University. The students who missed their placement will make up those placement hours with us over the remainder of their programme, which although it will increase demands on our capacity, will be managed by our PE Team.

In addition, with HEE and Nursing and Midwifery Council's (NMC) decision to introduce paid placements, the PE Team have also supported both students and ward staff to work in a very different way with students and they have provided significant pastoral support and oversight for those students.

4.2.2 Departmental and profession based support is provided for student Physiotherapist, Occupational Therapists, Healthcare Scientists, Dental nurses, Clinical Psychologists, Midwives, Paramedics, Radiographers, Speech and Language Therapists and Pharmacists. The ambition is that through the Education Development Group, all non-medical students can be included in our overall monitoring of figures and provision of support, this will be in line with the requirements of the new NHS Education Contract.

4.3 Recruitment

There was a Trust wide increase in recruitment of staff, which was supported by both our administration team and training teams through on-boarding and induction, including the rapid on-boarding and training of 49 military personnel who supported our workforce.

4.4 Virtual training

Non-essential face to face training was cancelled or delivered virtually; room capacity was severely impacted, reducing the numbers of staff that could be trained at any time and therefore in some cases, increasing the numbers of sessions that had to be delivered and therefore demand on teams.

The pandemic has also resulted in an opportunity to think differently about our mode of delivery, the use of virtual environments whilst not replacing face to face provision in the future will be a feature of training, enabling co-delivery across the system in a much more streamlined way.

We continue to look at the possibilities and impact of a blended delivery to support our learners across the Trust and take advantage of benefits that come from virtual learning environments.

4.5 Compliance

Statutory and Mandatory Training compliance has steadily declined in the past year from 91.9% in Sept 2020 to 86.52% in August 2021. For clinical staff this has been informally reported as being due to staff not being given time to complete this as patient care has been a greater priority with reduced staffing numbers and increased acuity of patients. For non-clinical staff this has been informally reported as being due to redeployment, and increased work pressures. A plan is now in place to address this downward trend.

All members of the education team have demonstrated flexibility and professionalism in their ability to adjust and change to meet the constantly changing needs of the organisation, within increasing constraints and challenges.

5. Continuous Professional Development- HEE Funded

Prior to the pandemic in 2019 the government committed to provide an increase in funding for continuous professional development (CPD) for registered nurses, midwives and Allied Health Professionals (AHPs). This funding was made available from April 2020 for 3 years. Each years funding provision is dependent on our ability to demonstrate our investment plan and provide updates on our spend. The subsequent years funding is dependent on our use of this funding in the previous year. This has been particularly challenging at a time where training providers have been cancelling or limiting their offer and the Trusts ability to release staff to attend has also been a challenge. However we were able to spend our entire allocation for 2020-21 and as a result had our allocation for 21/22 confirmed dependent on our investment plan. Our investment plan for 21/22 was also subsequently agreed by HEE and that funding is now secured. Funding for 22/23 will be dependent on our ability to appropriately spend this year's funding and on a further investment plan for 22/23.

Funding from Health Education England has not been confirmed or agreed beyond 22/23 and so consideration will need to be given to a process of investing in education and training in the future both for those staff groups that currently benefit from HEE funding and all other staff groups.

HEE South West 2020-21 CPD Summary attached as Appendix 1

Final Q1 HEE CPD Investment and Assurance Plan 2021-2022 V.4 attached as Appendix 2

6. Training Needs Analysis

The last 2 years have demonstrated that our current Training Needs Analysis process is not as effective as it needs to be. Requests for training are submitted each autumn and funding allocated in the spring once it has been confirmed by HEE. This results in a significant difference between what is requested and what is required due to changes to service and staffing.

In addition, as funding has historically been limited, what is submitted to education does not provide a full picture of the needs of the organisation. It has also been identified that where some departments and divisions will make funding for development available from within their budgets, others don't, resulting in an inequity in availability.

The Education Development Group intend to carry out a review of this process during the next 9 months, and will develop a robust and universally applicable process for divisions to carry out effective Training Needs Analysis.

This analysis process will then provide the platform from which funding needs can be identified and considered. Consideration will need to be given to how funding is provided for Statutory and Mandatory training, as well as individual CPD and service development, including backfilling roles where needed.

7. Compliance with the NHS Education Contract

(Previously Learning and Development Agreement)

7.1 NHS Education Contract

In April 2021 the NHS Education Contract was released nationally for agreement. The NHS Education Contract is a standardised contract across England to enable, fund and assure the core activity of Health Education England with Education and Placement providers. It reaches across Medical and non-medical Education.

HEE State that the contract will:

- Be applicable across multiple providers (HEI, Education Providers, NHS, independent, voluntary, private and social care) and settings (e.g. secondary care, GP/Primary Care, Dentistry);

- Align HEE's commissioning, procuring and workforce planning arrangements with its contractual and financing activities;
- Emphasise the roles and responsibilities of each party involved in delivering healthcare education and training;
- Focus on HEE's expectations on the outputs (volume, value, impact, quality) for the public investment received.

Issues with the contract resulted in a delay in organisations agreeing to sign the contract until August 2021. The resulting NHS Education Contract is attached as Appendix 3.

7.2 Quality review

As part of the Learning and Development Agreement previously in place with HEE, we took part in an annual quality review with HEE Wessex and the South East Health Education England team. Following the move into HEE South West, we have not had the same level of contact that we have been used to and therefore the content of this review was focused more on Medical Education. This balance we would expect to see addressed by the South West regional team as our position becomes more established.

There are 6 themes that we are required to measure ourselves against and we were able to demonstrate that we met the following themes:

Theme		Metrics Met
Learning Environment and Culture	Q1-4	4/4 Met
Library services, simulation and Technology Enhanced Learning	Q5-8	2/4 Met
Educational Governance and Leadership	Q9-13	2/5 Met
Support and Empowering Learners/Educators	Q14-16	3/3 Met
Developing a Sustainable Workforce	Q17-18	2/2 Met
Delivering Curricula and Assessment	Q19	0/1 Met

Each of these themes require ongoing work to ensure we can continue to maintain and develop in these areas.

The following table demonstrates the areas within the remaining 3 themes where we identified a need for further improvement/investment or where we were able to identify that work is in progress with 5/11 metrics not being completely met.

Theme	**Metric**	**Trust exceptions evidence / action plan where they did not think the metric was fully met**
Library services, simulation and Technology Enhanced Learning (TEL)	6. The organisation has sufficient organisational capacity to support delivery of Technology Enhanced Learning	Infrastructure is not sufficient to deliver everything we could support
	8. The organisation remains current with national Technology Enhanced Learning offerings and ensures employees can access all programmes and services	We access eLearning for Heath materials and also subscribe to other providers such as NHS Elect to ensure that a wide range of training materials and CPD sessions are available electronically. To date we do not access all of the TEL offerings

Educational Governance and Leadership	9. The organisation has valid partnership agreements in place with all education providers who regularly place learners with them and these are reviewed annually. We recognise this was not a requirement for out of area placements	Some partnerships agreements are out of date and are being reviewed.
	12. The organisation has an Education and Training Strategy which reflects workforce plans and an integrated multi-professional approach to learning	Our strategy is being updated to reflect a revision of the Trust strategy as a whole
Delivering Curricula and Assessment	19. The organisation's senior staff are actively involved with the planning and delivery of curricula, assessments and programmes that enable learners to meet the learning outcomes required by their curriculum or required professional standards	Not actively involved but do have oversight. Developing closer working relationships with Senior Nursing Team to increase this however.

To date we have not seen an example of the new quality review requirements however, progress and mitigations against our previous areas for improvement include:

Library services, Simulation and Technology Enhanced Learning

Our library services are currently being reviewed following the retirement of our Head Librarian in the summer and part of that process will need to look at the delivery of TEL. Our current offer in this category consists of our Simulation Service, which is far reaching but should not be the only method of delivering TEL, and the Managed Learning Environment (MLE). 2021-2022 will see the migration from MLE to Kallidus Learn, which will increase our TEL offer. We have also subscribed to NHS Elect which provides further options for education and training.

Our Simulation service is aligned with HEE National Framework for Simulation Based Education (SBE). We currently are working within the framework with regards to delivering meaningful and realistic training both in and out of clinical areas, systems testing and human factors. We are also ahead of the game with faculty development and are working with Wessex to share and grow a standardised programme across the region. HEE describe that SBE is growing at a fast pace and we will need to make the case for further investment in order to be able to develop our service in line with that growth requirement.

The Education Development Group will be tasked with reviewing our current TEL provision and identifying what would need to be in place.

Educational Governance and Leadership

Due to regional questions regarding the new education contract, there was a delay in this being signed until August 2021. This resulted in some of our partnership agreements expiring. With the new contract in place, these agreements are now being reviewed, amended and aligned by the HEI's for consideration.

The Education and Training Strategy is being reviewed and updated to align with our new Trust strategy. A first draft will be available in early 2022.

Delivering Curricula and Assessment

Currently the organisations senior non-medical staff are not actively involved in the planning and delivery of curricula, but with representatives across the workforce forming part of the Education Development Group, this will be reviewed and adapted as required.

Senior science staff are actively involved in planning and delivering the curriculum for their trainees. The opportunity to use the expertise of senior staff will be reviewed by the education development group and our provision expanded.

8. Covid 19- recovery

Any recovery from Covid 19 in the coming year will be impacted by a continued increase in staff absence due to sickness and isolation requirements, and a nationally anticipated increase in winter pressures on both numbers and acuity of patients and lack of staff.

Changes are starting to occur with the Education Department with a reduction in the social distancing requirements within the training rooms, increasing the number of staff that can be trained, but this will not impact the ability of staff to attend training. Attendance at training is sporadic across the board from clinical skills to Compassionate Culture workshops, with staff being pulled back from training due to low staffing numbers.

A project has been initiated to address the reduction in Mandatory training and appraisal compliance, looking at the issues and making suggestions for the Trust to appropriately support staff in accessing this training which is essential for staff and patient safety. This will look at alternative methods of delivery, but there are challenges in ensuring the content and quality is able to be maintained in line with the UK Core Skills Training Framework which we have signed up to pass-porting across the BSW region. This includes focusing on the subjects with the lowest compliance and delivering focused training and assessments to the departments with the lowest compliance- for example, hand hygiene assessments within the corporate division.

The education team are continuing to work with the senior nursing teams to ensure that we have staff who are appropriately trained to safely deliver care to acutely unwell respiratory patients, to ensure that our acute respiratory wards and RCU can deliver high quality and safe care to both Covid 19 and non-Covid 19 respiratory patients. Whilst there is an urgent short term requirement for this to ensure patient and staff safety over winter, a gap in experience and specialised knowledge has also been identified and will need to be addressed longer term.

The PE Team are also adjusting their delivery of training, recognising the challenges faced in staff being released from wards to attend training as well as staff ability to support learners in practice. As a result, their focus is moving to ward based support, where they can flexibly provide training and support when and where required.

Recruitment of a Head of Organisational Development and Leadership and the planned recruitment of three new team members, as fixed term contracts, will mean that our leadership and OD offer will continue to be developed in line with the recommendations of Best Place to Work and essential for the support of our 2021/22 corporate objectives and emerging Improving Together programme.

9. Apprenticeships

9.1 Context

The government's 2020 vision for creating a highly skilled workforce and addressing the UK's skill shortages and stimulating economic growth across all areas, has resulted in the reformation of apprenticeships. Since May 2017 we have been paying 0.5% of our total pay bill into the Apprenticeship Levy to fund apprenticeships within our organisation.

All NHS organisations have a legislated workforce target of 2.3% of the workforce to be employed as new apprenticeships starts by 2021. These new starts can be newly recruited staff members or existing employees upskilling through their apprenticeship.

Public Sector Apprenticeship Workforce Target for 2020-2021 attached as Appendix 4

The 2020 NHS People Plan states that we should:

"Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles."

The BSW Long Term Plan for 2020-24 reinforces this by stating that:

> "*We will address the national problems of an aging workforce, high turnover, shortages and reliance on agency staff through a series of initiatives including a well-established apprenticeship programme and internal recruitment programmes."*

9.2 Levy Spend

Salisbury NHS Foundation Trust currently pays 0.5% of its total pay bill into the Apprenticeship Levy per month, on average £60k with a current total of £1.35 million currently available for us to access. This money can only be used to pay training providers to provide apprenticeship training which makes up a minimum of 20% of the apprentices time. Any Levy not utilised within 2 years of being paid into the fund will expire and be returned to the treasury. See our current financial status below.

	2019/2020	**2020/2021**	**Sept 2021**
Total number of apprentices	84	128	140
Current Funds	£1,207,780.00	£1,318,012.00	£1,420,764.00
Total Spent to date	£407,238.17	£832,402.11	£1,065,334.00
Total Spend in Year	£325,294.01 Of which £6,000 (1.8%) was transferred to other organisations	£445,354.91 Of which £12,557 (2.8%) was transferred to other organisations	£232,932.89 Of which £6,124 (2.6%) was transferred to other organisations
% of monthly payment spent	48% (based on Feb' figures due to error payment in March)	48% (based on Feb' figures due to error payment in March)	63%
Annual Expired Levy	£102,815.50	£87,493.45	£35,407.30

The impact of Covid 19 on our apprenticeship programme has not been as significant as anticipated and we have continued to see a small rise in apprentices starting training and a reduction in our expired levy. It has resulted in staff being redeployed into different departments, reduced staffing numbers and significant increases in work pressures across the organisation. Understandably, there has been less capacity to support and train staff on apprenticeships in a way that we would like to. As expected, the focus on training and development has shifted as staff prioritise operational pressures.

There have been challenges regarding procurement of apprenticeships with one Higher Education Institution making last minute cancellation of a degree level apprenticeship that we had recruited to. This effected the credibility of apprenticeship programmes as a whole.

The range of apprenticeships being utilised across has increased and we have apprenticeships available at every academic level and across a range of staff groups. See table below

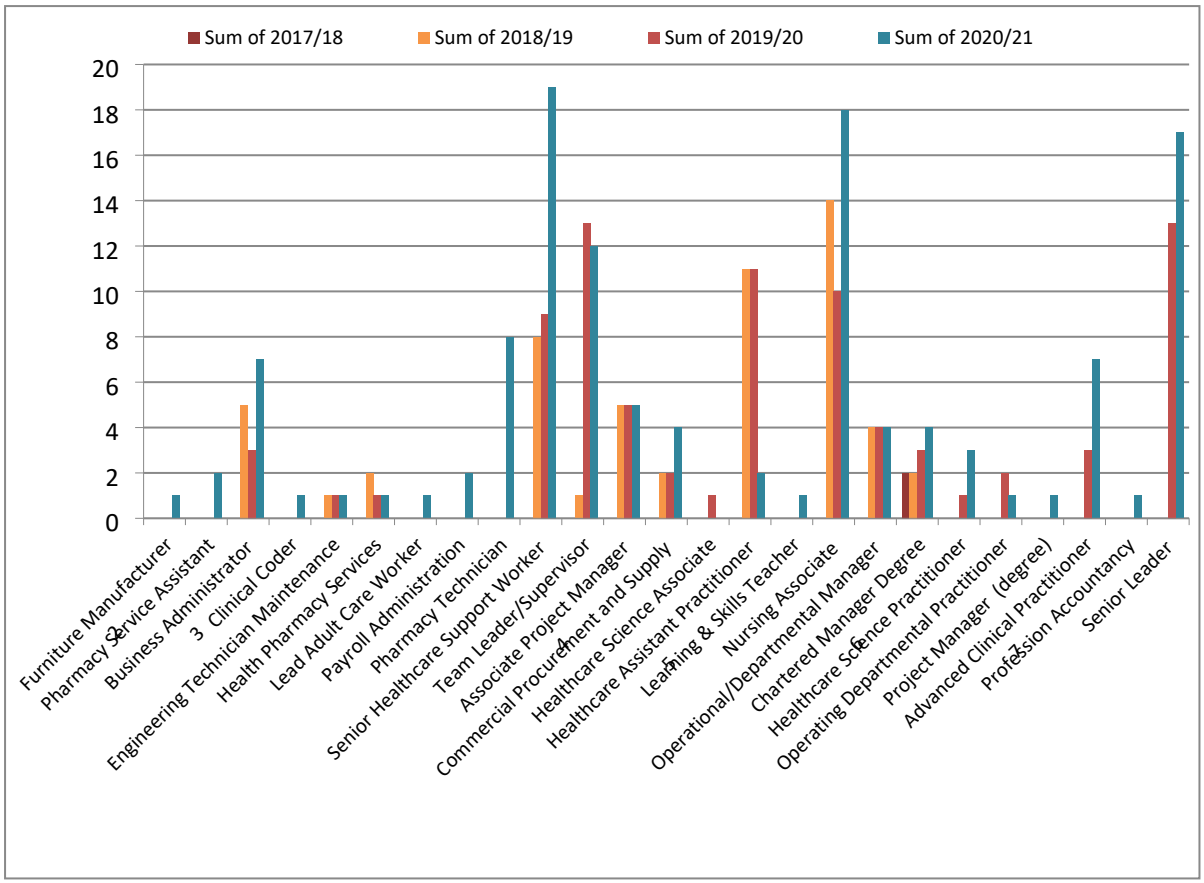


Table: Demonstrates the range of apprenticeships accessed by Educational Level, and the number of apprentices on each programme.

Levy utilisation has improved in the last 12 months, and we are on track for a decrease over the whole year. Currently a business case for a Registered Nurse Degree Apprenticeship Programme is being considered and is agreed in full will result in the following additional utilisation of the Levy. This will eliminate any expiry of Levy and support us towards a target 100% utilisation. SFT have already committed to support a further 9 apprentices through Levy transfer in 21/22, with an aim of increasing this further up to 25% of our total levy, to increase accessibility onto apprenticeships for our community.

		Mar 22	Sep-22/Mar 23	Sep-23/Mar 24 on wards
Levy utilisation	3yr RNDA	£45,000	£90,000	£135,000
Levy utilisation	2 yr NA/AP Top up	£75,000	£150,000	£150,000
Total annual usage		£120,000	£240,000	£285,000

The target this year, in the current climate, has been to maintain our current apprenticeships and continue to support them through to completion, whilst also responding to any requests for new programme and enrolments.

9.3 Procurement

SFT engaged in regional and system wide procurement of a number of degree level apprenticeships and have internally recruited onto these.

This was carried out on a much larger scale than last year, and carried out across the South West instead of just the BSW region.

Across BSW since April 2021, there has a 15% increase in apprenticeship starts and a 100% increase in Levy transfers, which is testament to the great work that is achieved in the network and reflects the identified maturity of the learning pillar.

9.4 Areas of focus for 21/22

9.4.1 A business case has been submitted for a programme of Registered Nurse Degree Apprentices which would include 5 apprentices on the full 3 year degree programme as well as 10 apprentices on the 'top-up' programme to progress from Nursing Associate or Assistant Practitioner to Registered Nurse.

9.4.2 Working with our divisional colleagues and People Business partners we intend to embed apprenticeships into workforce planning, with consideration given to long term planning for role replacements and increasing numbers of apprentices recruited directly into roles.

9.4.3 To establish a communication strategy to raise awareness of apprenticeships to staff and line managers, sharing staff stories of success.

10. Banes, Swindon and Wiltshire (BSW) Partnership work

Across BSW Education Leads have been working together to align our services and training and development offers. The BSW Academy Mobilisation Group identified that the Learning Pillar is currently the most mature of the pillars, which is a testament to the work the network has done. Work has been ongoing over 2020-2021 on the following work-streams:

- Development and utilisation of BSW Learning and Development Sharing Platform. Infrastructure build from 2019-21.
- Mapping, Alignment and pass-porting of mandatory training to the UK Core Skills Training Framework (UKCSTF) to allow wider pass-porting. SFT have signed a Memorandum of Understanding to allow staff to passport training completed under UKCSTF
- Development of a system wide TNA to inform commissioning/ co-delivery/ collaboration in provision of training in BSW. Training demands submitted in January 2021 and due again in 2022. Geographical challenges remain, with much of BSW's training being accessed from University of West of England and South West Higher Education Institution's. Many of our staff prefer Bournemouth and Southampton.
- Procurement of CPD at scale to secure discount across BSW in response to demand and aligning to system priorities such as Learning Disability (LD) and maternity. This has not been successful to date, but remains an active aim into 21/22. See challenges above also.
- Organisational Development system wide thinking training for Learning and Development leads to help move to a more devolved model of delivery and leadership.
- Development of Learning and Development communities of practice (COP's) for like for like Learning and Development staff to share, collaborate, standardise and support each other to underpin more devolved delivery engagement and accountability across the work-stream

and set up a collaborative working infrastructure that includes and supports social care. These have been developed in the following areas: Leadership Development, Work Experience, Return to Practice, Placement expansion, Care Certificate and Preceptorship and SFT have representation at each of these.

