Bundle Trust Board Public 9 March 2023

1	OPENING BUSINESS
1.1	10:00 - Presentation of SOX certificates
	Presented by Ian Green *January SOX of the month – Sally Crook, Odstock Health and Fittnes and Lisa Hill, Gastro Booking Coordinator* *January Patient Centred SOX – Lucy Weston, Midwife and Russell Tyrie, Porter* *February SOX of the month –* *February Patient Centred SOX -*
1.2	10:10 - Patient Story
	Presented by Judy Dyos
1.3	Welcome and Apologies
	Apologies received from Debbie Beaven and Melanie Whitfield
1.4	Declaration of Interests
1.5	Minutes of the previous meeting
	Minutes attached from previous meeting held on 12 January 2023 *For approval*
	1.5 V3 Draft Public Board mins 12 January 2023.docx
1.6	10:30 - Matters Arising and Action Log
	1.6 Public Trust Board Action Log March.pdf
1.7	10:35 - Chairman's Business
	Presented by Ian Green *For information*
1.8	10:40 - Chief Executive Report
	Presented by Stacey Hunter *For information*
	1.8a CEO Board Report March Board.docx
	1.8b AHA_February23_Briefing_220223_ V1.0.pdf
2	ASSURANCE AND REPORTS OF COMMITTEES
2.1	10:50 - Clinical Governance Committee - 28 February
	Presented by Eiri Jones *For assurance*
	2.1 Escalation report - from February 2023 CGC to March Board 2023.docx
2.2	10:55 - Finance and Performance Committee - 28 February
	Presented by Eiri Jones (In Debbie Beaven's absence) *For assurance*
	2.2 F&P Escalation Report 28th Feb.docx
2.3	11:00 - Trust Management Committee - 22 February
	Presented by Stacey Hunter *For assurance*
	2.3 TMC Escalation Report for March Board.docx
2.4	11:05 - People and Culture Committee - 26 February - to follow
	Presented by Michael von Bertele *For assurance*
2.5	11:10 - Integrated Performance Report to include exception reports
	Presented by Mark Ellis *For assurance*
	2.5a IPR cover sheet - Trust Board Mar '23.doc
	2.5b IPR Mar_23 FINAL v2.pdf
3	STRATEGY AND DEVELOPMENT
3.1	Digital Strategy Update - deferred to April
3.2	Improving Together Quarterly Update Report Q4 - deferred to April
4	FINANCIAL AND OPERATIONAL PERFORMANCE

4.1	11:40 - Charitable Funds Strategic Update *Presented by Mark Ellis* *For assurance* 4.1 Charitable funds update Mar23.docx
4.2	11:50 - BREAK
5	QUALITY AND RISK
5.1	12:20 - Patient Experience Report Q3 *Presented by Judy Dyos* *For assurance* 5.1a Patient Experience - Patient Feedback Report Q3 22-23 v1.0.docx 5.1b Appendix 2 - HWW Survey Feedback - Action Plan - Working Document - v2.docx 5.1c Appendix 3 - Real Time Feedback - FINAL Dec 2022 v1.pdf 5.1d Appendix 4 - Your Views Matter - Bereavement Survey Report Q3 2022-23 v1.docx
5.2	12:30 - National In-Patient Survey *Presented by Judy Dyos* *For assurance* 5.2a Cover Sheet - CGC 28.02.2023 - Agenda Item 5.2.docx 5.2b National Inpatient 2021_PP Thematically Coded Comments Report_RNZ Salisbury.pptx 5.2c National Inpatient 2021 CQC Summary for CGC - 28th Feb 2023 v4 PLC.pptx
5.3	12:40 - Maternity Quality and Safety Report Q3 22/23 *Presented by Judy Dyos* *For assurance* 5.3a Front sheet Trust board Maternity Q and S report Q3 22 23_ (003).docx 5.3b Maternity Q and S report Q3 22 23.docx
5.4	12:50 - Maternity Survey 2022 *Presented by Judy Dyos* *For assurance* 5.4a Cover Sheet - Maternity survey 2022.docx 5.4b SFT Maternity Survey 2022 and action plan JC - Read-Only - Compatibility Mode.ppt
6	PEOPLE AND CULTURE
6.1	Nursing Skill Mix Review - deferred to April
7	GOVERNANCE
7.1	13:00 - Constitution Annual Review 2023 *Presented by Fiona McNeight* *For approval* 7.1a Cover Sheet Constitution Annual Review.docx 7.1b Constitution V 2.4 March 2023.docx
7.2	13:10 - Trust Board 2023 Public/Private Cycle of Business *Presented by Fiona McNeight* *For approval* 7.2a Cover_Sheet Trust Board cycle of business.docx 7.2c Draft Private Board Annual Business Cycle 2023-24.pdf 7.2b Draft Public Board Annual Business Cycle 2023-24 v2.pdf
8	CLOSING BUSINESS
8.1	13:15 - Any Other Business
8.2	Agreement of Principle Actions and Items for Escalation
8.3	13:20 - Public Questions
8.4	Date next meeting *6 April 2022*
9	Resolution *Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)*