- Creation of multiple pipelines of future RNs to meet workforce plans and 50k nursing plans to increase nursing. Mitigation for post COVID 19 nurse leavers and to support 50K. SFT currently have a business case being considered for a Registered Nurse Degree Apprenticeship programme.
- The alignment, agreement and sign up to pass-porting of the Care Certificate across BSW employers. Ongoing
- Increase in apprenticeships as per workforce plans via BSW apprenticeship group and lead and aligning to system priorities such as LD and maternity. SFT are not accessing LD degree apprenticeships directly as we do not have registered LD staff to mentor.
- Placement support for at least 20 T-level students across BSW based on BSW T level strategy. Ongoing, to be considered as part of our Widening Participation offer. COP developed
- Collaborative development and delivery of a suite of BSW Leadership development training. Ongoing work- currently at sharing information stage. COP developed
- Via the BSW placement group – compilation of a BSW wide placement plan including all learners. Challenges for SFT in this due to utilising different HEI's from most other trusts. Scope for involvement however, with provision of a single point of contact for us to be able to access and offer placements
- Scoping, planning and building of a collection of resources linked to the digital platform and ICS website to support careers information.
- Scoping to understand and inform regarding the future use of a sole BSW e-learning platform in place of existing multiple platforms in BSW organisation.
- Regional team implemented to support embedding of Advanced Clinical Practitioner roles with organisation. One output of this has been a regionally agreed Job Spec, banded at 8a.

All of these workstreams have been impacted by Covid 19 in some way, some significantly more than others. COP's have been developed and are beginning to work together to plan options for working together in those fields. Work around pass-porting of training has to some extent increased due to the need for organisations to on-board staff in a more streamlined way. The development of the infrastructure of the shared learning platform has been able to continue as being delivered by an external organisation, but the population of that platform is held up by organisations inability to be able to prioritise this work.

Partners ability to accurately and concisely carry out Training Needs Analysis and submit demands is limited where staff are not available to discuss long term needs and compliance with appraisals is low due to staffing and work pressures. Priorities have been focused on Covid 19 and recovery rather than long term planning for service delivery in a relatively unknown future.
Large scale procurement has been challenging as HEI's and training providers are struggling to keep up with demand from the sector and so competition is limited.
Widening Participation placements are challenging to source in the current climate. SFT have a hold on all work experience placements which limits our ability to support programmes like T Levels, but we are involved in the ongoing discussions and communities of practice to develop an appropriate offer.

11. Looking forward

11.1 Improving Together

As part of the wider People Plan Pillar on New Ways of Working: Service Innovation, a priority action is required in order to support the intended launch of Improving Together across the Trust. In service of the above and the wider strategy under the People pillar, it is the intention of Organisational Development (OD) & Leadership to design, develop and deliver a set of coaching, leadership and OD interventions to support in creating the cultural conditions for the Improving Together initiative and Continuous Improvement (CI) to embed, and ultimately thrive. This will include recruitment to 3 new roles and fixed term recruitment is in train for x1 Coach Lead and x2 OD Leads who will work initially with the Coach House team to furnish their skillset with the mindset, leadership skills and coaching approach to engage and create the initial momentum required for our first wave of KPMG/SFT led workshops in priority areas across the Trust.

11.2 Alignment with NHS Contract, TEL and Simulation

We will be working with HEE SW to fully understand the requirements of SFT in line with the NHS Education Contract, understanding how our alignment with it will be monitored. We will continue to make the improvements identified within the Quality review including:

- reviewing our current TEL provision and what is available to us, as well as establishing what would be required in order to increase our TEL activity. We will need to make the case for further investment in order to be able to develop our service in line with anticipated growth.
- reviewing our current placement agreements and establishing what is required by the HEI's we work with in addition to the NHS Education Contract.
- development of an Education and Development Strategy.

11.3 Mandatory training and Appraisal Process

PIDs for these projects will be approved and actioned in the next 6-12 months, and success will result in compliance rates meeting and exceeding targets.

11.4 Nursing Skills and Role Development

We will continue to work with senior nursing team to identify a structure of training and development for nursing staff to improve the experience and specialised knowledge of our nursing workforce. The main focuses will be on improving skills and knowledge in recognising and caring for deteriorating patients across all staff as well as building a structure of role development and career pathways with standardised expectations placed on the training requirements within those roles. In the long term the intent will be to build similar structures within other professions where this is not already in place.

11.5 HEE Funded CPD

We will continue to monitor the spend of this funding for 21/22, and have started the process to assess the demand for funding for training and development from across the organisation. We will submit a training demand to the BSW Education group in January to establish if any collaborative work with delivery or procurement of training can take place.

11.6 Training Needs Analysis

The Education Development Group will lead on the review and development process of our current Training Needs Analysis. This will need to result in a standardised approach that includes all staff and departments and utilises the Appraisal System in place.

11.7 Apprenticeships

A business case has been submitted for a programme of Registered Nurse degree Apprenticeships which would include the full degree as well as 'top-up' from Nursing Associate or Assistant Practitioner to Registered Nurse.

We are working with KPMG to implement an Improving Together programme which alongside a new Trust Strategy will support the involvement of apprenticeships for staff development and workforce planning. The intention will be to embed apprenticeships into workforce planning, with consideration given to long term planning for role replacements and increasing numbers of apprentices recruited directly into roles.

We will establish a communication strategy to raise awareness of apprenticeships to staff and line managers, sharing staff stories of success.

11.8 BSW Partnership Work

By continuing to be involved in the Networks and COP's across BSW we will be able to ensure that we are developing in these areas, consistently with our partners and will be in the best placed position to share information, ideas and resources across the system. The digital platform will provide us with an opportunity to access training and development with colleagues from a wide range of backgrounds, providing a rich source of knowledge, skills and expertise, as well as adding our own strengths to the offer available.

11.9 Widening Participation (WP)

SFT is an outlier in terms of being without a widening participation team compared with the other Trusts in the system. We are working with our partners to explore best practice and scope our WP requirements with a view to bringing a business case to the Trust Investment Group in December.

11.10 HEAT project

The next steps with the HEAT project will be to select Higher Education partners to work with us to shape our education provision of the future

12. Conclusion

Despite a challenging year, the Education Department has managed to maintain, adapt and in some areas improve the services it offers the Trust. The team has supported the wider Trust in delivering a wide range of upskilling sessions, informing new practice, supporting students on placement and the staff working with them as well being redeployed.

The Covid 19 pandemic has served to highlight areas which were already under pressure and has enabled us to start reviewing and readdressing many things which have always been done a certain way, and to look at how we can improve on what we offer and how we support our staff more fully.

The Improving Together Programme, alongside the recommendations of the Best Place to Work Programme is an exciting opportunity to be able to introduce new methodology to SFT that can be delivered in ways that meet the identified needs of our staff. We want to work towards becoming a more attractive organisation to work for and one where the development and training of our staff to secure their sense of value and wellbeing and improve service delivery and outcomes for our patients is at the heart of all we do.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.4
Date of Meeting:	01 January 2022		

Report Title:	Annual Equality Diversity and Inclusion (EDI) Report 2021			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	x
Approval Process (where has this paper been reviewed and approved)	16/11/2021 – Organisational Development and People Management Board 25/11/2021 – People and Culture Committee			
Prepared by:	Rex Webb, head of Diversity & Inclusion			
Executive Sponsor (presenting):	Melanie Whitfield, Chief People Officer			
Appendices (list if applicable):	Annual Equality, Diversity and Inclusion Report 2021			

Recommendation:
Recommended that the Annual Equality Report 2021 be discussed and approved for publication by the 31st January 2022.

Executive Summary:
Our focus is on delivering high quality, safe and person focused care through teamwork and continuous improvement. During 2020/21 the Trust cared for 60,866 patients. As at 31st March 2021 our substantive workforce totaled 3,952 this was 89 less than on 31st March 2020. At that date 666 people were from a Black, Asian or Minority ethnic heritage, this equates to 17% of our total workforce. This was an increase of 28 people since 31st March 2020. The evidence from our Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and our ESR system indicates a lack of progression of BAME and disabled staff from lower to higher pay bands. There is also a reluctance on those from an LGBTQ+ background or those with disabilities to share their status with the Trust. A number of staff networks have been operating across the Trust over the past few years. However, the networks are at various stages of development. In the past year there has been a lack of staff engagement with the networks.

The following networks are currently in existence:

- Race Equality Network
- Mental Health First Aiders Network
- Rainbow Shed (LGBTQ+) Network
- Ability Network
- Women's Network

In August 2021 an internal EDI Audit was commissioned by the Trust Board. This identified six areas where improvement was needed across the Trust, including EDI strategies, policies, action plans and the governance arrangements being established to oversee progress against the plan.

The Trust is in the process of developing an EDI Strategy in collaboration with The Board, EDI Committee and Staff Networks to address the issues identified by the audit. This will include detailed actions to fully embed EDI and create an inclusive culture over the next three to five years.

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

Equality Report 2021

Commitment

Publishing our annual Equality, Diversity and Inclusion report provides an opportunity to step back and consider how we are doing in our efforts to ensure a more inclusive equal and diverse workplace, and also to consider why this is so fundamental .

It gives us a further platform for progress and accountability and a moment to pause and celebrate the work we are doing as an organisation to create an environment where people are encouraged to be themselves and to speak up about the issues that matter to them.

I am particularly proud of the members of our Employee/Staff Networks who represent the very best of Salisbury NHS Foundation Trust. They are passionate, courageous, honest and relentless in advocating for change. But it is not just up to our networks to do the hard work championing inclusion and diversity, and role modelling the right behaviours must happen at all levels and in all corners of our Trust. This is vital if we are really to create an organisation where the principles of equality and fairness are built-in to everything we do – whether that is how we attract, develop and retain colleagues, how we communicate and engage with each other or how we work together to respond to the health inequalities that exist in the communities we serve.

The Board wholeheartedly supports this priority and recognises that we alongside our leadership teams have a particular responsibility to lead the way in this work which is why it is important for me that this is one of our Strategic Objectives as an organisation. Through this work we want to send a clear message to colleagues and those considering a career with us about the type of Trust we are. Each person who works with us contributes to a culture which values true diversity and one which encourages people to speak up when we don't live up to our words.

Stacey Hunter
Chief Executive Officer

No matter what our role is it is our job to build a workplace where diversity and inclusion are valued and celebrated and equality is at the heart of everything we do. This will ensure that the services we deliver can meet the needs of our local people and partners.

I know that at times the issues of EDI generates strong views for some people in why we should focus our energies into tackling these issues. The evidence and some of the feedback we receive points to some of our colleagues experiencing prejudice and discrimination at work as well certain groups of patients having poorer experiences and health outcomes. As an organisation built on the principles of social justice and improving and saving lives this priority is central to our mission.

We have made some progress over this year but we are not yet in a position whereby we can be confident that all of our colleagues feel that they truly belong , can flourish and achieve their fullest potential. There is more for us to do and I look forward to working together to achieving this ambition. The Board will receive an Equality, Diversity and Inclusion Strategy in the coming weeks which will detail how we embody a diverse workforce at all levels to bring the wealth of experience and perspective to deliver the best possible outcomes for our population. This work will build upon our 5 year Trust Strategy, our collective leadership culture work and the development of our Improving Together programme highlighting the values and behaviours we live by at Salisbury NHS Foundation Trust.

Introduction

At Salisbury NHS Foundation Trust we respect and value the diversity of our patients, their relatives, carers, and our people and we are committed to meeting the needs and expectations of the diverse communities we serve, providing high quality care.

The Annual Equality Report is a legal requirement and a real opportunity to update the Board and the public on progress being made towards the development of a culture of inclusion as a service provider and an employer, where all people are valued and respected for their individual differences in accordance with the Trust values.

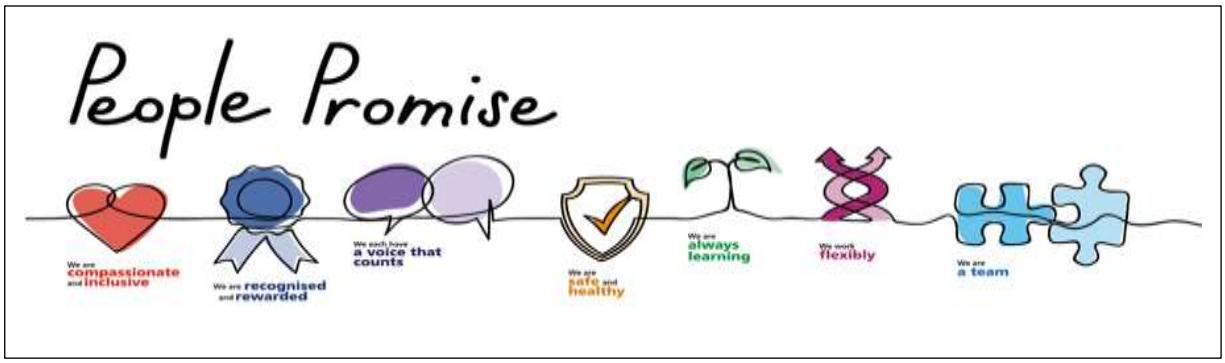
The report also provides the Board and the public with assurance about the steps taken to meet the Trust's commitment to comply with the Public Sector Equality Duty under the Equality Act 2010, our compliance with equality and diversity requirements of the NHS standard contract, NHS Constitution and CQC criteria. (See Appendix C for details of Public Sector Equality Duty requirements).

Melanie Whitfield
Chief People Officer

We are pleased to highlight a number of activities and initiatives which have taken place during the year to help us achieve the aims of the NHS People Promise.

The People Promise

- 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



Executive Summary

During 2020/21 the Trust continued to celebrate and mark a number of equality, diversity and inclusion events across the year. This report highlights some of those activities.

Our focus is on delivering high quality, safe and person focused care through teamwork and continuous improvement. During 2020/21 the Trust cared for 60,866 patients.

The demographics of our patients, our workforce and our volunteers is included at Appendix A.

As at 31st March 2021 our substantive workforce totalled 3,952 this was 89 less than on 31st March 2020. A breakdown of starters and leavers is attached at Appendix B.

At that date 666 people were from a Black, Asian or Minority ethnic heritage, this equates to 17% of our total workforce. This was an increase of 28 people since 31st March 2020.

The evidence from our Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and our ESR system indicates a lack of progression of BAME and disabled staff from lower to higher pay bands. There is also a reluctance on those from an LGBTQ+ background or those with disabilities to share their status with the Trust.

A number of staff networks have been operating across the Trust over the past few years.

Rex Webb
Head of Diversity & Inclusion

However, the networks are at various stages of development. In the past year there has been a lack of staff engagement with the networks.

The following networks are currently in existence:

- Race Equality Network
- Mental Health First Aiders Network
- Rainbow Shed (LGBTQ+) Network
- Ability Network
- Women's Network

In August 2021 an internal EDI Audit was commissioned by the Trust Board. This identified six areas where improvement was needed across the Trust, including EDI strategies, policies, action plans and the governance arrangements being established to oversee progress against the plan.

The Trust is in the process of developing an EDI Strategy in collaboration with The Board, EDI Committee and Staff Networks to address the issues identified by the audit. This will include detailed actions to fully embed EDI and create an inclusive culture over the next three to five years.

Our Vision

Our Values

How we will work together

We have reflected on our core values and behaviours which have been developed and tested with our staff. These are the characteristics which define how our organisation works, and reflect how we want to be viewed by the communities we serve.

We have restated and refined our values to ensure they remain relevant and drive the way we work towards our strategic priorities as an organisation. In recognising the scale of our current and future challenges, we have added a further value, Progressive. This reflects our desire and commitment to tackle future challenges and opportunities with positivity and a continuous improvement ethos.

Person Centred and Safe – Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.

Professional – We will be open and honest, efficient and act as role models for our teams and our communities

Responsive - We will be action oriented, and respond positively to feedback.

Friendly - We will be welcoming to all, treat people with respect and dignity and value others as individuals.

Progressive - We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.

Our Patients

Why is it important to consider patient experience?

The heart of our success as an organisation is the involvement of our patients, carers, their friends and families and the local population to give them the best experience of care possible. Ultimately by consistently asking people whether they are receiving the care they need, listening to what they are saying and using their feedback to improve services helps people feel more supported and better cared for.

Katrina Glaister has been engaging with patients, carers, their friends and families and other key stakeholders in her role of Head of Patient Experience since December 2018 and is supported in the trust's engagement work by Helen Rynne.

Effective engagement leads to improvement in health service delivery and health outcomes and is part of everyone's role in the NHS.

The NHS Constitution states:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes, in the way those services are provided, and in decisions to be made affecting the operation of those services".

We want to ensure that our services are responsive to individual needs and have an engagement strategy that describes a range of activities to achieve this. Our engagement priorities for 2019 – 2022 were discussed and agreed with patients, the local Health Watch Manager, Health Watch patient representatives and an NHS England Patient Engagement Fellow and are set out within the Patient/Public Engagement Strategy and published on our website.

Our priorities are:

1. Communication

We want to build on the work that has already taken place and improve the way we listen to and communicate with our patients their families and their carers

2. Working together

We want to review patient experience (positive and negative) and learn from it so we can improve our services and how people are involved

3. Outstanding care

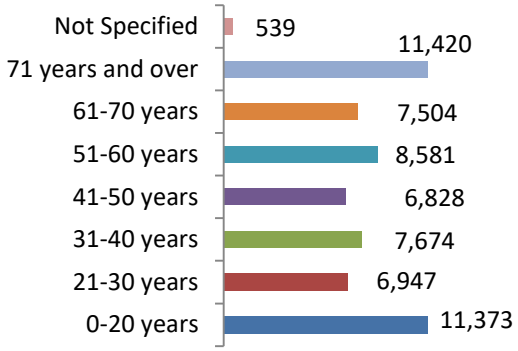
We want our patients, their families and carers to have an outstanding experience first time and every time they come into contact with our staff

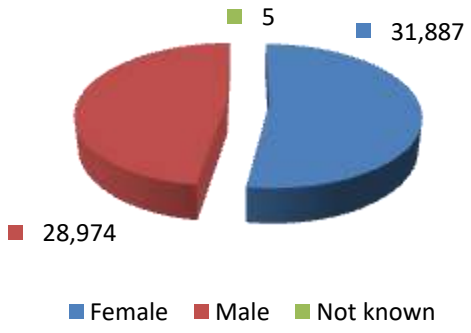
Activities against each of these priorities are reported on and shared at Trust committees and the public Trust Board.

We have strong and growing links with various third sector organisations including: Healthwatch (and Young Healthwatch Wiltshire), Bath & North East Somerset, Swindon and Wiltshire CCG, Maternity Voices Partnership, South West Quality network, Mencap and carers groups from across the community in order to work collaboratively and ensure we are meeting the needs of our wide and diverse community.

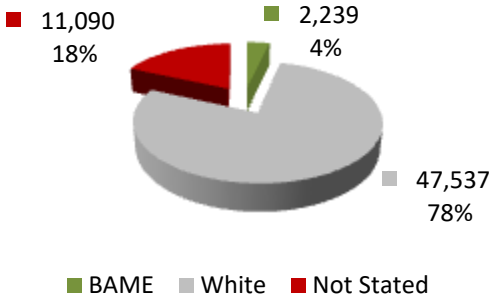
Patient data 2020/21

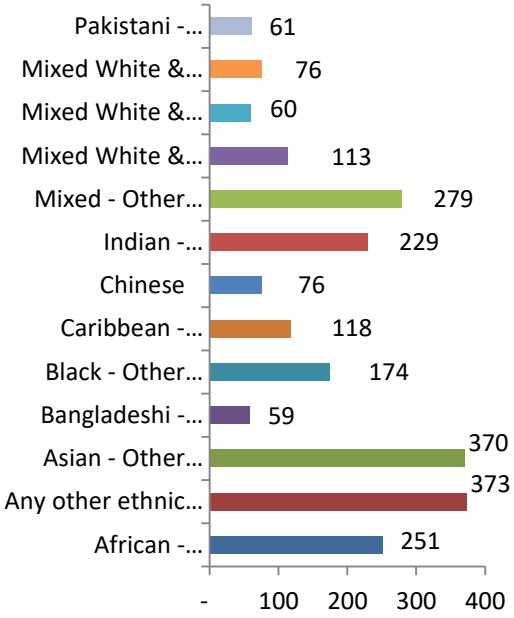
During the financial year 2020/21 the Trust saw 60,866 patients

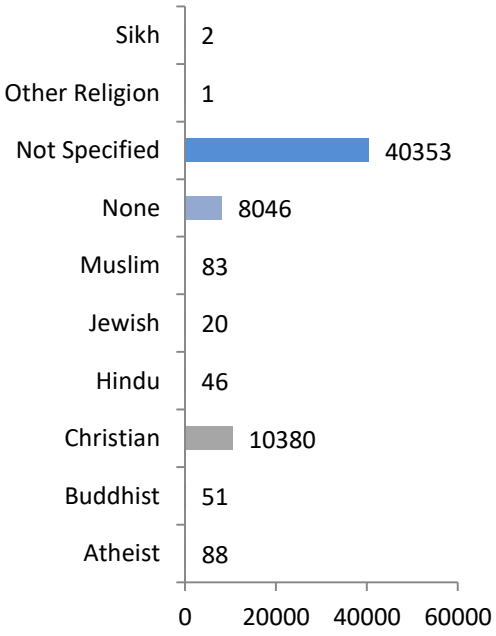




The Trust does not record the sexual orientation of patients at the present time.







Hospital Chaplaincy

The Chaplaincy consists of a team of Ecumenical Chaplains who are available to offer religious and spiritual support for peoples of all faiths, or none. A Chaplain is on site during the daytime. The Chapel is open for quiet reflection and prayer. There are regular services that take place in The Chapel (times can be found on The Chaplaincy notice boards throughout the hospital).

Our Chaplains can call upon Faith Leaders from all Faiths to ensure that the needs of our patients and staff are fully catered for.

The Chaplaincy if partly sponsored by the Hospital Charity.

Salisbury Hospital Chaplaincy is part funded by the Stars Appeal

EDI Activity since October 2020.

EDI activity continued throughout the past year despite the various Covid 19 restrictions in place. Where possible we have carried out activities taking into account the necessary social distancing arrangements.

Communications Team activity

The communications and engagement team have supported a number of ED&I initiatives, working with network colleagues to highlight the projects, contribute to the planning and supporting with video and photography.

These have included:

Rainbow Tugs for Pride 2020

Capturing the delight of Diwali

Black History Month 2020

The Communications Team assisted the Race Equality Network to run an event in Springs Restaurant. This gave people the opportunity to showcase their country of origin.

The Communications team also assisted with the "The Importance of a Name" initiative by recording words and video.

A number of other equality and diversity events which took place during the year were marked by the Trust.

On 3rd December 2020 to celebrate the UN International Day of Persons with Disabilities we flew the Purple flag supporting #PurpleLightUp. An initiative which has been driving momentum for disability inclusion across hundreds of organisations since 2017.

The Trust flew the rainbow flag in support of our LGBTQ+ staff and communities to celebrate LGBTQ+ History month in February and pride month in June.

A further project, lead by the communications team was the establishment of a number of rainbow crossings on the hospital site. These were installed in recognition and support of our LGBTQ+ staff and patients.

Staff Networks

The Trust has a number of staff networks which are at different stages of development across. They have been attempting to continue to operate despite the effects that the pandemic has had on face to face meetings.

During the year we have identified Executive Sponsors for each of the following networks:

- Race Equality Network (formally known as the BAME Forum)
- Rainbow Shed (LGBTQ+) Network
- The Ability Network
- Women's Network
- EU Staff Network
- Mental Health First Aider's Network.

To be effective tools to improve inclusivity and tackle discrimination at work, staff networks need to function as vehicles for employee voice at an individual and collective level.

The four main aims that can be achieved by an effective staff network are to:

1. Provide a safe space for discussion of issues.
2. Help to raise awareness of issues within the wider organisation.
3. Provide a source of support for individual staff who may be facing challenges at work.
4. Offer a collective voice for the workforce to communicate with management.

Mental Health First Aiders Network

The Trust has a growing network of mental health first aiders to create an unshakable belief that we can all talk freely about mental health and seek support when we need it. To date the Trust has a total of 60 people who have completed the Mental Health First Aider training.

What is Mental Health First Aid?

Mental health first aid is the **help offered to a person who is developing a mental health problem or who is experiencing a mental health crisis**, until appropriate professional treatment is received or until the crisis resolves. It follows the model that has been successful with conventional first aid.

By becoming an MHFA England accredited First Aider people can help to improve the mental health of our colleagues. This initiative positively impacts all of us working for the Trust.

The network has recently elected a new chair and deputy chair.

Natasha Grover (Pharmacy)
Chair

"I am a compassionate individual who is focussed in creating an open and honest culture for our staff, so they can talk about their mental health without judgement or fear of reprehension."

Joe Cousins (OD & People)
Deputy Chair

"I have a can do attitude and passion in mental health."

Women's Network

Kelly Kerrigan, Chair

It has been difficult to commit the time I would have wanted to the network over the past year, however the Women's Network continues and there have been committee meetings taking place.

There has been a common theme to the discussions, which has been **flexible working**, including working from home, and this is something the network is keen to explore further to ensure voices are heard when policies are being created and reviewed.

Some areas of challenge that have been discussed include:

- the ability to complete mandatory training when working flexible/part time hours;
- development opportunities aimed at people with full time contracts; meetings
- governance structures not supporting those with flexible/shift working patterns;
- the need for a culture that supports and welcomes flexible working opportunities to ensure all staff are engaged and feel comfortable within their team.

We are very keen to identify opportunities to ensure experiences are heard when reviewing the relevant policies and processes.

In addition, we have again this year shone a spotlight on World Menopause day and are also supporting attendance at the Health and Care Women Leaders Network Annual Conference.

Listening to other Network leads, I'm keen to establish a supportive community rather than a top down network and will be looking for opportunities to learn from more established networks to do this.

Race Equality Network
(Formerly the BAME Forum)

The Race Equality Network was formally known as the BAME Forum. After some discussion within the group they have relaunched as the Race Equality Network to be more inclusive.

During the year the network has run a number of events to raise awareness across the Trust. They have also worked with Senior Managers to create an inclusive culture within the Trust.

The network has continued to assist our Recruitment department to support the onboarding of overseas recruits.

Paula Lewis
Chair

Who we are
Members of staff who promote inclusion, champion diversity and uphold equality for **everyone**.

What we do
- Support the organisation in shaping and delivering strategies to improve experience of staff from under-represented groups.
- Work in partnership with our executive sponsor, allies and wider system to tackle discrimination, eliminate racism and raise awareness of equality issues.
- Provide support to improve recruitment, retention and progression of staff.
- Create and offer a safe space for all staff to share their experience and facilitate learning and development.

Rainbow Shed LGBTQ+ Network

There has been a lack of engagement from staff with the Rainbow Shed network in 2020/21. Two members of staff have championed the network and made attempts to attract members without success.

At the present time the staff members involved are working with the executive sponsor to review the current network structure and aims.

Ability Network

Unfortunately the Ability Network has not been active through 2020/21. The Lead for this network had to stand down and plans are in hand to recruit a new lead.

During the year many staff who identify with disabilities have been self-isolating or working from home. This has limited the opportunities to meet face to face within the Trust.

Review of support for staff networks across the Trust

The Trust is undertaking a review of the support required to ensure that we have effective and efficient staff networks.

This includes involving Staff Network Leads and members to identify some of the barriers and solutions to achieve that aim.

Staff Network Executive Sponsors and Trust Board development

During the past twelve months there have been a number of changes within the Trust's executive team. This has created an ideal opportunity to review and revisit executive sponsorship of staff networks.

After discussion the following Executive Directors have been nominated as Sponsor's of our staff networks:

Race Equality Network:	Esther Provins Stacey Hunter
Rainbow Shed (LGBTQ+):	Peter Collins
Women's Network	Lisa Thomas
Ability Network	Judy Dyos
Mental Health First Aiders Network	Melanie Whitfield

The Executive Sponsors are working with Network leads to identify ways to develop and support network activity across the Trust.

Three Things Every Good Executive Sponsor Must Do

1. Identify and develop a relationship with their Staff Network
2. Be Present as a Sponsor
3. Use their Voice to make an impact

Trust Board Development Day - EDI

In August 2021 the Trust Board scheduled an equality, diversity and inclusion training session on the Trust Board Development Day that month.

A number of colleagues from the Race Equality Network attended the session to share their lived experience of working within the Trust.

"There is a well-known saying that to understand someone else's experience of life you should walk a mile in their shoes. This can be good advice when you are talking about someone from a similar background or culture. It is more difficult to understand or imagine when that colleague is from a different culture and background and has had a completely different life experience.

The stories that the members of the networks shared with the board painted in vivid detail what it is like for them with a different culture and background. As a result of their stories the board could start to grasp what their life must be like and is determined to redouble its efforts to ensure that we minimise the differences and accentuate the common values we all share.

I am incredibly grateful to those who bravely and honestly told us of their experiences and you have my assurance that the board will continue to focus on ensuring we do not rest until the situation have improved significantly."

Nick Marsden
Chair of the Trust Board

"I felt a mixture of emotions during and following the opportunity we had to meet with some members of our Race Equality Network.

I felt ashamed of some of the behaviours and treatment that our colleagues described they experience in our teams.

I was immensely humbled by the courage of colleagues to tell their stories to us – many of which were exceptionally painful for people to recollect and share.

I felt encouraged by the response of my Board colleagues who recognise that there is more for us to do and that the leadership of the Board on EDI is critical to progress.

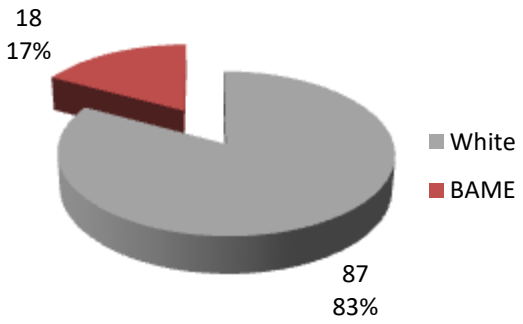
As importantly I felt and feel strongly that our approach has to be one of not demonising people's unconscious bias as we seek to tackle prejudice and inequalities but one whereby we demonstrate our Trust and NHS values in our day to day actions and behaviours."

Stacey Hunter
Chief Executive Officer

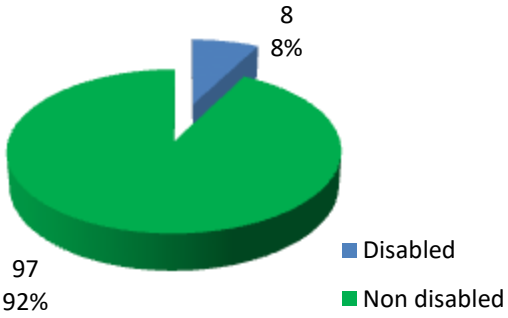
Freedom To Speak Up Program

The number of concerns raised to the FTSUG has increased from 85 cases during 2019-20 to 105 cases, which is an increase of 23.5% during 2020-21. Of these, 17 concerns were Covid-19 related which may have contributed to this significant increase. Where issues are complex external investigations commissioned by the Executive Team have taken place.

As of the 31st March 2021 17% of the Trust workforce identified as being from a BAME background. 18 of those who raised concerns were from a BAME background, this equates to 17% of cases. This is representative of the workforce.

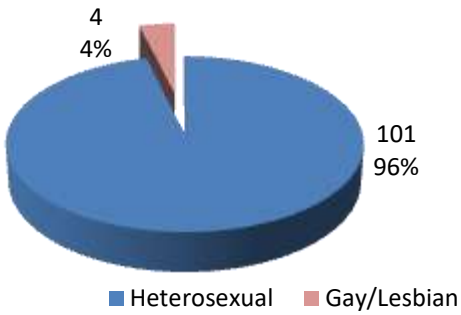


A total of 8 people who raised concerns shared that they had some form of disability.



Lizzie Swift
Freedom To Speak Up Guardian

4 people who raised concerns identified as gay or lesbian.



The FTSUG is in regular contact with the Guardians at Royal United Hospitals Bath and also Great Western Hospitals. This relationship is key for peer support, benchmarking and working together to push the Speaking Up agenda forwards as part of the BSW partnership.

EDI Committee

The Trust EDI Committee continued to meet via Teams during the year.

Membership:

- Non-Executive Director (Chair)
- Chief People Officer
- Chief Nursing Officer
- Associate Director of Education, Inclusion, Comms & Engagement
- Freedom To Speak Up Guardian
- Head of Diversity and Inclusion
- Directorate Senior Nurse
- Directorate General Manager
- Staff Side Representative
- Head of Patient Experience
- Head of Communications
- Trust Governor
- Race Equality Network Representative
- LGBTQ+ Network Representative
- Women's Network Representative
- Ability Network Representative
- Mental Health Network Representative
- Doctors Representative

Purpose:

Using the compassionate leadership model all committee members show active commitment to the EDI agenda for the benefits of patients, service delivery and our people.

To provide support and direction to Trust board, Executives, Senior Managers on the Equality Act 2010 and its requirements.

Lead on the compliance of the PSED (Public Sector Equality Duties), whilst ensuring the Trust remains exemplar in its innovative approaches to diversity and inclusion.

During the past year the committee has been developing and monitoring a number of equality, diversity and inclusion actions. They have been monitoring progress and giving guidance and advice.

The committee has also been facilitating the voice of the EDI Networks. Each network lead has a seat on the committee and regularly provide updates as to their network activities.

Review of Governance:

[EDI Audit overleaf.]

The committee is now taking the opportunity to review its membership and terms of reference in line with activity being undertaking to develop and promote the equality, diversity and inclusion agenda across the Trust.

This review will link with the audit recommendation to "Improve EDI governance structure and management information in order to successfully track progress".

Internal PwC Audit 2020/21

Audit Approach

In 2020/21 the Trust commissioned an internal audit to identify the status of equality, diversity and inclusion within the organisation.

The audit looked at the following areas:

- key strategy, policy, plans and/or procedure documents in place, and the governance arrangements in place;
- the design of the controls in place to address the key risks;
- minutes and papers for a selection of key meetings in the EDI governance process;

The audit team undertook meetings with a cross section of employees within the Trust, including representatives from the six Trust EDI Networks, to understand their engagement with the EDI strategy, policy and/or plans, and EDI more broadly within the Trust.

Recommendations

An Audit report was produced by the audit team and it was discussed at the Trust Finance and Audit Committee. The report made the following six recommendations:

- Formally define an EDI Strategy.
- Revise the EDI Action Plan to include measures of success in response to the new strategy
- Improve the data analysis capabilities for EDI metrics
- Improve EDI governance structure and management information in order to successfully track progress
- Identify further opportunities for embedding EDI
- Review available EDI resources both within the Trust and

Action as a result of the Audit

Following the recommendations work has begun in developing an EDI Strategy in alinement with the aims of the NHS People Plan and Trust Strategy.

A review is taking place of the governance of EDI within the Trust and of the resources required to achieve any identified equality objectives within the Strategy.

Gender Pay Gap Report 2021

The gender pay audit obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

As an organisation that employs more than 250 people and listed in Schedule 2 to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 we must publish and report specific information about our gender pay gap.

Nationally the 2020 mean gender pay gap (the difference between men's and women's average hourly pay) is 6.5% and the median gender pay gap is 15.9%. In monetary terms, the mean hourly difference in ordinary pay is £1.65 and the median hourly difference is £4.04.

The last accurate figure for the NHS average gender pay gap is taken from 2019 figures. Due to the Covid19 pandemic a number of organisation were not able to provide details in 2020. The NHS average for 2019 was 23%.

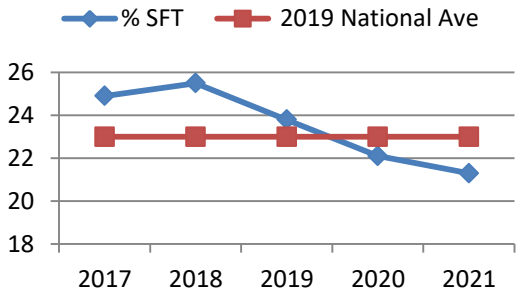
Salisbury NHS Foundation Trust has reported similar pay gap data for the past four years. Over that period of time there has been a reduction of 4.18% in the overall pay gap. At the present time Salisbury NHS Foundation Trust gender pay gap is 21.32%.

Within our staff groups there has been some movement and at the present time two groups have double figure gaps. The staff groups concerned are:

- Administrative and Clerical
- Medical and Dental

The Additional Professional, Scientific and Technical group pay gap has reduced from 12.6% in 2020 to 3.11% in 2021, this is a 9.49% reduction.

There have been no specific, targeted initiatives within the Trust to reduce the gender pay gap in the past year. It would appear that the movement on the pay gap has been the result of staff movement in and out of the staff groups identified.



Workforce Race Equality Standard Report 2021

The WRES return is completed annually and requires information regarding workforce indicators which compare data for White and BAME staff and National NHS Staff Survey data which compares the survey responses from White and BAME staff.

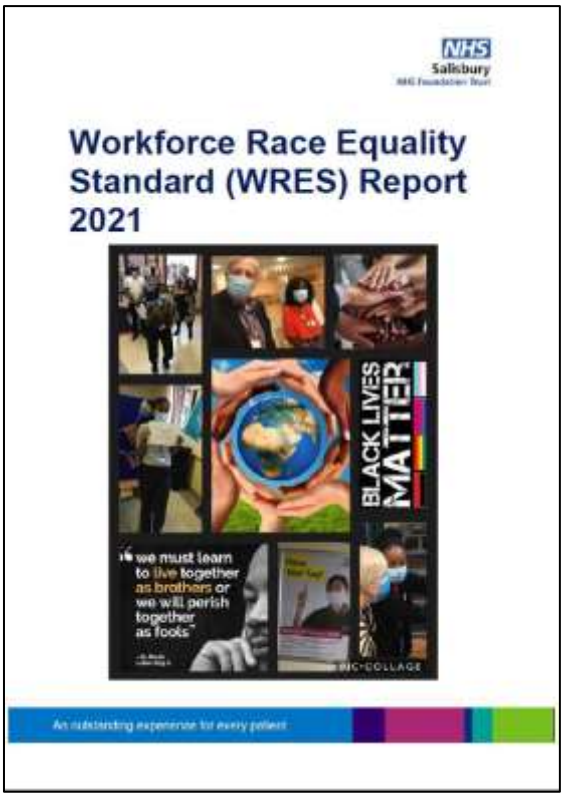
Having compared our data this year with the National WRES results there are a number of areas where we need to take action. We have also compared our progress from our position in 2017 as the National report has done.

Our workforce has grown from **3,377** staff in 2017 to **3,952** in 2021. This is an increase of **575**. Over that period our BAME workforce has consistently grown from **338** in 2017 to **666** in 2021.

One highlighted area where the Trust needs to concentrate some effort is in recruitment and progression.

When we look at the proportion of people appointed from shortlisting, it is clear that, excluding the overseas recruitment program, there is an issue as White applicant are **2.1** times more likely to be appointed from interview than BAME applicants.

On the 24th May 2021 guidance was released updating the Model Employer Goals. The Trust used the guidance to review its ambition to ensure that all roles above Band 6 are representative of the workforce by 2025. These goals are based on **15.7%** of our workforce being from a BAME background.



The national NHS WRES team introduced a new matrix to measure the likelihood of staff progressing to higher management roles. Completion of the disparity ratio matrix shows that in Salisbury NHS Foundation Trust White staff are **9.8** times more likely to progress from middle to higher AfC pay bands than BAME staff.

Our BAME Forum was actively involved in encouraging people to engage in the 2020 Annual NHS staff survey. **38.7% (258)** of our BAME workforce took part in the survey.

The results were very similar to last year's figures and are outlined in the WRES report. It will be noted that there was a slight reduction in the number of people believing that the Trust provides equal opportunities for career progression or promotion. Both White and BAME colleagues showed a reduction on 2017 figures.

Workforce Disability Equality Standard Report 2021

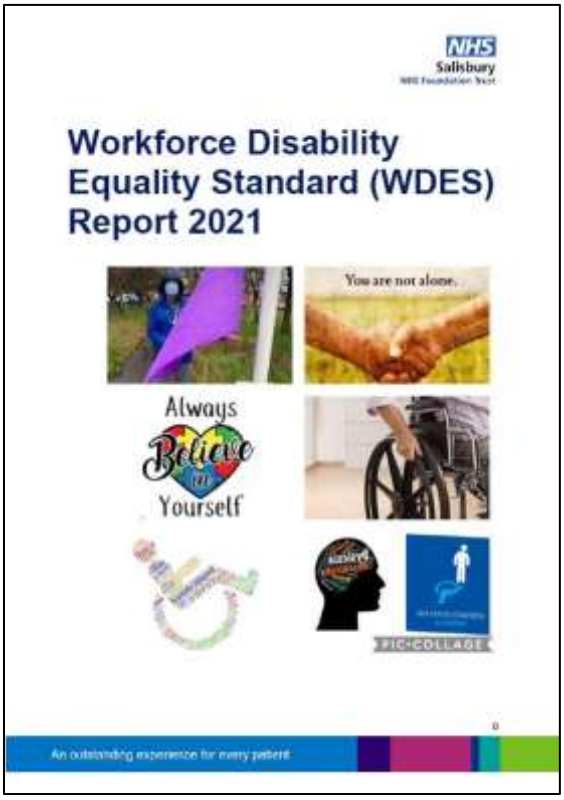
The past twelve months have been incredibly challenging for many of our people including those who identify as having a disability.

The Trust's successful risk assessment process for vulnerable staff has meant that many staff with disabilities have been redeployed or have been working from home.

We are now three year's into reporting against the Workforce Disability Equality Standard and identifying how as an organisation we treat our people who identify with a disability. As will be seen in this year's report despite the disruption caused by Covid19 we are now proactively working to update our disability policies, processes and organisational culture. We are doing this to ensure that our culture is compassionate, fair and non-discriminatory.