Draft
Minutes of the Public Trust Board meeting
held at 10:00am on Thursday 12th January 2023, MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:	
Eiri Jones (EJ)	Non-Executive Director
David Buckle (DBu)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director (Chair)
Michael von Bertele (MVB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Stacey Hunter (SH)	Chief Executive
Melanie Whitfield (MW)	Chief People Officer
Lisa Thomas (LT)	Chief Operating Officer
Judy Dyos (JD)	Chief Nursing Officer
Mark Ellis (ME)	Chief Finance Officer
Peter Collins (PC)	Chief Medical Officer

In Attendance:	
Naginder Dhanoa (ND)	Chief Digital Officer
Fiona McNeight (FMc)	Director of Integrated Governance
Lucinda Herklots (LH)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Rich Rogers (RR)	Governor (observer)
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Ian Green (IG)	Chairman (observer)
Amila Maduragoda (AM)	Visiting Fellow (Staff Story TB1 12/1/1.2)
Abigail Kingston (AK)	Clinical Director Women and Newborn (item TB1 12/1/3.1)
Joanne Cowan (JC)	Head of Midwifery (item TB1 12/1/3.1)
Hannah Boyd (HB)	Divisional Director of Operations Women and Newborn (item TB1 12/1/3.1)

ACTION

TB1 12/1/1 **OPENING BUSINESS**

TB1 12/1/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

- **November SOX of the month** – Jinu John, Tracey Quinney, Suzie Crane and James Wigley.
- **November Patient Centred SOX** – Heather Spicer, Physio Pitton Ward /The Clinical Biochemistry Team
- **December SOX of the month** – Catering Team
- **December Patient Centred SOX** – Spinal Team

TB noted the wide variety of nominations that are put forward each month and the great work underway during extremely challenging times. TB and the Board congratulated the members of staff who had received a SOX award.

TB1 12/1/1.2 **Staff Story**

PC introduced Dr Amila Maduragoda to the meeting to present his story of working in the Trust as a visiting fellow from Sri Lanka. AM shared his story of his time at Salisbury NHS Foundation Trust (SFT) and what he had learnt from his experience and how he would apply this when he returned to Sri Lanka.

AM highlighted how important his time at SFT had been and how he hoped the Trust would continue receiving visiting fellows as it was a productive and valuable exercise.

Discussion:
TB thanked AM for sharing his story from his perspective as a colleague and patient and for sharing his ideas for improvement.

SH thanked AM noting that the two-way process of learning is so beneficial. SH also thanked PC who had facilitated the Trust receiving a visiting fellow and had taken the time and effort to support AM in his role in the hospital.

DB agreed with the sentiments shared by other members of the Board, noting that it is clear that every healthcare system across the world has its own set of issues.

EJ thanked AM and noted he would be missed in the Trust.

AM left the meeting.

TB1 12/1/1.3 **Welcome and Apologies**

TB welcomed everyone to the meeting and noted that apologies had been received from:

- Paul Kemp, Non-Executive Director
- Debbie Beaven, Non-Executive Director
- Rakhee Aggarwal, Non-Executive Director

TB1 12/1/1.4 **Declarations of Conflicts of Interest**

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

SH noted her standing declaration in relation to being an Integrated Care Board (ICB) Member, noting that there was no conflict of interest with any of the agenda items at the meeting.

TB1 12/1/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 3rd November 2022.**

TB presented the public minutes from 3rd November 2022.

MvB noted that his apologies had been missed.

Subject to this amendment, the board approved the minutes as a correct record of the meeting.

TB1 12/1/1.6 **Matters Arising and Action Log**

TB presented the action log and noted the following key updates:

TB1 3/11/1.9 Feedback from Shadow Board – EJ noted that she had spoken to colleagues at the last Shadow Board in November about someone from the meeting feeding back directly to the Trust Board. EJ noted that they were considering this approach and a member of the group will feedback in February. Item closed.

It was noted that any other matters arising was either closed, covered on a future agenda or was to be discussed as part of the meeting agenda.

TB1 12/1/1.7 **Chairman's Business**

TB thanked the executive team and staff as the ongoing heightened operational challenges continued over December and into January. TB explained that it remains a difficult time which has been exacerbated over the festive period.