We do not have a true picture of people with a disability within our Electronic Staff Record (ESR) system. Within those systems 104 people shared their disability status and 175 people did not state whether they had a disability or not.

358 of our people identified as having some form of disability in the NHS Staff Survey. There is a discrepancy with the numbers shared on ESR. This continues to indicate that we need to work on our organisational culture as well as encouraging our people to provide accurate and up-to-date equality data.



The relative likelihood of staff with disabilities entering the formal capability process has decreased to 1.47 times that of non-disabled staff. This is calculated as a two year average.

Data indicates that there has been an increase in the number of staff with disabilities who feel that the organisation does not value their work. This is a staff survey question and 229 responded to the question negatively.

The Trust collected it's data on the 31st March 2021 when our workforce consisted of 3,952 people. 2,944 were in clinical roles and 1,008 in non-clinical roles. When we look at the overall workforce we see that 3% of our people have identified with a disability, 93% as non-disabled and 4% have preferred not to say.

Future influencing factors.

The following initiatives will have an effect and influence our approach to ED&I over the coming months:

- PwC EDI Audit 2021
- NHS People Plan – Belonging in the NHS
- Improving Together program
- Best Place To Work Program
- The NHS Long Term Plan
- Annual contribution to the WRES and WDES programmes
- Annual reporting against the Gender Pay Gap programme.
- The NHS Workforce Race Equality Standard (WRES) leadership strategy.
- The Learning Disability programme
- The Sexual Orientation Monitoring programme
- Equality Delivery system three.
- The Ethnicity Pay Gap Reporting
- Annual NHS staff Survey
- Covid-19 pandemic response

Following the results of the PwC EDI Audit work has commenced on developing a Trust EDI Strategy aligned to the NHS People plan.

The development of the Strategy will be influenced by the programs and initiatives mentioned above.

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Sponsor:

Melanie Whitfield
Chief People Officer
Melanie.Whitfield3@nhs.net

Appendix A

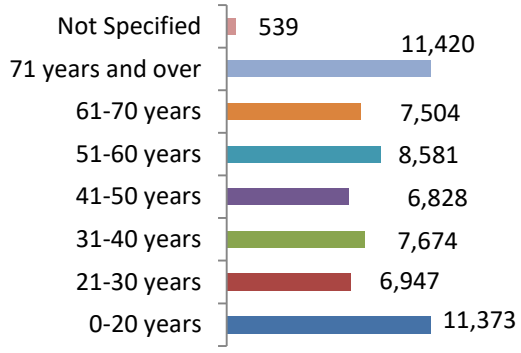
Understanding Our Communities and Workforce

The Trust has a core catchment population of around 270,000 people. The Trust also provides specialist services on a regional basis to a population of two million and supra regional services extend to a population of approximately eleven million people.

Age The shift in the age balance of the population covered by the Trust in the local area is part of a broader national and international pattern. According to the last census (2011) 62.45% of Wiltshire's population are over 40 years old.

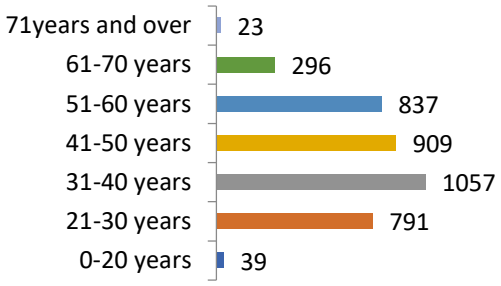
Our Patients

During the financial year 2020/21 the Trust saw 60,866 patients



Our substantive workforce

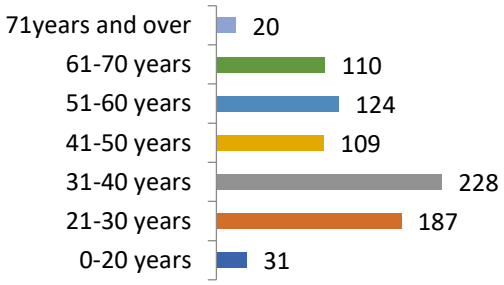
On the 31st March 2021 our substantive workforce consisted of 3,952 people



52.25% (2,065) of our substantive workforce are above the age of 40 years.

Our temporary workforce

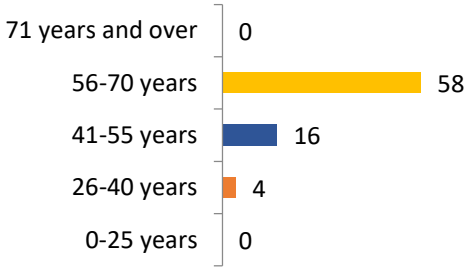
On the 31st March 2021 our temporary workforce consisted of 809 people



44.9% (363) of our bank workforce are above the age of 40 years

Our Volunteers

On the 31st March 2021 the Trust had 78 active volunteers working in the Hospital.



Sex A person's sex is often based on biological factors, such as their reproductive organs, genes, and hormones. But similar to gender, sex isn't binary.

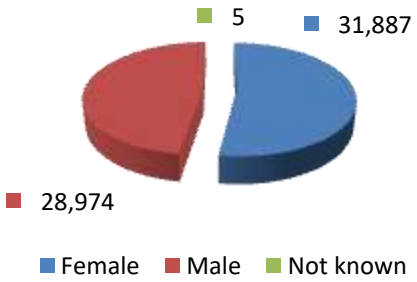
Someone can have the genes that people associate with males and females, but their reproductive organs, genitals, or both can look different. This is known as differences in sex development. People may also refer to this as intersex.

Typically, people use the terms "male," "female," or "intersex" regarding a person's sex.

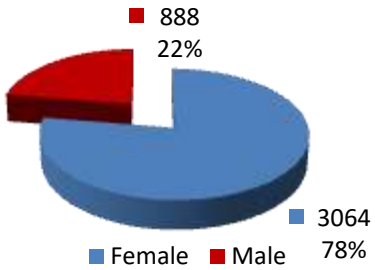
The sex profile of the local area broadly reflects the national picture with the split between male and female being 49:51.

The longevity of women is very different from those of men. On average, women live longer but have lower incomes. Because women are also often younger than their partners, more women than men live alone in their later years. Traditionally, women have also left the labour market earlier

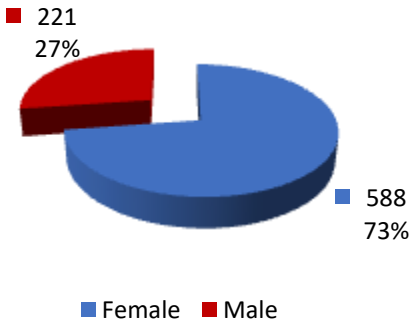
Our Patients



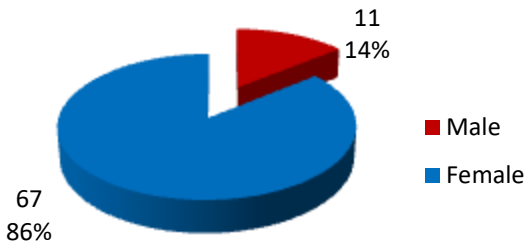
Our substantive workforce



Our temporary workforce



Our Volunteers



Disability In relation to the Equality Act, a person has a disability if they have “a mental or physical impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.”

In 2014 The Office for Disability Issues and Department for Work and Pensions estimated that there were 11.6 million disabled people in the UK, 5.7 million of which were adults of working age, 5.1 million over state pension age and 0.8 million children.

The population of disabled people includes those with visible disabilities e.g. wheelchair users, blind people and deaf people – and many people who have other (often less visible) impairments.

National trends show among adults an increasing number of people who have mental illness and behavioural disorders, while the number of people reporting physical impairments is decreasing.

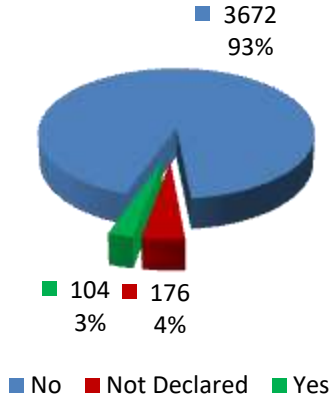
Although older people are more likely to be disabled than younger people, trends show an increasing number of children with complex needs, Autistic Spectrum Disorders or mental health issues.

Research indicates that people with disabilities are disadvantaged in a wide range of areas when compared to those without disabilities. Disabled people are more likely to achieve lower outcomes in terms of employment, income and education. They are more likely to face discrimination and negative attitudes, and often experience problems with housing and transport.

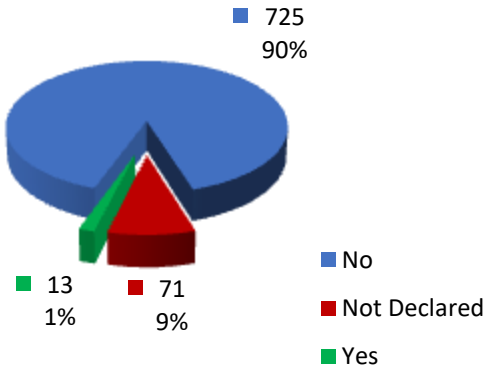
Our Patients

Data currently not available.

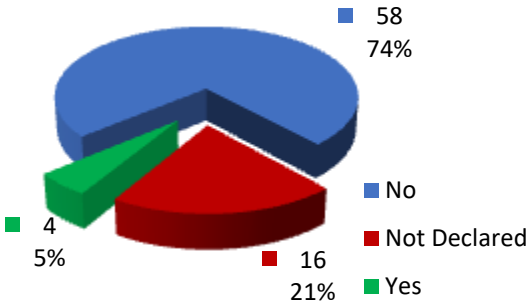
Our substantive workforce



Our temporary workforce



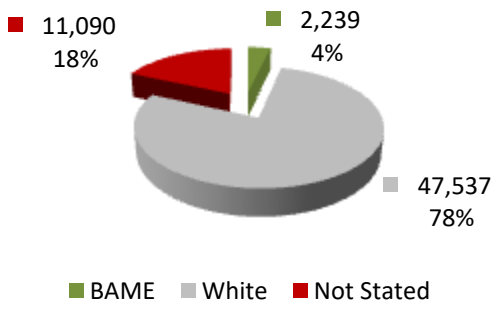
Our Volunteers

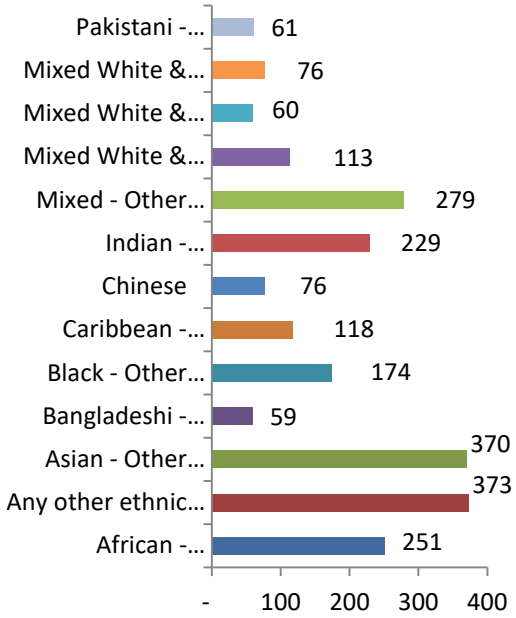


Ethnicity If we look at the demographics in the Salisbury area we see that 95.73% of the population are white, 4.27% Black, Asian or minority ethnic. These details have been taken from the Census of 2011.

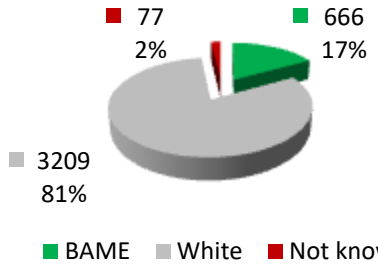
Our wider footprint covered by our spinal unit ranges from the South West region, where 95.4% of the population is white and 4.6% Black Asian or minority ethnic to parts of Hampshire and Thames valley area where on average 90% of the population are white and 10% Black, Asian or minority ethnic.

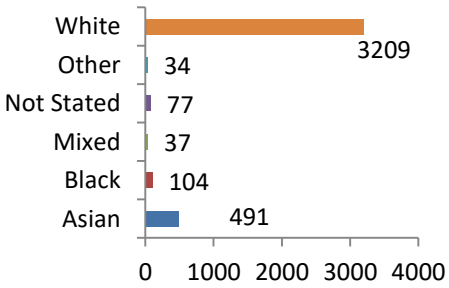
Our Patients



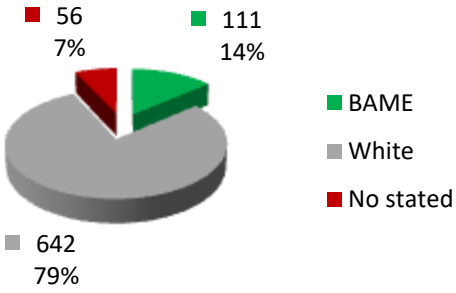


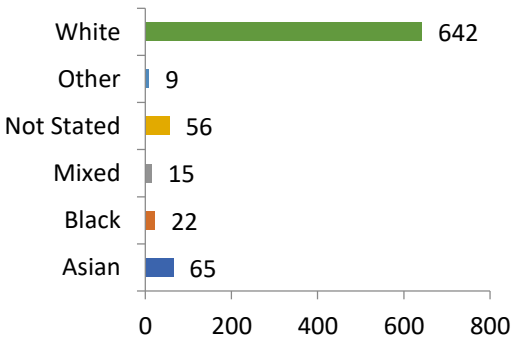
Our substantive workforce



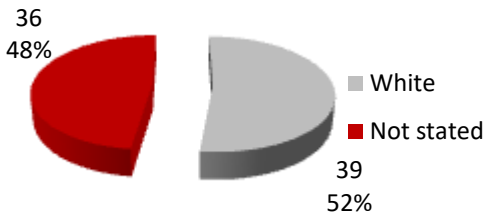


Our temporary workforce





Our Volunteers



Sexual Orientation and Gender Identity

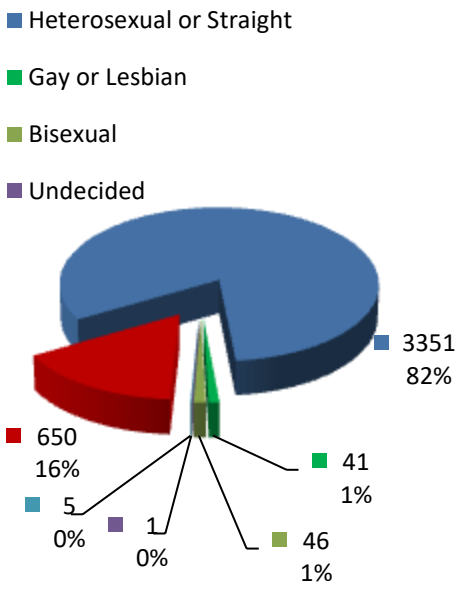
Lesbian, gay, bisexual, transgender, intersex, and associated identities have been present in various ways throughout history. All cultures have included, with different degrees of acceptance, those who practice same-sex relations and those whose gender, gender identity, and gender expression test current norms.

Although the number of lesbians, gay men and bisexuals in the UK as no national census has ever asked people to define their sexuality, government actuaries estimate that 6% of the population is lesbian, gay or bisexual (LGB). This represents around 3.6 million people – or 1 in 16.

Our Patients

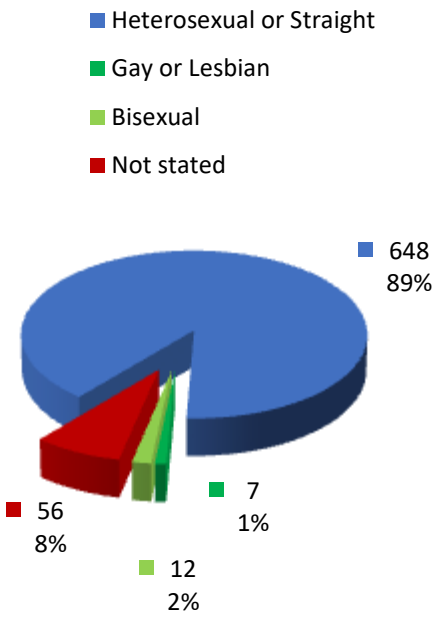
At the present time the Trust does not collect details of patient's sexual orientation or gender identity.

Our substantive workforce

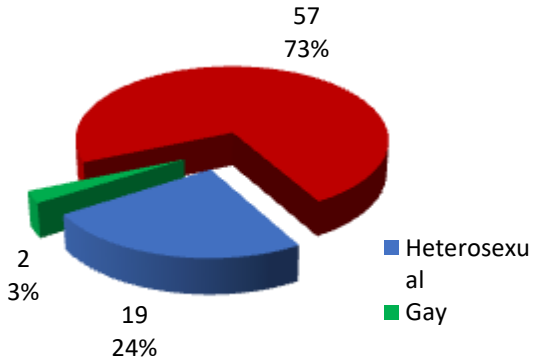


It will be noted that 2% (93) of our substantive workforce have shared that they are gay, lesbian or bisexual on our ESR Workforce systems. This is significantly lower than the estimated 6% mentioned above.

Our temporary workforce



Our Volunteers



Gender identity is the personal sense of one's own gender. Gender identity can correlate with a person's assigned sex at birth or can differ from it.

Gender expression typically reflects a person's gender identity, but this is not always the case. While a person may express behaviors, attitudes, and appearances consistent with a particular gender role, such expression may not necessarily reflect their gender identity. The term gender identity was originally coined by Robert J. Stoller in 1964.

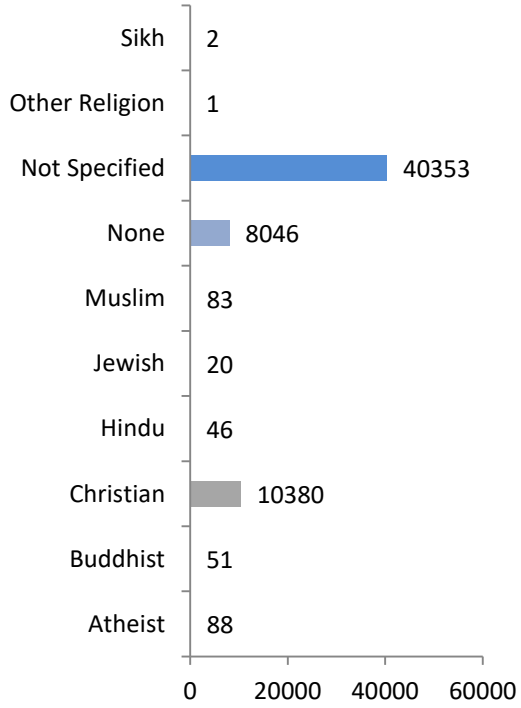
The number of transgender people and those with diverse gender identities is not accurately recorded at this time.

Transgender people have very specific protection against discrimination within the Gender Recognition Act 2014.This protects a trans person who intends to undergo, is undergoing or has undergone gender reassignment. In addition, good NHS practice dictates clinical responses be patient-centred, respectful and flexible towards all trans people including those who do not meet criteria but who live continuously or temporarily in their confirmed gender role.

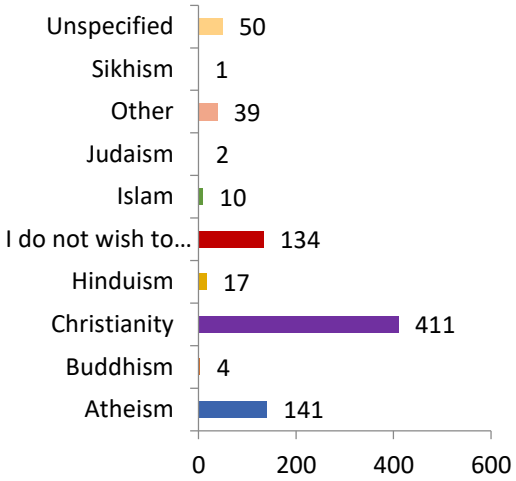
Religion/Belief

The question on religious affiliation in the census was introduced in 2011 and is voluntary. Those affiliated with the Christian religion remained the largest groups in the South West area (60.4%), with no religion (28.7%), Muslim (1%) and Hindu (0.3%).

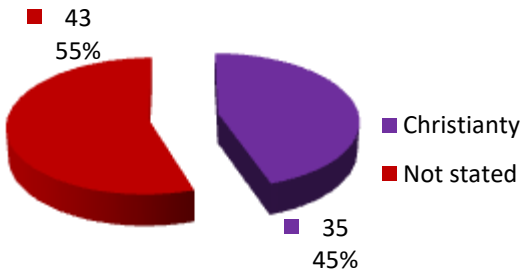
Our Patients



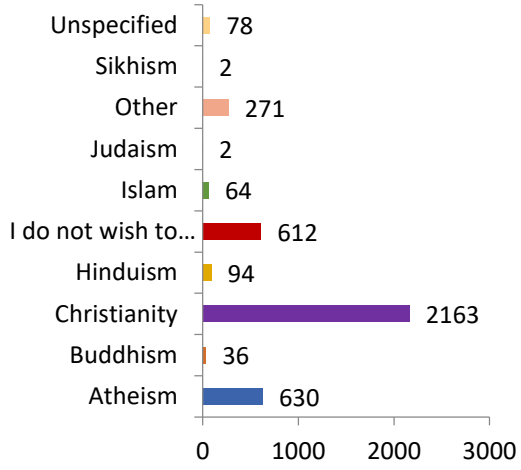
Our temporary workforce



Our Volunteers

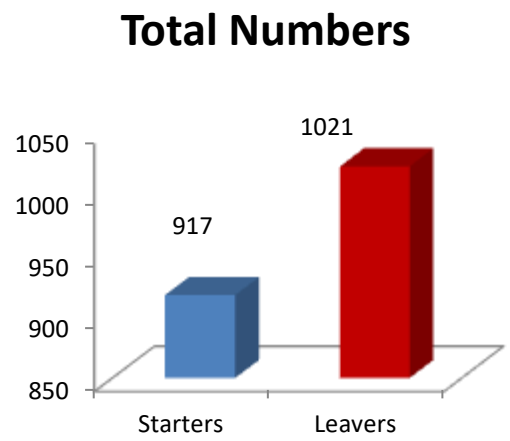


Our substantive workforce



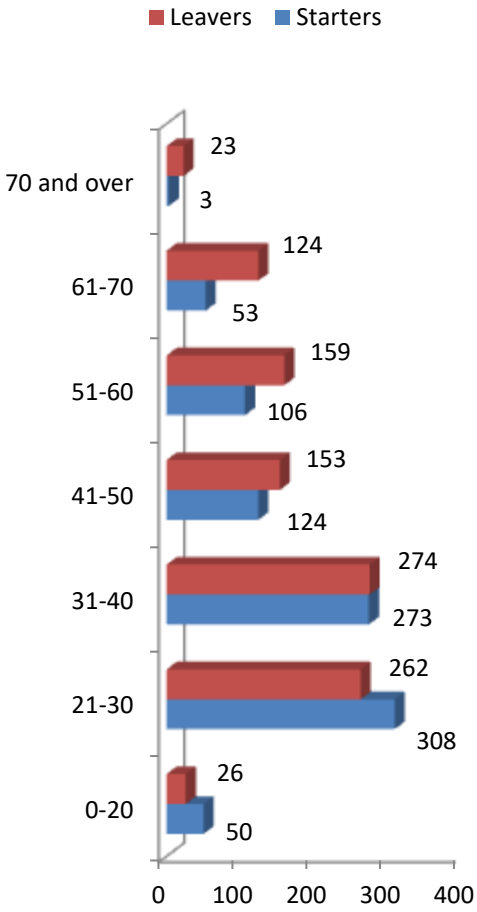
Appendix B

Starters and Leavers

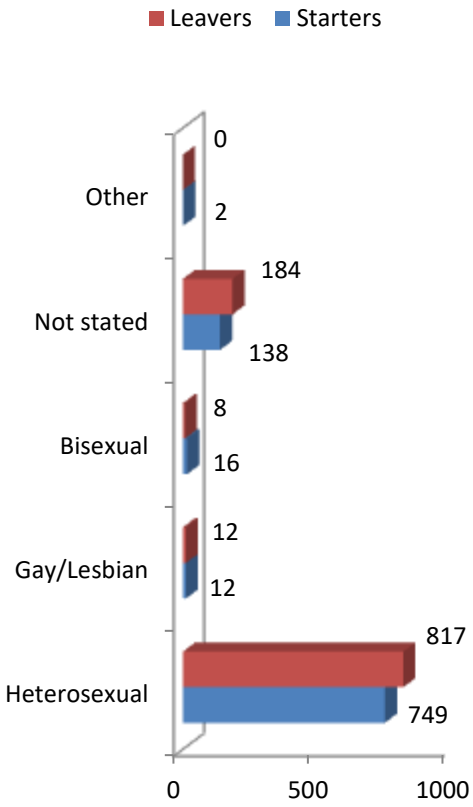


During 2020/21 1,021 people left the Trusts' employment. Over that period 917 people joined the Trust.

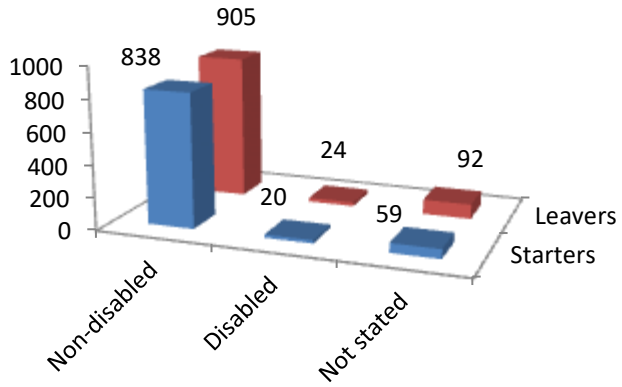
Age Profile



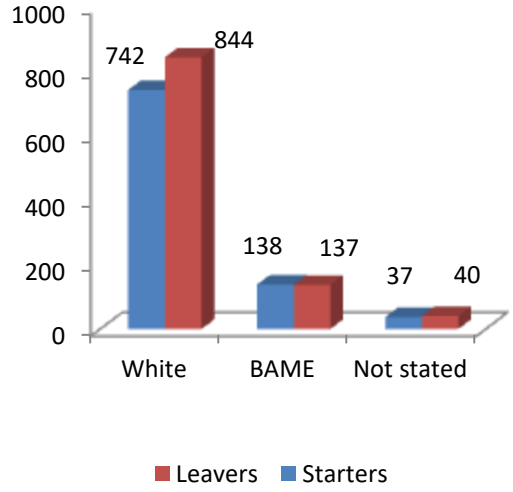
Sexual Orientation

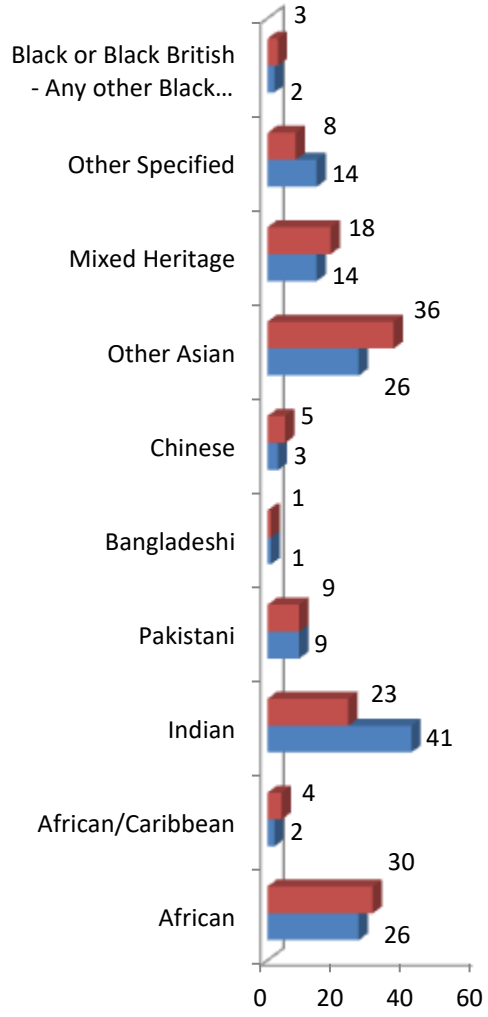


Disability

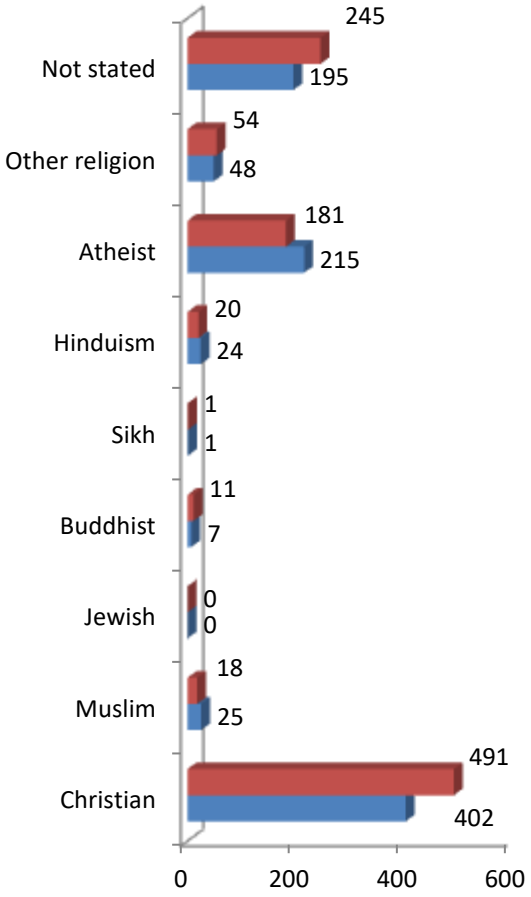


Ethnicity





Religion & Belief



Appendix C

Salisbury NHS Foundation Trust

Public Sector Equality Duty
Section 149 Equality Act 2010

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the general duty and all public authorities are adherent to the following obligations to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general duty is underpinned by a set of actions and assurances termed the specific duties. These serve as guidance on how the general duty can be met, through a range of actions and the provision of evidence in varied formats. The specific duties are to:

- Publish Information outlining how they will comply with the general duty by 31/1/2012 (Annually thereafter).

- Formulate at least one Equality objective

- All information published on how they will meet the equality duty must be presented in such a manner that it is accessible to the public.

Report to:	Trust Board (Public)	**Agenda item:**	**6.1**
Date of Meeting:	13th January 2021		

Report Title:	Emergency Preparedness Resilience & Response (EPRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Approval Process	Finance and Performance Committee			
Prepared by:	Tracey Merrifield – EPRR Manager			
Executive Sponsor (presenting):	Andy Hyett – EPRR Accountable Officer			
Appendices (list if applicable):	None			

Recommendation:

Recommendations:
The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to sign off this annual EPRR assurance report as part of the NHSE/I assurance process.

Purpose of Report:
To provide assurance to the Trust Board as part of the National EPRR Assurance process. The Trusts self-assessment against the National EPRR Core Standards has been confirmed by NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group and approved by NHSE/I, as delivering FULL assurance.

This report, through a summary of EPRR activity, including the assurance process and training and exercising demonstrates our compliance.

Background:
The Trust is defined as a category 1 responder under the Civil Contingencies Act and is subject to civil protection duties discharged through the EPRR assurance process.

Executive Summary:

Based on the National RAG status for EPRR compliance SFT has been rated by NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning and NHSE/I as 'Fully' compliant for the fifth consecutive year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).
Fully compliant means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve to the minimum level.

1. Purpose

This paper provides an annual report on the Trust's emergency preparedness in order to meet our statutory requirements of the Civil Contingencies Act (CCA) (2004) and the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework 2015 and NHS England Business Continuity Framework.

2. Background & Statutory Framework

The Civil Contingencies Act outlines a single framework and establishes clear roles and responsibilities. SFT are defined as a category 1 responder in the CCA and is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place Emergency Plans;
- Put in place Business Continuity Arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with local responders to enhance co-ordination;
- Co-operate with other local responders to enhance coordination

3. National EPRR Framework & Core Standards

The NHS England EPRR Frameworks contain principles for health emergency planning for the NHS in England and the NHS Core Standards for EPRR provides the minimum standards that an NHS organisation must meet.
It is expected that that the level of preparedness will be proportionate to the role of the organisation and the services provided:

- SFT must meet the minimum core standards and provide evidence these standards are being met
- SFT must identify an Accountable Office (Chief Operating Officer) who is responsible for ensuring these standards are met

4. NHS Bath and North East Somerset, Swindon and Wiltshire EPRR Assurance process 2020-21

The responsibility for undertaking the local assurance process for SFT was undertaken by the NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (CCG) in conjunction with NHSE/I. SFT provided the CCG with a core standard spreadsheet with each standard RAG rated with supporting evidence to support this rating.
Our self-assessment stated (August 2021): As part of the national EPRR assurance process for 2020/21, Salisbury NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against the core standards which are applicable to the organisation, Salisbury NHS Foundation Trust:

- Is compliant with all of the core standards: - the overall rating is 'Full'

The CCG conducted the 'confirm and challenge' meeting on 3rd November 2021, with Julie-Anne Wales, Director of Corporate Affairs and Data Protection Officer , Louise Cadle, Head of Emergency Preparedness Resilience and Response and Lorraine Binstead, Business

Support Administrator – EPRR (Emergency Preparedness Resilience Response) all from NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group. In attendance from SFT, Andy Hyett, Chief Operating Officer; Jane Dickinson, Deputy Chief Operating Officer and Tracey Merrifield, EPRR Manager.

The outcome letter detailed SFT progress:
The team in the last year has significantly increased (albeit some temporary), however this has been reflected in their full compliance rating and their ability to maintain a response to the NHS Alert level 3 and continue with many EPRR activities which would ordinarily be paused e.g., steering group meetings, training and exercising.
EPRR Awareness now forms part of mandatory training for all staff with various methods of learning - online, induction and an EPRR leaflet. An EPRR Awareness week was held 19-23rd July to showcase the EPRR function and share training opportunities with all staff. What a great way to showcase the work!

The final outcome letter was received on 18th November with the final compliance rating for SFT for EPRR Core Standards 2020/21 based on the National RAG status for EPRR compliance stating that SFT are rated in the 'Fully' category. See figure 1 below for compliance levels:

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis

Figure 1:

5. Training & Exercising

Statutory requirement set out that the Trust will undertake:

- Live Exercise – Every 3 years
- Table Top Exercise – Yearly
- Communication Test – Every 6 months

Please note the training and exercising Domain 5 of the Core Standards was removed from the Assurance self-assessment templates for 2020/2021.

A variety of training and exercising and live events have taken place in the last year, including despite the ongoing Level 4 / Level 3 Incident response to COVID-19.

See tables below in relation to training and awareness and exercises and live incidents:

Training August 2020 – to date

- Loggist Refresher Training 16/09/2020 (x2) , 29/09/20 (x1), 14/10/2020 (x1)
- Loggist New training 15/09/2021(x4) 30/09/2020 (x4)
- COVID Plan Stress testing table top 23/11/2020
- Legal Training – COVID the aftermath 16/03/2021 (x1), July session attended by (x1)
- Strategic Leadership in a Crisis 14/04/2021
- NPAG Resilience Group 22/09/2020, 6/01/2021, 11/05/2021
- EPRR Mandatory Overview Training 19/05/2021 (x2)
- Virtual HAZMAT Day 1 18/05/2021 (x4)
- Virtual HAZMAT Day 2 19/05/2021 (x4)
- BCAW 2021 Creating a common language to build resilience 17/05/2021 (x3)
- B BCAW 2021 Buying-in: How the best practitioners engage the business and embed BC & Resilience 18/05/2021 (x4)
- BCAW 2021 - Is now the opportunity we've been waiting for to embed business continuity into business operations?" (x1)
- Exercise Comet - National Burns Exercise 29/05/2021 (x5)
- SWAST CBRN Train the Trainer 28/05/2021 (x3)
- CBRN ED Training 16/12/2020 (x5), 15/06/2021 (x2)
- Spinal Unit Fire/Evacuation Exercise 09/06/2021

Training Scheduled which has been postponed (due to COVD-19 response)

- Exercise Alchemic 2 – CBRN Live Exercise June 2021 – postponed proposed to reschedule 2022

Table 2: Live Incidents, including internal incident responses August 2020 – to date

Type of Exercise/Live	Audience/Description	Date
COVID-19 Level 4 / Level 3 Response	Trust wide	Jan 2020 - to date
SSL Critical Incident	Steam Leak	27th April 2021
SSL Critical Incident	Chemical Spill	5th May 2021
SSL Critical Incident	Steam Failure	30th June 2021
Air Handling unit failure – asceptics	Air Handling Failure impacting Cancer Services	30th June – 24th August 2021

	(Chemotherapy)	
Theatre Crash System Failure	Theatre & DSU	4th August 2021
Water Cooler removal	Trust wide – removal of water coolers due to risk identified	19th August 2021
Beckton Dickinson – Blood tube supply issue	Trust wide (national response)	20th August – December 2021
SFT Operational Challenges due to ED Spike	ED / SWAST	9th September 2021
SSL Critical Incident	Steam Failure	14th September 2021
Operation Zambezi	Train Crash – Fisherton Tunnel Salisbury	31st October 2021
Entonox shortage	Maternity	02nd November 2021
Theatre Pest Issue	Theatre 7	10th November 2021

All exercises and live events are debriefed so lessons learnt and action plans can be captured, and plans updated/modified as required.

6. 2020/21 Exercising Schedule – dates planned

Live Exercises	Table Tops	Communications Test	Training
CBRN Exercise Alchemic 22nd June 2021	Clinical Governance Day – Radiology BCP TBX 05/4	Everbridge MI Cascades adhoc – no notice	NPAG February / May / September
DWFRS Live Exercise TBC	Burns MI - postponed 2021 TBC		Loggist Training March / September / December
	Trust-wide Emergo TBC		Rapid Response Team PRPS Training

7. Partnership Working

Externally the Trust is embedded in multi-agency planning through the Wiltshire & Swindon Local Health Resilience Partnership LHRP. This ensures a proactive and coordinated approach to planning and sharing of best practice. The Trust participates on a regular basis on the Everbridge SWAST communications cascade as well as regular Health Community Response Plan activities, and actively works on the LHRP task and finish groups where appropriate and works with partners with the coordinated planning of the modular response tool iRespond which has been implemented across the Health economy in Wiltshire, the work of the LHRP has all been completed virtually during 2020. SFT have also been supporting GWH and Gloucester Hospitals with sharing of documentation during the COVID-19 Response, due to EPRR staff changes and challenges.

This partnership working has been strengthened further with the multi-agency partnership working during the continued Level 4 (National) / Level 3 (Regional) response to COVID-19, where partners have worked together and forged greater relationships with partners.

There has also been the establishment of the SW EPRR Acute Provider Forum, which is led by NHSE, and from this group there have been a number of task and finish sub groups established for which SFT have been represented at. In addition the EPRR SW Forum

which is Chaired by Dickie Head and supported by Libby Beesley, John Wintle and Tracey Merrifield for group preparation, agendas etc., a group for Acute Trusts which is attended by member of the regional NHSE EPRR team.

8. Identified Gaps in EPRR portfolio & Next Steps

Gaps	Action	Date
Instigate a switchboard automated procedure for our internal cascade procedures	Investigate options e.g. Confirmer, PageOne and Everbridge	2022
In a mass casualty type MI response, ED currently revert to paper, need to enact an electronic module to enable the flow throughout the organisation which rely on patient ID e.g. the laboratories, theatres etc.	Investigate with Informatics the use of the MI module in Lorenzo	Work progressing with ED and Informatics 2022
Maintain compliance against the core standards and improve on these minimum standards	To ensure we maintain full compliance at the next Core Standards CCG Confirm and Challenge meeting	August 2022
Continue to build on the links with the Wessex network of the LHRP, to ensure a consistent approach for response to an incident linking the Trauma Centre and Units and to build on the relationships and sharing with MTW	Continued participation in regional exercising, building on links with partners at other organisations	2022
Emergo Table top Trust - Wide		TBC Sept 2022
Continue to raise awareness of EPRR so its fully embedded and understood by all, to build on the 2021 EPRR Awareness Week	EPRR Awareness Week	Date TBC

In spring 2021, the Trust agreed to fund two EPRR Officers, one WTE Permanent and one WTE Secondment; this was in addition to the existing EPRR Officer 0.6 WTE. The posts were advertised in February; interviews took place in March and recruited to both posts in May 2021.

The successful recruitment to these posts has enabled us to plan and commit to a number of incidents, and training and exercising in 2021 while maintaining our response to the Pandemic and EPRR being the single point of contact and maintaining the functions of the Incident Coordination Centre and enhancing our EPRR resilience internally.

In addition the team has been supported at weekends by a team of three bank staff or work on rotation to provide support to the EPRR team with the weekend reporting of the daily COVID situational reports.

9. Summary

Based on the National RAG status for EPRR compliance SFT has been rated by NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group and NHS England as 'Fully' compliant for the fifth consecutive year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).
Full compliance means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve.

10. Recommendation

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to support the work required within the EPRR portfolio as we transition into the Integrated Care System (ICS) Structures in 2022 and to approve this full compliance statement by signing off this annual EPRR assurance report as part of the NHS England assurance process.

NHS
Bath and North East Somerset,
Swindon and Wiltshire
Clinical Commissioning Group

6 January 2022

Leigh Clarke
Head of Emergency Preparedness, Resilience and Response
NHS England and NHS Improvement
Via Email

Dear Leigh

EPRR Core Standard 2021/22 Provider assurance summary.