Whilst operationally, circumstances have slightly improved and lots of actions have been put in place, the hospital is facing huge challenges in delivering safe, effective, and timely care. It is acknowledged that the public and staff have been understanding in relation to the current circumstances but it should also be understood that staff are going above and beyond every day to keep services going.

TB1 12/1/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- SH referred to a news article which had been released by The Sun newspaper relating to temporary mortuary facilities. SH explained that during certain periods, particularly winter, it is not unusual to use temporary mortuary facilities. SH noted that it was unclear how this became a front-page news article but her key concern was ensuring that this information was not taken out of context.
- The IPR highlights the operational challenges during November but LT has pulled together some additional information to complement the information in the IPR, to provide transparency about what impact this has on the care staff are able to deliver in the current environment.
- The patient experience in terms of waiting times are not consistent or where they need to be. However, staff and teams on the ground are doing their absolute best to manage this on a daily basis.
- Additionally, it had been a challenging flu season particularly in relation to the acuity of patients. There has been some vaccine hesitancy amongst our own staff. However, relative to the rest of

the southwest, the team who have led the flu vaccinations have performed well.

- With so many challenges currently, one of the key issues is staffing. Therefore, the Trust's focus is on maximising staff availability, absence management, recruitment and retention and trying to keep pace with challenging availability pressure. There is also a focused piece of working around staff well-being which is linked to retention efforts.
- The Royal College of Nursing (RCN) have notified the Trust that SFT will be included in the strike action over the 18th -19th Jan. Communications to staff have highlighted that the Trust will be respectful to all colleagues and, where they have expressed a lawful right to take action, this is their right. However, the Trust's focus will be delivering safe, timely and consistent care to the population and therefore plans have been put in place to ensure these days are appropriately managed.
- SH noted the positive stories from the Trust over the last month, including the Trust offering all staff a free Christmas lunch or breakfast. The catering team did very well to serve just under 2000 colleagues and the feedback was excellent.
- There is also work ongoing to with investment from the Hospital League of Friends to improve rest areas for staff across the Trust.

Discussion:
EJ queried the ongoing upward trajectory of turnover and asked if there is any indication of these figures plateauing or improving. The Board discussed the efforts in relation to retaining staff but noted this was one of the Trust's focuses in terms of performance indicators. However, the several initiatives to improve staff retention will not be realised straight away.

TB referred to the story in The Sun and noted that there is a broader issue around a particular narrative in relation to the NHS in the media at the moment. TB noted that people should not lose sight that the NHS is delivering good healthcare under extreme circumstances. SH noted that this narrative has been generated for political reasons. However, the reality is that experiences for staff are harder than they have ever felt. SH explained that the comms team were working on internal and external messaging to get a balanced message out

TB referred to vaccination rates and noted that in previous years, the Trust was achieving around 80% but rates were now approximately 60%. TB asked if there was any indication as to the cause and if there is any action at a national level to ensure people are encouraged to get vaccinated. PC explained that the vaccination lead for the Trust has investigated soft intelligence around vaccinations and people's perceptions. The overall outcome is that the lower uptake is a reaction against a managed state and some degree of understanding that the implications of getting Covid are less than they were previously. The Trust continue to reinforce the message that this is about protecting staff and patients. PC noted that the Trust have done better than many organisations due to hard work of vaccination team. EJ agreed, highlighting the way in which the vaccine had been delivered had been positive. EJ asked that, considering staffing pressures, has the Trust

been able to organise the roving teams visiting wards. JD confirmed the Trust were able to undertake this exercise.

TB1 12/1/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 12/1/2.1 **Clinical Governance Committee (CGC) 20th December 2022**

EJ presented the report, providing a summary of escalation points from the meeting held on 20th December 2022. EJ asked for the report to be taken as read highlighting the key points as detailed.

EJ highlighted that the Maternity Incentive Scheme paper was on this month's Board agenda and had not been received via CGC due to timings of the meeting.

The report was noted.

TB1 12/1/2.2 **Audit Committee 15th December 2022**

TB presented PK's report providing a summary of escalation points from the meeting held on 15th December 2022. TB asked for the report to be taken as read.

The report was noted.

TB1 12/1/2.3 **Trust Management Committee (TMC) 21st December**

The Board noted that the meeting had been cancelled in December due to operational pressures.