This assurance summary has been completed by Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group in fulfilment of the NHSEI South West EPRR Core Standards assurance process. The summary includes the following elements:

1. Final provider assurance levels for the last three years
2. Details of partially compliant organisations
3. Areas of notable EPRR best practice
4. LHRP considerations for EPRR improvement/development activity

The summary findings of providers should be noted in the context of responding to a protracted Covid-19 incident response, EU Exit and continued demand and capacity challenges. It would also be fair to say that BSW has had a number of 'curve balls' thrown into the ongoing response which has meant any return to business-as-usual activity for EPRR colleagues hasn't been as successful as hoped because a number of response plans and support has had to be prepared at pace e.g., Managed Quarantine Service, humanitarian repatriation efforts in support of Afghanistan, Bridging Hotels and an Asylum Seeker hotel.

Also, the assurance compliance ratings have changed from full / substantial / partial to full or partial which does suggest most providers assurance compliance has declined however when you analyse returns many would have remained at substantial.

Provider Assurance levels:

Organisation	2019	2020	2021
Great Western Hospital NHS Foundation Trust	Substantial	Substantial	Partial
Royal United	Substantial	Substantial	Partial

Organisation	2019	2020	2021
Hospital NHS Foundation Trust			
Salisbury NHS Foundation Trust	Full	Full	Full
Medvivo	Full	Full	Full
Virgin Care BaNES	Partial	Substantial	Partial
Virgin Care Wiltshire	Substantial	Substantial	Partial
Wiltshire Health and Care	Substantial	Substantial	Partial

Partially Compliant Providers:

Organisation:	**Great Western Hospital NHS Foundation Trust (GWH)**
Summary of compliance concerns:	Areas of partial compliance full largely into: 1. EPRR resource (core standard 5) 2. Governance (core standard 3) 3. Risk (core standard 7 & 8) 4. Business Continuity (core standard 48 & 53)
Summary of Provider improvement monitoring process:	**EPRR resource (core standard 5)** GWH EPRR staffing resource has increased in the last year to 2 x FTE EPRR posts, by withdrawing EPRR resource support to Wiltshire Health and Care in 2020. Unfortunately, the EPRR Manager has been on long-term sick and subsequently left the organisation. During this period the EPRR Officer stepped up to cover and additional interim resource was put in place to support the ongoing response to Covid-19. A review of responsibilities and salary grading has meant the EPRR Manager has recently been advertised with interviews to take place 22nd November where it is hoped the post will be filled. *Action – BSW CCG Head of EPRR is part of the interview process and will feedback to NHSEI on the outcome of the interview.* **Governance (core standard 3)** As the EPRR assurance was a light touch in 2020, a Board report was not submitted 2021 however a full report of EPRR activity will be tabled in January 2022. *Action – A copy of the Board report will be shared with BSW CCG January 2022.*

	Risk (core standard 7 & 8) An EPRR steering group has been established to provide a robust governance structure to ensure consistency and corporate ownership of EPRR and associated risks. A review of the risk process is underway to fully incorporate EPRR risks as part of GWH Corporate Risk Management Programme to ensure any EPRR risks are reviewed alongside the organisation's risk process. This review will be completed and embedded by March 2022 *Action – BSW CCG Head of EPRR is monitoring progress of this action and with the intention of completion by March 2022* **Business Continuity (core standard 48 & 53)** CS 48 - Following events over the last 18 months, GWH are reviewing their Business Continuity Policy as part of an overhaul of processes. This is to be agreed by June 2022. CS 53 – A more formal audit process is being developed and integrated in to the governance structure. Learning will be incorporated into plans and reported within the Board report in January 2022. *Action – BSW CCG Head of EPRR is monitoring progress of this action and will feedback on progress with the intention of completion by June 2022*
Summary of any support requested/ required:	No support has been requested. BSW CCG has shared its EPRR Corporate Risk Register with GWH for information.

Organisation:	**Royal United Hospital NHS Foundation Trust**
Summary of compliance concerns:	Areas of partial compliance full largely into: 1. Business Continuity 2. CBRN/Hazmat planning
Summary of Provider improvement monitoring process:	**Business Continuity (core standard 51 and 53)** An internal review of business continuity is underway following events over the last 18 months with a series of planned internal audits to review and agree divisional plans. *Action – BSW CCG Head of EPRR is monitoring progress of*

	this action and will feedback at quarterly intervals. **CBRN / Hazmat Planning arrangements (core standard 57 and 59)** A new decontamination unit has been established at RUH to replace an out-of-date unit providing robust arrangements for decontamination. This means that the trust's CBRN response plans remain mostly valid however because of changes to the estate and storage of kit, plans need to be amended to reflect the new unit. *Action – RUH EPRR team to review procedures in the next month as some hard FM is planned in the next week. Once the unit is fully functioning all staff will be provided with training on the new unit and refresher as appropriate.* *A live CBRN decontamination exercise will be carried out with the new unit to consolidate plans and training.* *BSW CCG Head of EPRR is monitoring progress of this action and will feedback at quarterly intervals.*
Summary of any support requested/ required:	Potential support required for the CBRN Live exercise.

Organisation:	**Virgin Care BaNES**
Summary of compliance concerns:	Areas of partial compliance full largely into: 1. Mass Casualty 2. Shelter & Evacuation 3. Lockdown
Summary of Provider improvement monitoring process:	**Mass Casualty (core standard 18)** This core standard is marked as partial however it should be noted that Virgin Care does have robust surge and capacity plans that would be utilised to support any mass casualty scenario whether that be supporting P3 'walking wounded' or escalated discharges to support admissions to acute trusts. Virgin Care are keen to review their mass casualty plans and align to any lessons identified from Salisbury rail crash and the recently updated BSW Emergency Treatment Centre Plan. *Action – BSW CCG Head of EPRR is monitoring progress of this action and will feedback at quarterly intervals.*

	Shelter and Evacuation (core standard 20) Virgin Care has a unique role within incident response being a provider of NHS services and Local Authority social care. This core standard is marked as partial because detailed planning is underway in supporting BaNES Council in their rest centre plans and a training programme is underway for Virgin Care staff. From an NHS perspective Virgin Care has plans in place for its staff and patients in relation to shelter and evacuation. This partial compliance is in relation to the local authority support only. **Lockdown (core standard 21)** Processes for locking down sites need to be reviewed (although they have been tested on several occasions over the last year when inpatient areas were closed for infection prevention). With the changes to sites, fewer people working in offices, plans are due a review *Action – BSW CCG Head of EPRR is monitoring progress of this action and will feedback.*
Summary of any support requested/ required:	CBRN / Hazmat – it was felt that plans and further training could be carried out for MIU staff. This will be picked up as part of the LHRP work plan. Strategic Leadership in an Emergency – several new senior members of staff have come into post and will require training going forward. Support for delivering SLE training would be helpful.

Organisation:	**Virgin Care Wiltshire**
Summary of compliance concerns:	Areas of non-compliance full largely into: 1. Business Continuity
Summary of Provider improvement monitoring process:	**Business Continuity (core standard 50)** Business Continuity plans are in place but a review is required to incorporate changes to services following on from lessons identified over the last year. Virgin Care – however are confident their plans are still fit for purpose should a business continuity incident impact them.

	Action – plans to be reviewed by Spring 2022.
Summary of any support requested/ required:	Strategic Leadership in an Emergency – several new senior members of staff have come into post. Support for delivering SLE training would be helpful.

Organisation:	**Wiltshire Health and Care**
Summary of compliance concerns:	Areas of non-compliance full largely into: 1. Business Continuity Audit (core standard 53) 2. Equipment and supplies (core standard 60) 3. Staff training decontamination (core standard 68)
Summary of Provider improvement monitoring process:	**Business Continuity (core standard 53)** There is an outstanding action around governance processes for WHC Audit Committee to align business continuity into the risk process. A meeting is being held on 16th November 2021 to address this with further quarterly meetings to be put in place to review. **Equipment and supplies (core standard 60)** A review of equipment and supplies hasn't been carried out in 2021. This will be rectified by the end of March 2022 alongside a review of training for CBRN Hazmat response arrangements. There are ample stocks of supplies, but a formal inventory record hasn't been carried out. *Action – BSW Head of EPRR to review action in the next quarter.* **Staff Training decontamination (core standard 68)** MIUs have been closed for walk in appointments until very recently and with staff changes, there is a requirement to provide basic CBRN training to frontline staff working in the MIUs. Work is underway to complete this *Action – BSW Head of EPRR to review action in the next quarter.*
Summary of any support requested/ required:	As with Virgin Care BaNES it was agreed that the CBRN / Hazmat – it was felt that plans and further training could be carried out for MIU staff. This will be picked up as part of the LHRP work plan.

Areas of notable EPRR good practice:

As a system the last year has strengthened relationships with the number of additional challenges that have occurred alongside the protracted response to Covid-19, disruption of supplies, establishment of a Managed Quarantine Hotel, Asylum Seeker Hotel and two Bridging Hotels as well as continued demand and capacity impacting all providers across health and social care. BSW could not have managed without all health and social care partners input and indeed support from both Avon & Somerset and Wiltshire & Swindon (W&S) Local Resilience Forum (LRF) colleagues.

Mutual Aid

The close operational and tactical working across BSW and both LRFs meant that support from other Category One responders was offered in support of staffing challenges in NHS organisations and support with use of venues for the Covid-19 Vaccination programme.

Staffing was utilised with the acutes for portering, HR support to recruitment for vaccination programme, staff supporting the vaccination centres, staff to assist in the hospital mortuaries moving bodies from wards to the mortuary and meeting funeral directors, security guidance around vaccination sites and direct support with anti-vaxx protests experienced.

Notwithstanding robust communication arrangements with sharing of public messages warning and informing the public where appropriate e.g., sharing of vaccination programme across their networks thus reaching a far wider audience.

It should be noted that all providers have stepped up over the last year to offer support whether that be staff, supplies and or clinical equipment.

NHS Support to Managed Quarantine Hotel, Asylum Seeker Hotel and two Bridging Hotels

These 3 projects were led by national government departments and set up at short notice with little guidance or direction to the local teams expected to support the facilities. An NHS group was pulled together supported by W&S LRF to agree patient pathways for the 3 facilities that meant guests in the facilities had the most appropriate level of healthcare and alleviated as much pressure as possible on local NHS organisations by collaborative working, jointly agreed risks, and robust information sharing.

Training and Exercising

Several Strategic Leadership in Emergencies were delivered across BSW system which involved all providers as well as CCG on-call, this enabled on-call staff to network and run through some short typical scenarios.

A paediatric surge exercise was delivered in August to help review current plans and inform preparation of a BSW Paediatric Surge escalation and triggers plan. An exercise is planned for 23rd November to test the agreed plan.

Medvivo

Medvivo have been a key partner over the last year, their strengths lie with their ability to be flexible in their support and whilst many of the EPRR core standards do not apply to them, they do consider where their support could be of value and what they can do to assist all parts of the system. Medvivo have been assessed as fully compliant.

Great Western Hospital (GWH)

GWH have had to review their service delivery plans to support many 'curveballs' thrown at them, particularly in support of the MQF, Bridging hotels and Asylum Seeker Hotel. These have been done at pace and it has been helpful that many staff from GWH have been involved in the preparations and response to this. This has meant the support has been evidenced as corporate ownership.

Throughout Covid-19 – their internal email briefings should be held as a matter of good practice – they are informative short and concise. In the early days they were daily but have now moved to when required or weekly. Also, staff were invited to nominate staff or services who went over and above and this was shared as part of the briefing. Also, at the start of the incident, staff were invited to nominate a song in relation to how they were feeling, and this was pulled together as a playlist for all staff to listen too!

Royal United Hospital (RUH)

The EPRR team sought financial funding to renew their CBRN decontamination unit. The previous unit was old, outdated and potentially would not have worked. A new unit and associated storage capacity were agreed and is currently being put in place. We are told it's the Rolls Royce of all units!

The unit is about to go live and will be exercised with a live exercise in the New Year.

Salisbury Foundation Trust (SFT)

The team in the last year has significantly increased (albeit some temporary), however this has been reflected in their full compliance rating and their ability to maintain a response to the NHS Alert level 3 and continue with many EPRR activities which would ordinarily be paused e.g., steering group meetings, training and exercising.

EPRR Awareness now forms part of mandatory training for all staff with various methods of learning - online, induction and an EPRR leaflet. An EPRR Awareness week was held 19-23rd July to showcase the EPRR function and share training opportunities with all staff. What a great way to showcase the work!

Virgin Care – BaNES and Wiltshire

Despite a significant role in the protracted response over the last year EPRR leads have worked tirelessly to keep their EPRR workstreams on target. The BaNES team also have the dual role of providing NHS support and also social care provision so close work is underway with BaNES Local Authority to ensure rest centre support is provided.

Wiltshire Health & Care

A review of on-call arrangements has taken place and on-call rota is now split into two, this has provided staff with confidence in their respective roles and enabled more dedicated training:

1. on-call for patient facing / staffing issues supported by those staff who deal with this daily
2. on-call for EPRR type of issues

Common challenges/issues:

Common themes that have been identified across all organisations is the inability to resume normal business as usual activities because of the longevity of the incident response and the amount of additional time that has had to be spent pulling procedures and services together to coordinate the response to some of the additional 'curveballs' thrown in some of which haven't necessarily impacted other EPRR teams across the South West. Many of the processes and response arrangements have had to be built from scratch because of this.

Review of business continuity plans is an area that will need a review over the next year noting the changes to many organisations and service delivery models.

Whilst training and exercising has been delivered it has been virtual and it's not always as effective when people are behind screens, and you lose the richness of conversations that would have been held in person.

Staff fatigue as a result of the protracted response and continued demand and capacity must not be underestimated.

LHRP Considerations for EPRR improvement/ development activity:

Work has commenced slowly on reviewing the LHRP response arrangements and capabilities building on what has been identified over the last 18 months.

CBRN and Strategic Leadership in Emergencies will be picked up as part of the LHRP Work Plan.

The teams across BSW should be commended for their hard work and continued support over the last year.

Deep Dive – re Piped Oxygen resilience

As discussed with NHSEI, providers have submitted the deep dive assurance where appropriate within their assurance returns. These will be shared with estates leads across the system as well.

Please could you confirm in response to this letter and whether you would like to challenge any elements of our assurance process.

Yours sincerely,

Julie-Anne signature

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.2
Date of Meeting:	13 January 2022		

Report Title:	Register of Seals			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			
Approval Process (where has this paper been reviewed and approved)	Approved by Lisa Thomas, Director of Finance and Stacey Hunter, Chief Executive			
Prepared by:	Sasha Grandfield, PA and Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices				

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in July 2021. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Register of Seals entries

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
367	17/12/2021	Premises at a new health care centre, Westbury Leigh, Westbury, Wiltshire	Laurence Arnold	Lisa Thomas	Stacey Hunter

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

Report to:	Trust Board (Public)	**Agenda item:**	6.3
Date of Meeting:	13 January 2022		

Report Title:	Salisbury Hospital NHS Foundation Trust Constitution			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				☒
Approval Process (where has this paper been reviewed and approved)	Approved at Board Ratified by Council of Governors (Feb 2022 meeting)			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Constitution V2.2			

Recommendation:
The Board is asked to recommend approval of the constitution to the Council of Governors.

Executive Summary:
The Trust's constitution was completely revised at the end of 2020 and approved in early 2021. The constitution has been reviewed as part of the annual process and no significant changes have 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) -	☐

Salisbury
NHS Foundation Trust

SALISBURY NHS FOUNDATION TRUST

CONSTITUTION

Post Holder Responsible for Policy:	Director of Integrated Governance
Directorate Responsible for Policy:	Chief Executive's
Contact Details:	Ext: 2774
Date Written:	2005
Date Revised:	January 2022
Approved by:	Council of Governor's/ Trust Board
Date Approved:	
Next Due for Revision:	January 2023
Date Policy Becomes Live:	

CONTENTS:

Version No.	Updated By	Updated On	Description of Changes
1.0	Director of Corporate Governance	See amendment history below	
1.1	Director of Corporate Governance	April 2020	Annex 9 Updated
2.0	Director of Corporate Governance	October 2020	Complete revision
2.1	Corporate Governance Manager/ Membership Manager	December 2020	Further amendments as per amendment history below agreed at CoG.
2.2	Head of Corporate Governance	January 2022	No significant changes – annual review

Amendment history – 2013 to 2019

- **2014:**
  - The addition of paragraph 21 of the Council's Standing Orders was approved by the Council on 21 July 2014
- **2016:**
  - Amendment of paragraph 37 of the Constitution was approved by the Board of Directors on 29 February 2016 and by the Council of Governors on 11 April 2016.
  - The new Model Election Rules were issued by the former Foundation Trust Network (NHS Providers) in August 2014 and formally adopted by the trust on 29 February/11 April 2016
  - Amendment of paragraph 16 of the Council's standing orders was approved by the Council on 16 May 2016.
- **2018:**
  - April 2018 minor amendments to Board Standing Orders
  - Addition of Standing Financial Instructions – approved February 2018
- **2019:**
  - Amendment of Annex 1 to a) insert the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency; (b) delete West Wiltshire as a constituency; (c) increase the number of governors for the South Wiltshire Rural Constituency from 5 to 6. – approved November 2019.
- **2020**
  - Annex 8 Standing Orders of the Board of Directors has been completely revised and is included as an appendix to the Constitution.
  - The wards and constituencies have been updated. This includes merging West Wiltshire into South Wiltshire Rural. North Dorset and East Dorset constituencies have also been updated based on the electoral ward.
  - Within Annex 2 the Hotel and Property Class in the Staff Constituency is merged with the Clerical, Administrative and Managerial staff class. The name has been amended to "Administrative, Facilities and Managerial".
  - The unused paragraphs have been removed and the document renumbered and reformatted to reflect this.

1 Interpretation and definitions

1.1 Unless otherwise stated, words or expressions used in this constitution have the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

1.2 Words importing the masculine gender only shall include the feminine gender. Words importing the singular shall import the plural and vice versa where it is appropriate that they do so.

1.3 The 2006 Act is the National Health Service act 2006 as amended at any time, and the 2012 Act is the Health and Social Care Act 2012 as amended at any time.

1.4 Monitor is the corporate body known as NHS Improvement, as provided by section 61 of the 2012 Act.

1.5 Constitution means this constitution and its annexes (save that the standing orders set out for convenience in annexes 7 and 8 are not part of the constitution). It comes into effect when it has been approved both by more than half of the members of the Council of Governors voting, and by more than half of the Board of Directors voting.

1.6 The Accounting Officer is the person who discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

1.7 The Code of Conduct is the Code of Conduct as set out in the Standing Orders of the Council of Governors.

2 Name

2.1 The name of the foundation trust is the Salisbury NHS Foundation Trust, and the Trust means that trust.

3 Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to–

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in this paragraph for the purpose of making additional income available in order better to carry out its principal purpose.

3.5 The Trust may carry out research in connection with the provision of health care, and may make facilities and staff available for the purposes of education, training or research carried on by others.

4 Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5 Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 A public constituency

5.1.2 A staff constituency

6 Application for Membership

6.1 An individual who is eligible to become a member of the Trust shall become a member on his application to the Trust to become a member or by being invited by the Trust to become a member of the staff constituency in accordance with paragraph 9.

7 Public Constituencies

7.1 The public constituencies are the areas specified in Annex 1 and individuals living within them may become members of the Trust.

7.2 The individuals who live in the areas so specified are referred to collectively as a Public Constituency.

7.3 An individual who ceases to live in the areas specified in Annex 1 shall cease to be a member of the Trust. A member who moves from one such area to another shall continue to be a member but shall have a right to vote in any election of governors in accordance with the new area.

7.4 The minimum number of members in each Public Constituency is specified in Annex 1, and if the number of members does not equal or exceed the minimum the area shall not be treated as a Public Constituency for the purpose of electing governors.

8 Staff Constituencies

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust other than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided that they have exercised these functions continuously for a period of at least 12 months.

8.3 Individuals eligible for membership of the Trust under this paragraph are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into 5 classes of individuals as set out in Annex 2

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2, and if the number of members in a class does not equal or exceed the minimum number that class shall not be treated as a class for the purpose of electing governors.

9 Automatic Membership by default – Staff

9.1 An individual who is:

9.1.1 Eligible under paragraph 8.1 to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency, shall become a member of the Staff Constituency and in the appropriate staff class without an application being made, unless they inform the Trust that they do not wish to do so.

10 Patients' Constituency

There is no Patients' Constituency

11 Restrictions on Membership

11.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while such membership continues be a member of any other constituency or class.

11.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any other constituency.

11.3 An individual must be at least 16 years old to become a member of the Trust.

11.4 An individual may not become or remain a member of the Trust if they have been convicted of any offence involving violent, threatening or abusive behaviour on Trust property or in connection with receiving services from the Trust.

11.5 A member of the Trust shall inform the Secretary of the Trust of any circumstances which may affect their entitlement to be a member.

11.6 Where the Trust has reason to believe that a person may be disqualified from becoming a member or no longer entitled to be a member, the Secretary may give the member 14 days written notice to show why he should not become or remain a member. On receipt of such response as may be made by the member, or failing any response, the Secretary may, if he considers it appropriate, refuse the application to become a member or remove the member from the register of members. If the person wishes to dispute a decision of the Secretary not to admit him to membership or to remove him, he may refer the issue to the Council of Governors, whose decision by a majority of the governors voting shall be final.

11.7 A member may resign by written notice to the Secretary of the Trust.

12 Annual Members' Meeting

12.1 The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public. This should be held no later than 30th September.

13 Council of Governors - Composition

13.1 The Trust is to have a Council of Governors comprising both elected and appointed governors.

13.2 The composition of the Council of Governors is specified in Annex 4.

13.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency or class is specified in Annex 4.

13.4 No person may stand for election as a governor or be appointed as a governor unless he will be at least 18 years old when he becomes a governor.

14 Council of Governors – Election of Governors

14.1 Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules current at the time of the election.

14.2 The Model Election Rules are those as published from time to time by the Department of Health, and form part of this Constitution. The Rules current at the time of the coming into effect of this constitution are set out in Annex 5.

14.3 A subsequent variation of the Model Election Rules by the Department of Health does not constitute an amendment of the constitution for the purpose of paragraph 48 hereof (amendment of the constitution).

14.4 An election, if contested, shall be by secret ballot.

14.5 In the event of an elected governor ceasing to hold office, if there are then more than 15 months of his term of office left after his resignation, ceasing to hold office or death, then an election shall be held for his replacement. The person elected shall hold office for the remainder of the period for which the governor he is replacing was last elected.

15 Council of Governors - Tenure

15.1 Subject to 14.5 and 15.2, an elected governor may hold office for a period of up to 3 years.

15.2 An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than 9 years in all.

15.3 An appointed governor may hold office for a period of up to 3 years and may then be re-appointed but shall not hold office for more than 9 years in all. He shall cease to hold office if his appointing organisation withdraws its appointment of him by notice in writing to the Trust or if the appointing organisation ceases to exist.

15.4 A governor may resign by giving notice in writing to the Chairman of the Trust.

15.5 In the event of an appointed governor ceasing to hold office, the body appointing him may make a further appointment.

15.6 The limits of 9 years in sub-paragraphs 15.2 and 15.3 shall in the case of an elected governor include any time served as an appointed governor, and in the case of an appointed governor include any time served as an elected governor.

16 Council of Governors – Disqualification and Termination of Office

16.1 The following may not stand for election or continue as a member of the Council of Governors:

16.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

16.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

16.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

16.1.4 The further persons set out in Annex 6.

16.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

16.3 If a governor fails to attend 3 consecutive scheduled meetings of the Council of Governors, he shall cease to be a governor unless a voting majority of the other governors are satisfied that:

16.3.1 the failure was in their opinion due to a reasonable cause or causes, and

16.3.2 he will be able to, and will, start attending meetings of the Council within such period as they consider reasonable.

16.4 A governor shall cease to be a governor if he is adjudged by not less than 75% of the remaining Council of Governors to have:

16.4.1 acted in a manner inconsistent with the core principles set out in the Trust's authorisation, or with the Constitution, or with the Code of Conduct, in such a way that he should cease to be a governor, or

16.4.2 failed to declare a material interest pursuant to paragraph 21 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

16.5 Where circumstances arise which give rise to an issue as to a governor's ability to remain a governor (other than those referred to in paragraphs 16.3 and 16.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

16.6 In the event of a notice being given under sub-paragraph 16.3 which states that the governor is not resigning, or where no such notice is received but circumstances as to a governor's ability to remain a governor (other than those set out in paragraphs 16.3 and 16.4 above) come to the notice of the Trust, the issue shall be considered by the other governors at a meeting and if 75% of the remaining Council of Governors consider that the governor is disqualified from continuing as a governor, he shall cease to be a governor.

16.7 A governor shall not exercise any function as a governor (including attending any meeting of the Council as a governor) if he has not signed and delivered to the Secretary a statement in the form required by the Council confirming that he accepts the Code of Conduct.

16.8 If a governor who is an employee of the Trust is suspended as an employee as a part of a disciplinary process, the Chairman of the Trust may suspend the governor from acting as a governor while the governor remains suspended as an employee.

17 Council of Governors – Duties of Governors, Equipping Governors, Lead Governor and Deputy Lead Governor

17.1 The general duties of the Council of Governors are–

17.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

17.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

17.2 The Trust must take steps to secure that the governors are equipped with the skills and with the knowledge that they require in their capacity as governors.

17.3 The governors shall choose a Lead Governor and a Deputy Lead Governor as set out in the Council's standing orders. The Lead Governor and the Deputy Lead Governor shall have the functions set out in the standing orders.

18 Council of Governors – Meetings of Governors

18.1 The Chairman of the Trust, that is the Chairman of the Board of Directors, or in his absence, the Deputy Chairman or, in his absence, the Lead Governor (or Deputy Lead Governor), shall preside at meetings of the Council of Governors.

18.2 Where it is inappropriate by reason of the subject matter of a meeting that it should be chaired by the Chairman, the Deputy Chairman may preside unless it is also inappropriate that the Deputy Chairman preside, in which case the Lead Governor or in his absence the Deputy Lead Governor may preside.

18.3 Meetings of the Council of Governors shall be open to members of the public, but the public may be excluded from all or any part of the meeting by resolution of the Council for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

18.4 The Council of Governors shall meet at least 4 times a year, including an annual meeting no later than 31 October when the Council shall receive and consider the annual accounts, any report of the Auditor on them, and the Trust's annual report. The meetings shall be called by the Secretary after consultation with the Lead Governor.

18.5 The Lead Governor (or in the case of the Lead Governor's unavailability the Deputy Lead Governor) or at least 10 governors may, by written notice to the Secretary stating the business to be considered, requisition a meeting of the Council, and the Secretary shall arrange for a meeting to be held as soon as practicable after notice has been given to the governors.

18.6 For the purpose of obtaining information about the Trust's performance of its functions or the directors performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18.7 The Council of Governors will establish statutory committees to carry out such functions as are required by law and to carry out such functions as the Council specifies.

18.8 The Council of Governors will establish working groups to carry out such functions as the Council specifies.

19 Council of Governors – Standing Orders

19.1 The Council of Governors shall adopt standing orders for the practice and procedure of the Council. Those in force as at the date of the adoption of this constitution are set out in Annex 7. They may be amended as provided in them.

20 Council of Governors – Referral to the Panel

20.1 In this paragraph the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

20.1.1 to act in accordance with its constitution, or

20.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

20.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

21 Council of Governors – Conflicts of Interest of Governors

21.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21.2 For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

22 Council of Governors – Travel Expenses

22.1 The members of the Council of Governors are not entitled to remuneration, but the Trust shall on application pay travelling and other expenses incurred by a member for the purpose of his duties at rates to be decided by the Trust.

23 Board of Directors – Composition

23.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 a maximum of 7 other non-executive directors

23.2.3 a maximum of 6 executive directors (subject to 23.4 below), to include:

23.2.4 a Chief Executive who shall be the Accounting officer,

23.2.5 a Finance Director.

23.3 One of the executive directors must be a qualified medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and one must be a registered nurse or midwife.

23.4 The number of non-executive directors including the Chairman must always exceed the number of executive directors. At any meeting where there is parity of non-executive and executive directors the Chairman, or in his absence the Deputy Chairman, shall have a casting vote.

23.5 Only a member of a public constituency or the patients' constituency is eligible for appointment as a non-executive Director.

24 Board of Directors – General Duty

24.1 The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25 Board of Directors – Appointment and Removal of Chairman and Non-executive Directors

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the Trust and the other non-executive directors.

25.2 Removal of the Chairman or any other non-executive director shall require the approval of 75% of the members of the Council of Governors.

25.3 The Standing Orders of the Council shall provide for nomination committees to identify appropriate candidates for appointment as Chairman and as non-executive directors.

26 Board of Directors – Deputy Chairman

26.1 After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chairman. The Deputy Chairman shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

27 Board of Directors – Appointment and Removal of the Chief Executive and Executive Directors

27.1 The non-executive directors shall appoint or remove the Chief Executive.

27.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

27.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

28 Board of Directors – Disqualification

28.1 The following may not be appointed or continue as a member of the Board of Directors:

28.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

28.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

28.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

28.1.4 The persons referred in Annex 9.

29 Board of Directors – Meetings

29.1 Before holding a meeting the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

29.2 As soon as practical after holding a meeting the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

29.3 Meetings of the Board of Directors shall be open to members of the public.

29.4 Members of the public may be excluded from all or any part of a meeting by a resolution of the Board for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings

30 Board of Directors – Standing Orders

30.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8. They may be amended as provided in them.

31 Board of Directors – Conflicts of Interest of Directors

31.1 The duties that a director of the Trust has by virtue of being a director include in particular–

31.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust;

31.1.2 a duty not to accept a benefit from a third party by reason of being a director or by reason of doing or not doing anything in that capacity.

31.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.4 In sub-paragraph 31.1.2 'third party' means a person other than the Trust or a person acting on its behalf.

31.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors before the Trust enters into the transaction or arrangement.

31.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

31.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

31.8 This paragraph does not require a declaration of an interest of which the director is not aware, or where the director is not aware of the transaction or arrangement in question.

31.9 A director need not declare an interest –

31.9.1 if it cannot be reasonably regarded as likely to give rise to a conflict of interest;

31.9.2 if, or to the extent that, the directors are already aware of it;

31.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered by a meeting of the Board of Directors, or by a committee of the directors appointed for the purpose under the constitution.

32 Board of Directors – Remuneration and Terms of Office

32.1 The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

32.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms of office, of the Chief Executive and the other executive directors.

32.3 The Chairman and other non-executive directors may be appointed for initial terms of up to 4 years, which may be renewed by the Council for a further term of up to 4 years, and may be renewed thereafter for such term, if any, as will bring the total length of service to 8 years. Where a director has served 8 years, his appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal.

33 Registers

33.1 The Trust shall have a register of members, showing in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which he belongs.

33.2 a register of members of the Council of Governors;

33.3 a register of interests of Governors;

33.4 a register of interests of directors;

33.5 and a register of directors.

34 Registers – Inspection and Copies

34.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out in the next sub-paragraph or as otherwise prescribed by regulations.

34.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:

34.2.1 any member of the Rest of England Constituency; or

34.2.2 any other member of the Trust, if the member so requests.

34.3 So far as the registers are required to be made available:

34.3.1 They are to be available for inspection free of charge at all reasonable times; and

34.3.2 A person who requests a copy or extract from the registers is to be provided with a copy or extract.

34.4 If the person requesting a copy or extract is not a member of the trust, the Trust may impose a reasonable charge for doing so.

35 Documents Available for Public Inspection

35.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

35.1.1 A copy of the current constitution;

35.1.2 A copy of the latest annual accounts and of any report of the auditor on them; and

35.1.3 A copy of the latest annual report

35.2 The Trust shall also make the following documents available for inspection by members of the public free of charge at all reasonable times:

35.2.1 A copy of any order made under section 65D (appointment of special trust administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

35.2.2 A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

35.2.3 A copy of any information published under section 65D (appointment of special trust administrator) of the 2006 Act;

35.2.4 A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

35.2.5 A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

35.2.6 A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

35.2.7 A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

35.2.8 A copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

35.2.9 A copy of any statement published under section 65J (power to extend time), or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

35.2.10 A copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

35.3 Any person who requests a copy or extract from any of the above documents is to be provided with a copy.

35.4 If the person requesting an extract or copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36 Auditor

36.1 The Trust shall have an auditor.

36.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council.

36.3 The auditor must be qualified to act as auditor in accordance with paragraph 23 of schedule 7 to the 2006 Act.

36.4 The auditor shall comply with schedule 10 of the 2006 Act and shall have the rights and powers there set out.

36.5 The Trust shall provide the auditor with every facility and all information which he may reasonably require for the purpose of his functions.

37 Audit Committee

37.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

38 Accounts

38.1 The Trust must keep proper accounts in such form as NHS Improvement may with the approval of the Treasury direct and proper records in relation to those accounts.

38.2 NHS Improvement may, with the approval of the Secretary of State for Health, give directions to the Trust as to the content and form of its accounts.

38.3 The accounts are to be audited by the Trust's auditor.

38.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

38.4.1 the accounts;

38.4.2 the records relating to them; and

38.4.3 any report of the Auditor on them

38.5 The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as NHS Improvement may with the approval of the Secretary of State for Health direct.

38.6 NHS Improvement may with the approval of the Secretary of State for Health direct the Trust:

38.6.1 to prepare accounts in respect of such period or periods as may be specified in the direction; and/or

38.6.2 that any accounts prepared by it by virtue of sub-paragraph 38.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

38.7 In preparing its annual accounts or in preparing any accounts by virtue of sub-paragraph 44.6.1 above, the Trust is to comply with any directions given by Monitor with the approval of the Secretary of State for Health as to:

38.7.1 the methods and principles according to which the annual accounts are to be prepared; and/or

38.7.2 the content and form of the annual accounts

38.8 The Trust must –

38.8.1 lay a copy of the annual accounts, and any report of the Auditor on them, before Parliament; and

38.8.2 send copies of the annual accounts, and any report of the Auditor on them to NHS Improvement within such a period as NHS Improvement may direct

38.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 38.6 above and a copy of any report of the Auditor to NHS Improvement within such a period as NHS Improvement may direct.

38.10 The functions of the Trust referred to in this paragraph 38 shall be delegated to the accounting officer.

39 Annual Report, Forward Plans and Non-NHS work

39.1 The Trust shall prepare an annual report and send it to NHS Improvement.

39.2 The annual report must give:

39.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and of the patients' constituency is representative of those eligible for membership

39.2.2 information on any occasions in the period to which the report relates on which the council of governors exercised its power to require one or more of the directors to attend a meeting as provided by paragraph 18.5 hereof

39.2.3 information on the corporation's policy on pay and on the work of the committee established under paragraph 32(2) hereof and such other procedures as the corporation has on pay

39.2.4 information on the remuneration of the directors and on the expenses of the governors and the directors

39.2.5 any other information that NHS Improvement or requires

39.3 The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement

39.4 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

39.5 In preparing the document, the directors shall have regard to the views of the governors, and the directors shall provide the governors with information appropriate for them to be able to form their views.

39.6 Each forward plan must include information about:

39.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

39.6.2 the income it expects to receive from doing so

39.7 Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 39.6.1, the Council of Governors must:

39.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

39.7.2 notify the directors of the Trust of its determination

39.8 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England, the Trust may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

40 Presentation of the Annual Accounts and Reports to the Governors and Members

40.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council:

40.1.1 the annual accounts

40.1.2 any report of the auditor on them

40.1.3 the annual report.

40.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

40.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 40.1 with the Annual Members' Meeting.

41 Instruments

41.1 The Trust shall have a seal.

41.2 The seal shall not be affixed except under the authority of the Board of Directors

42 Amendment of the Constitution

42.1 The Trust may make amendments of its constitution only if –

42.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

42.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments

42.2 Amendments made under paragraph 42.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result, not accord with Schedule 7 of the 2006 Act.

42.3 Where amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

42.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

42.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment

42.4 If more than half of the members voting approve the amendment, the amendment continues to have effect. Otherwise it ceases to have effect and the Trust must take such steps as are necessary as a result.

42.5 Amendments by the Trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

43 Mergers etc. and Significant Transactions

43.1 The Trust may only apply for a merger, acquisition, separation or dissolution, as referred to in sections 56,56A, 56B, and 57A of the 2006 Act with the approval of more than half of the members of the Council of Governors.

43.2 The Trust may only enter a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

43.3 A 'significant transaction' is a transaction which, if entered into by the Trust:

43.3.1 would increase or reduce the turn-over of the Trust (in a financial year relative to the previous financial year) by £20 million or by 10%, whichever is the greatest;

43.3.2 would involve a receipt of or capital expenditure of £10 million or more; in the case of expenditure, this is after the deduction of any grant or gift which specifically relates to the expenditure in question

43.3.3 would involve a service contract, asset rental or lease running for period of 3 years or more with a planned income or cost over its duration of £10 million or more

43.3.4 would be likely to put at risk the Trust's ability to provide its services as a whole, or a significant part of its services, to the appropriate regulatory standard;

43.3.5 would be likely to put at risk the Trust's ability to maintain the minimum required financial risk rating/ continuity of service risk rating

43.3.6 Where it might reasonably be considered that a transaction falls within paragraph 43.3 the Board shall inform the Council of the transaction at the earliest opportunity

43.3.7 The Board shall in any event inform the Council of a transaction which it is considering and which may involve a sum which is greater than 2% of the Trust's income in the previous year, but the Board need not so inform the Council of any such transaction if the transaction has been clearly identified in the Annual Estimate, the Capital Programme or the Annual Plan

43.4 In deciding whether to approve a proposed significant transaction the Council will:

43.4.1 act in accordance with its judgment of the best interests of the Trust; and

43.4.2 have regard to the risks the transaction might entail and the adequacy of steps proposed to mitigate those risks, and to the risks which not entering into the transaction might entail

43.5 If the Council votes not to approve a significant transaction, the reasons advanced in the course of the Council's discussion of the transaction for and against approval shall be recorded in the minutes.

43.6 The Board shall inform the Council of transactions not featuring in the annual estimates, capital programme or annual plan for the year which the Board is considering which involve a sum which is greater than 2% of the Trust's income or capital in the previous year.

44 Indemnity

44.1 Members of the Council of Governors and of the Board of Directors who act honestly and in good faith will be indemnified by the Trust against any civil liability which is incurred in the execution or purported execution of their functions relating to the Trust, save where they have acted recklessly. The Trust shall take out insurance against liability under this indemnity.

45 Dispute Resolution

45.1 In the event of a dispute arising between the Board of Directors and the Council, the Chairman shall take the advice of the Secretary and such other advice as he sees fit, and he shall confer with the Vice-Chairman and the Lead Governor and shall seek to resolve the dispute.

45.2 If the Chairman is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

45.3 If the dispute is not resolved, the Chairman may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
Salisbury City	3	50
South Wiltshire Rural	6	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area formerly covered by North Dorset District Council, comprising the following electoral wards: ▪ Beacon ▪ Blandford ▪ Cranborne Chase ▪ Gillingham ▪ Hill Forts & Upper Tarrants ▪ Shaftesbury Town ▪ Stalbridge & Marnhull (Marnhull parish) ▪ Sturminster Newton
Kennet	The area formerly covered by Kennet District Council comprising the following electoral wards: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South • Ludgershall & Perham Down • Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke • The Collingbournes & Netheravon • Tidworth • Urchfont & The Cannings

New Forest	The following electoral wards within New Forest District Council: ▪ Downlands & Forest ▪ Fordingbridge ▪ Forest North West ▪ Ringwood East & Sopley ▪ Ringwood North ▪ Ringwood South
Salisbury City	The following electoral wards formerly covered by Salisbury District Council: • Salisbury Bemerton • Salisbury Fisherton & Bemerton Village • Salisbury Harnham • Salisbury St. Edmund's & Milford • Salisbury St. Francis & Stratford • Salisbury St. Marks & Bishopdown • Salisbury St. Martin's & Cathedral • Salisbury St. Paul's
South Wiltshire Rural	The following electoral wards • Alderbury & Whiteparish • Amesbury East • Amesbury West • Bourne & Woodford Valley • Bulford, Allington & Figheldean • Downton & Ebble Valley • Durrington & Larkhill • Ethandune • Fovant & Chalke Valley • Laverstock, Ford & Old Sarum • Mere • Nadder & East Knoyle • Redlynch & Landford • Till & Wylye Valley • Tisbury • Warminster Broadway • Warminster Copheap & Wylye • Warminster East • Warminster West • Warminster Without • Westbury East • Westbury North • Westbury West • Wilton & Lower Wylye Valley • Winterslow

East Dorset	The following electoral wards within the area formerly covered by East Dorset District Council: • Cranborne & Alderholt • St. Leonards & St. Ives • Stour & Allen Vale (Horton, Holt, Hinton, & Charbury parishes • Verwood • West Moors & Three Legged Cross
Rest of England	All other areas of England not covered above

ANNEX 2 – THE STAFF CONSTITUENCY

(See paragraph 8)

The Staff Constituency is divided into 5 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUB GROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries Health Care Assistants (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers Orthoptists Physiotherapists and Helpers Art/Music/Drama Therapists Speech and Language Therapists and Helpers Psychologists and Psychology Technicians Psychotherapists Medical Physicists and Technicians Pharmacists and Pharmacy Technicians Dental Technicians Operating Department Practitioners Social Workers Chaplains Clinical Scientists Biomedical Scientists and Technical Staff Geneticists and Technicians Audiology Staff Cardiographers and Support Staff
Administrative, Facilities and Managerial Staff	Ancillary Staff Works and Maintenance Staff Ambulance Staff
Voluntary Staff	

1. The minimum number of members of each class shall be 10.
2. The Secretary to the Trust shall assign persons to the classes set out above in accordance with the groups set out by each. In case of any difficulty the Secretary shall have discretion to allocate the person to the class which is in his opinion the most appropriate.
3. The Secretary shall maintain a register of volunteer schemes designated for the purposes of membership of the Trust.
4. A volunteer is a person who carries out functions on behalf of the Trust on a voluntary basis under a scheme on the register referred to in paragraph 4 above.
5. Where a person is eligible to be included both in the volunteers class and another class, the Secretary shall assign the person to that other class.

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

(See paragraph 13)

1. There shall be 15 public governors as set out in Annex 1.
2. There shall be 5 staff governors, one to be elected by the members of each class set out in Annex 2 from the members of the class in question.
3. Wiltshire Council may appoint one governor by notice in writing signed by the senior executive of the Council.
4. There shall be one governor appointed by Wessex Community Action.
5. The following Clinical Commissioning Groups may each appoint one governor.
    a. Bath and North-East Somerset, Swindon and Wiltshire (BSW)
    b. Dorset
    c. West Hampshire

6. There shall be one governor appointed by the Commander of 1 Artillery Brigade or the Officer holding a position nearest to that position to represent local army interests

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
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7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
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18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"***corporation***" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:
- **a)** a Saturday or Sunday;
- **b)** Christmas day, Good Friday, or a bank holiday, or
- **c)** a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

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4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:
- (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
- (b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:
- (a) the constituency, or class within a constituency, for which the election is being held,
- (b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
- (c) the details of any nomination committee that has been established by the corporation,
- (d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation,
but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:
(a) full name,
(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:
(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party,
and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:
(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after

publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge**.**

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:
(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or
(ii) to whom the voter ID number contained within the e-voting information was allocated,
(b) that he or she has not marked or returned any other voting information in the election, and
(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
(d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or
(b) only be sent e-voting information; or
(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
  (i) enter his or her voter ID number; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;
  in order to be able to cast his or her vote;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
  (v) instructions on how to vote and how to make a declaration of identity,
  (vi) the date and time of the close of the poll, and
  (vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
  (i) the voter’s voter ID number;
  (ii) the voter’s declaration of identity (where required);
  (iii) the candidate or candidates for whom the voter has voted; and
  (iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to
  (i) enter his or her voter ID number in order to be able to cast his or her vote; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may

apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election,

notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she

wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified

documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:
(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote

inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

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41. -[NOT USED]

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

PP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified

except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

[PARAGRAPHS 45-50 NOT USED]

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who he or she has declared elected:
  (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
  (ii) in any other case, to the chairman of the corporation; and
(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are

forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

F**PP59.3** Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:
(a) account and record the number of ballot papers, internet voting records, t telephone voting records and text voting records that have been received,
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:
(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS - DISQUALIFICATION

(See paragraph 16)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation;

2. A person who is disqualified from being a company director under the laws of England and/or Wales;

3. A person who is a director of the Trust, or a governor, director, Chairman or chief executive of another NHS Foundation Trust or NHS Trust;

4. A person who is incapable by reason of mental disorder or illness or injury of managing his property and affairs;

5. A person who occupies the same household as an existing governor or a director of the Trust;

6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election, or becomes employed by the Trust

7. A person who has been removed from any list prepared under Part II of the National Health Service Act 1977, or has been removed from a list maintained pursuant to regulations made under section 28X of that Act, and has not been reinstated.

ANNEX 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(See paragraph 19)

CONTENTS

1. Introduction

1.1 Paragraph 14 of Schedule 7 to the National Health Service Act 2006 provides that the constitution of an NHS foundation trust must make provision for the practice and procedure of the Council of Governors. The Council made such provision in its standing orders adopted in 2006. Paragraph 3.13 of those orders provided that they might be amended as there set out. At a meeting of the Council on 25 February 2013 in accordance with paragraph 3.13, these standing orders as set out herein were adopted in substitution of those orders.

2. Interpretation

2.1 The expressions and terms used herein shall have the same meaning as in the Trust's Constitution.

2.2 'The Constitution' means the constitution of the Trust.

2.3 'The Council' means the Council of Governors.

2.4 A 'motion' means a formal proposition to be considered and voted on at a meeting of the Council.

2.5 An 'item for the agenda' means a matter to be considered at a meeting of the Council.

2.6 'The Secretary' means the person appointed as the Secretary to the Trust.

3. Meetings of the Council

3.1 Paragraph 18.3 of the Constitution provides that meetings of the Council shall be open to members of the public but that the public may be excluded as there set out.

3.2 The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given

3.3 If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4 Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5 Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. Agenda Items and Motions

4.1 Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor.

4.2 A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second the motion, and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chairman of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3 A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the chairman of the meeting.

4.4 No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chairman of the Trust.

4.5 The proposer of a motion shall propose it and shall have a right to speak before a

vote is taken.

4.6 During the consideration of a motion a governor may move:

4.6.1 an amendment to the motion;

4.6.2 that the consideration of motion be adjourned to a subsequent meeting;

4.6.3 that the motion be summarily dismissed and the meeting to proceed to the next business;

4.6.4 that the motion be voted on immediately.

4.7 No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the chairman of the meeting.

4.8 Save where the chairman of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. Quorum

5.1 No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. Relevance and Concision

6.1 Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2 The chairman of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3 In any matter relating to the interpretation of the Constitution and Standing Orders the chairman of the meeting shall consider the advice of the Secretary.

7. Voting

7.1 Save where it is otherwise provided by the constitution or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2 In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3 At the discretion of the chairman of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4 Save in the case of a secret paper ballot, if at least one third of the governors present request, the voting for and against of each governor shall be minuted.

7.5 If a governor requests, his vote shall be minuted.

7.6 No one may vote unless physically present: there shall be no votes by proxy.

8. Minutes

8.1 Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting.

8.2 The minutes shall record the names of those attending.

9. Suspension of Standing Orders

9.1 Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the chairman of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2 A decision to suspend standing orders shall be recorded in the minutes.

9.3 A separate record of matters while the orders were suspended shall be made, and shall be provided to the governors with the minutes.

10. Committees

10.1 The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2 The powers of the Council may be delegated to a committee for a specific purpose if

the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3 The powers of the Council shall be exercised in general meeting.

10.4 The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the committee on such terms as the Council may determine.

10.5 Meetings of the Council's committees, sub-committees and working groups shall be private. Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. Nominations Committee

11.1 Paragraph 27 of the Constitution provides for the appointment and removal of the Chairman of the Trust and the other non-executive directors by the Council. Paragraph 27.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2 For the appointment of the Chairman, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director

11.3 For the appointment of non-executive directors, the Nominations Committee shall consist of:

- the Chairman (or, at the Chairman's request the Deputy Chairman)
- 2 public governors
- 1 staff governor
- 1 appointed governor
- the Chief Executive.

11.4 When the formation of a Nomination committee is required the Secretary shall:

11.4.1 ask governors to put themselves forward as members within 10 days of his request, and if more governors put themselves forward than are places for particular categories of governor shall conduct an election or elections for each category with each governor having one vote in respect of each governor place on the committee;

11.4.2 In the case of a nomination for Chairman invite the non-executive directors to appoint a non-executive director to serve on the committee.

11.5 If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. Declarations and Register of Interests

12.1 Paragraph 21 of the Constitution provides for declarations of interest. It states:

21.1 *If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.*

21.2. *For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question*.

12.2 Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3 If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4 Subject to the exceptions below, material interests include:

12.4.1 any directorship of a company;

12.4.2 any interest held in any firm, company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3 any interest in an organisation providing health and social care services to the National Health Service;

12.4.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

12.4.5 any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter before the Council fairly.

12.5 The exceptions are:

12.5.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

12.5.2 an employment contract with the Trust held by a staff governor;

12.5.3 an employment contract held with the appointing body by an appointed governor;

12.6 If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7 The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting

12.8 The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9 If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the chairman of the meeting shall rule on the question having taken the advice of the Secretary.

12.10 A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11 A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 16.4 of the Constitution.

13. Code of Conduct

13.1 Governors shall agree to, and shall upon appointment sign a copy of, the Code of Conduct set out in the Appendix to these orders, and shall at all times comply with the Code.

14. Confidentiality

14.1 It is the duty of a governor not to divulge any information which he receives in confidence, whether that confidence is expressed or arises from circumstances relating to the information.

14.2 Governors must keep secure all confidential matter recorded on paper or electronically, and must ensure that their NHS mail and forum details are not disclosed.

14.3 Agendas and minutes and information relating to those parts of meetings of the Board of Directors, or of meetings of the Council, which are not open to the public, are confidential.

14.4 The proceedings of committees and working groups which take place in private are confidential until reported to the Council at a meeting open to the public.

14.5 A governor should keep confidential any information which may come into his possession concerning a patient, a person associated with a patient, or a member of staff or a person associated with a member of staff, unless the information has entered the public domain.

14.6 Any matter which the Council has resolved shall be treated as confidential shall be so treated.

15. Expenses

15.1 Paragraph 22 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2 Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3 The total of the expenses paid to governors will be published in the Annual Report.

16. Lead and Deputy Lead Governor's Appointment

16.1 The Lead Governor and the Deputy Lead Governor must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.
b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.
c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead

Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. Lead Governor and Deputy Lead Governor – Roles

17.1 The role of the Lead Governor is:

17.1.1 to chair meetings of the Council which cannot for any reason be chaired by the Chairman or the Deputy Chairman;

17.1.2 to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chairman;

17.1.3 to communicate regularly with the Chairman, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4 to be a point of contact for NHS Improvement when appropriate;

17.1.5 to provide input into the appraisal of the Chairman;

17.1.6 to take an active role in the activities of the Council;

17.1.7 to be a point of contact for governors when they have concerns;

17.2 The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. Lead and Deputy Lead Governors – Vote of No Confidence

18.1 If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor and present it to the Chairman, the Chairman shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2 The Chairman will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting

18.3 The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4 At the meeting the Chairman will present the reasons for the motion and it will be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5 A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governor's present support the motion, then the Lead Governor (or Deputy Lead Governor) shall stand down.

18.6 A Lead Governor or a Deputy Lead Governor against whom a motion of no confidence succeeds shall not be eligible to be Lead Governor or Deputy Lead Governor for 2 years.

19. Directors' Attendance

19.1 Paragraph 18.6 of the Constitution provides that the Council may require the attendance of one or more of the directors to attend a meeting for the purposes set out in the paragraph, which include the purpose of obtaining information about the Trust's performance of its functions.

19.2 The attendance of a director pursuant to paragraph 18.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chairman. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. Forward Plan

20.1 Paragraph 39.5 of the Constitution provides that in preparing the Trust's forward plan the directors must have regard to the views of the governors, and that the directors shall provide the governors with information appropriate for them to be able to form their views.

20.2 The Trust's Strategic Development Working Group shall consider aspects of the proposed plan as they become available.

20.3 The proposed plan shall be considered at a joint meeting of the directors and the governors. It shall be provided to the governors, with the information required to form their views, in good time, at least 7 days, for the governors to consider it in advance of the meeting

21. Amendment of Standing Orders

21.1 Paragraph 19.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders.

21.2 The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors).

21.3 No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included but which has been altered at the meeting.

APPENDIX 7.1

CODE OF CONDUCT

Governors will:

1. Actively support the purpose and aims of Salisbury NHS Foundation Trust;
2. Act in the best interests of the Trust at all times, with integrity and objectivity, recognising the need for corporate responsibility, without expectation of personal benefit;
3. Contribute to the work of the Council of Governors so it may fulfil its role, in particular attending meetings of the Council and training events, serving on the committees and working groups of the Council, and attending members meetings, on a regular basis;
4. Recognise that the Council exercises collective decision-making on behalf of patients, public and staff;
5. Acknowledge that, other than when carrying out their duties as governors, they have no rights or privileges different from other members of the Trust;
6. Recognise that the Council has no managerial role within the Trust other than as provided by statute;
7. Respect the confidentiality of all confidential information received by them as governors as more particularly set out in paragraph 15 of the Council's Standing orders;
8. Conduct themselves in a manner to reflect positively on the Trust and not to conduct themselves so as to reflect badly on the Trust;
9. Recognise that the Trust is a non-political organisation;
10. Recognise that they are not, save in the case of appointed governors and their appointing body, representing any trade union, political party or other organisation to which they may belong, or its views, but are representing the constituency which elected them;
11. Seek to ensure that no one is discriminated against because of their religion, race, colour, gender, marital status, sexual orientation, age, social or economic status, or national origin;
12. Comply with the Council's Standing Orders;
13. Not make, or permit to be made, any statement concerning the Trust which they know or suspect to be untrue or misleading;
14. Recognise the need for great care in making public pronouncements, in particular any statement to the media, and will recognise the harm that ill-judged statements can cause to the Trust and to the patients and public the Trust and its governors serve. To this end:
    a) advice of the Trust's press officer and of the Lead Governor, and take their observations into account;
    b) any request by the media for comment should be forwarded to the Trust's press officer;
    c) if a governor considers that a media story requires a response, he will communicate his concern to the Lead Governor and the Trust's press officer rather than responding himself;
    d) it is not the role of a governor to speak in public on operational matters or matters concerning individual patients or staff;
15. Uphold the seven principles of public life as set out by the Nolan Committee, namely:

Selflessness:

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity:

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity:
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability:
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness:
Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty:
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership:
Holders of public office should promote and support these principles by leadership and example

Governor's undertaking

I,_____, of , undertake as a Governor of Salisbury NHS Foundation Trust to abide by the above Code of Conduct including the obligations as to confidentiality and as to dealing with the media there set out.

Signed:_____ Date:_____

ANNEX 8 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(see paragraph 30)

1. INTERPRETATIONS AND DEFINITIONS

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3. Any expression to which a meaning is given in the Health and Social Care Act 2012, or any legislation or any regulations made under this Act, shall have the same meaning in these standing orders and in addition:

1.3.1 **"Accounting officer"** means the person responsible and accountable for funds trusted to the Trust. The Officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, this shall be the Chief Executive;

1.3.2 **"Board"** means the Board of Directors, consisting of the Chairman, the independent non-executive directors and the executive directors;

1.3.3 **"Audit Committee"** means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework;

1.3.4 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources;

1.3.5 **"Committee"** means a committee or sub-committee appointed by the Trust;

1.3.6 **"Committee Members"** shall be persons formally appointed by the Trust to sit on or to chair specific committees;

1.3.7 **"Contracting and Procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets;

1.3.8 **"Council"** means the Council of Governors, formally constituted in accordance with the constitution and presided over by the Chairman;

1.3.9 **"Director of Finance"** means the chief financial officer of the Trust;

1.3.10 **"Executive Director"** means a member of the board who is an officer of the Trust;

1.3.11 **"Motion"** means a formal proposition to be discussed and voted on during the course of a meeting;

1.3.12 **"Nominated Officer"** means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

1.3.13 **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

1.3.14 **"SFIs"** means standing financial instructions;

1.3.15 **"SOs"** means Standing Orders.

1.3.16 **"Trust"** means Salisbury NHS Foundation Trust

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP AND ROLE OF MEMBERS

2.1 Composition of the Board of Directors

The composition of the Board of Directors shall be in accordance with paragraph 23 of the Constitution.

2.2 Role of Members of the Board of Directors

The Board of Directors will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal members. Their role will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. The Director of Finance shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however; exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair

The Chair shall be responsible for the operation of the Board of Directors and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of employment and with these Standing Orders.

The Chair shall take responsibility either directly, or indirectly, for the induction, portfolios of interests and assignments, and the performance of Non-Executive Directors.

The Chair shall work in close conjunction with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the discussion and ultimate resolutions.

Senior Independent Director

The Board of Directors should in consultation with the Council of Governors, appoint a Non-Executive Director to be the Senior Independent Director. Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board of Directors may thereupon, in consultation with the Council of Governors, appoint another Non-Executive Director as Senior Independent Director.

2.3 Corporate role of the Board of Directors.

2.3.1 All business shall be conducted in the name of the Trust.

2.3.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3.3 The powers of the Trust established under statute shall be exercised by the Board except as otherwise provided for under Section 4 of this annex.

2.3.4 The Board has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters reserved to the Board' and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 Admission of the Public and the Press

3.1.1 The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.1.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Vice Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

3.2 Observers at Board Meetings

3.2.1 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.2.2 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

3.3 Calling of Meetings

3.3.1 Ordinary meetings of the Board shall be held at such times and places as the Board determines. Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board of Directors so resolves for special reasons.

3.3.2 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings

3.4.1 Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear days before the meeting.

3.4.2 In the case of a meeting called by Directors in default of the Chair, the notice shall

be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.10 below

3.4.3 Agendas will normally be sent to members of the Board seven calendar days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than five clear days before the meeting, save in emergency.

3.4.4 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least five clear days before the meeting.

3.5 Agendas and supporting papers

3.5.1 The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 12 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.7 Chair of Meeting

3.7.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and he/she is present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, then the remaining non-executive directors present shall choose which non-executive director shall preside.

3.8 Notices of Motion

3.8.1 A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 12 clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chairman shall include in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. This Standing Order 3.8.1 shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda.

3.8.2 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.8.3 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he/she considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Motions – procedure at and during meetings

3.9.1 Who may propose?

A motion may be proposed by the Chair or any Director present at the meeting. Such motion must also be seconded by another Director.

3.9.2 Contents of Motions

The Chair may (at his discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.8, other than a motion relating to:

(a) the reception of a report;
(b) consideration of any item of business before the Trust Board;
(c) the accuracy of minutes;
(d) that the Board proceed to next business;
(e) that the Board adjourn;
(f) that the question be now put.

3.9.3 Amendments to Motions

A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.9.4 Rights of reply to motions

Amendments: The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Original motion: The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9.5 Motions Once Under Debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put;
- that a Director be not further heard;
- a motion resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.10 Emergency Motions

Subject to the agreement of the Chair and SO 3.9 above, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.11 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matter shall be final.

3.12 Voting

3.12.1 Save as provided in SO 3.15 Suspension of Standing Orders, every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.12.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.12.4 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.14 Quorum

3.14.1 The quorum of a meeting will be at least half of the whole number of members of the Board of Directors (including at least one Non-Executive Director and one Executive Director).

3.14.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.14.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.15 Suspension of Standing Orders

3.15.1 Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present votes in favour of suspension.

3.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the

meeting.

3.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.15.4 No formal business may be transacted while Standing Orders are suspended.

3.15.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.16 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 Emergency Powers

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.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

4.6 Scheme of Delegation

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Discharge of the Direct Accountability

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or NHS Improvement requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 Overriding Standing Orders

If for any reason these Standing Orders 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 formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by NHS Improvement), the Board of Directors may appoint committees of the Trust

5.2 Applicability of Standing Orders and Standing Financial Instructions to committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of Powers

The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute, or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.5 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.6 Approval of appointments to committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory Functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.8 Committees established by the Board of Directors

The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Disclosure of Interests

The Constitution, the 2006 Act and the Foundation Trust Code of Governance requires Board Directors to declare interests which are relevant and material to the NHS board of

which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 Declaring interests

6.3.1 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.3.2 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.3.3 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.3.4 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.

6.3.5 Financial Reporting Standard (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3.6 This standing order applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

6.4 Register of Interests

6.4.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

6.4.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.4.4 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their

respective Directors for clarification.

6.5 Exclusion of Chair and Members in proceedings on account of pecuniary interests

6.5.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.5.2 The Board of Directors may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

6.5.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.5.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 6.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7 STANDARDS OF BUSINESS CONDUCT POLICY

7.1 All staff and members must comply with the Trust's Standards of Business Conduct, the Regulatory Framework and the National guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff".

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

7.4 Canvassing of and Recommendations by, Directors in Relation to Appointments

7.4.1 Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 7 shall be included in application forms or otherwise brought to the attention of candidates.

7.4.2 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 7 shall not preclude a Director from giving written testimonial of a

candidate's ability, experience or character for submission to the Trust.

7.4.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 Relatives of Directors or Officers

7.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

7.5.2 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.5.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8 CUSTODY OF SEAL, SEALING OF DOCUMENTS ANDSIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

8.2 Sealing of Documents

8.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Trust Secretary; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

8.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly.

(The report shall contain details of the seal number, a description of the document and the date of sealing).

8.4 Signature of documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

ANNEX 9 – Additional Provisions - Directors – DISQUALIFICATION

(See Paragraph 28)

The following may not be appointed or continue as a director:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the law of England and/or Wales.
3. A person who is a governor of the Trust, or a governor, director, chairman or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the chairman) may be a non-executive director or a governor of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two directorships or directorship and governorship.
4. A person whose physical or mental wellbeing is such that their ability to act as a director of the Trust is materially affected.
5. A person who occupies the same household as an existing director of the Trust or a governor.