TB1 12/1/2.5 **Integrated Performance Report (IPR) (M8)**

LT presented the Integrated Performance Report which provided a summary of November 2022 performance metrics. LT highlighted some key points from the report:

- There were some performance positives in November as it was a busy month in terms of elective activity. There were 127 more-day cases due to the pre-winter focus to get more cases through.
- Additionally, ambulance handovers were better during November.
- An area which remains a concern is bed occupancy which is placing additional pressure on the organisation and also contributing to pressure ulcers and falls. It is worth noting that the improvements in November have not been sustained during December, with the Trust under extreme pressure.
- The Trust is one of the lowest performing in the Southwest in relation to Care Hours Per Patient, Per Day.
- Infection control has added additional pressures with Covid, Flu and RSV.

Discussion:
MvB referred to theatre performance, noting it's absence from the IPR. MvB asked if there could be an update on current performance in the next iteration of the IPR. SH referred to the Improving Together

methodology and trying to focus the Board's attention on the priorities that have been highlighted as part of this process through the breakthrough objectives and vision metrics. This is about having fewer priorities with a lot more focus.

PC noted that as part of the Board development around Improving Together, one of the suggestions was that a scorecard agreement be developed between NEDs and Execs. This might provide a further line of sight to key areas of assurance and PC noted he would be content to facilitate if required. LT reminded the Board that a report around theatre productivity went to the F&P Committee at the end of 2022. The Board discussed oversight of key deliverables with EJ supporting MVB's request, noting the theatre investment agreed the previous year and the importance of understanding outcomes and delivery of elective activity. SH explained that whilst elective teams have done well, the Trust currently is not delivering the volume of activity expected which is contributing to financial pressures. The Trust is meeting what GIRFT say is reasonable, e.g., 85% inpatient theatres. However, Day Case activity is not achieving the standard. SH noted that the executive would come back with a suggestion on how to keep the Board sighted on theatre activity. **ACTION: PC/LT/SH**

PC/LT/SH

JD referred to the agreed theatre investment and recruitment noting that the agreement was to phase this over a period of time. There is a plan and a training programme, particularly for those overseas staff who need to sign off competencies. LT explained that she was going to initiate and embed new meetings to focus on urgent and planned care to help provide a forward look.

TB summarised that the Trust has a structure of reporting that the Board should not be diverted from through IT programme but it is important that there is a mechanism for picking up specific issues.

DBu referred to the increase in mortality nationally and the Board discussed how this could be related to the increased operational pressures and the long waits experienced in Emergency Departments. It was agreed that there should not be assumptions made about the reasons for the national increased mortality rates, noting the complexities in measuring mortality within an organisation as well as taking a national view. SH noted that in relation to safety, LT was going to provide a presentation in the private session to give the Board line of sight to safety priorities. SH further explained that the Trust had invested in additional staffing in ED, which has contributed to financial pressures, but is considered the most appropriate action to take. PC referred to the access targets noting that time to triage and time to first assessment is less than four hours.

LT noted the Trust's key concern relating to the 31% beds occupied by patients waiting for ongoing care and the consequences to those patients in escalated areas. TB noted that the executive team have assured the Board there are actions taken to prevent and highlight safety issues but that is not to say they are not occurring. JD referred to the weekly safety meeting which reviews every moderate and above incident and the safety huddle which reviews the harm resulting from people waiting in an

inappropriate space e.g., in an ambulance, ED etc. DBu noted that it was assuring that management actions were prioritising safety.

The Board discussed Stroke services and MvB asked for further assurance that patient care is not being negatively impacted. PC explained that there are no issues of patients not being given thrombolysis. PC to provide further assurance around the statement in the IPR **ACTION: PC** JD noted that the wording is not clear and there is a thrombolysis nurse. **PC**

MW discussed the ongoing recruitment plans in the Trust, noting that more people are being recruited than are leaving. The Board discussed how they could gain further data and information about leavers and gain intelligence to support retainment. SH referenced the retire and return scheme noting that the systemic issues relating to pensions causes a real issue for a number of colleagues considering this move. There is a lot of work underway in relation to flexible working as a number of staff might leave to do agency work, which generally allows for better work/life balance. This is part of a wider piece of work looking at workforce planning. The Board was sighted that 40% of new starters cannot afford to join pension scheme and it was agreed that this is a real issue that requires reform.

TB summarised that there is a huge amount of work underway to manage the staffing concerns across the Trust. This is vitally important as staff availability has been highlighted as a key focus which, if not mitigated, affects all services and care delivery.

TB1 12/1/3 QUALITY AND RISK

TB1 12/1/3.1 Clinical Negligence Scheme for Trusts (CNST) /Maternity Incentive Scheme

Abi Kingston (AK), Joanne Cowan (JC), and Hannah Boyd (HB) from Women and Newborn joined the meeting to co-present the Maternity Incentive Scheme report. The team presented the following key points:

- The CNST scheme has grown in the last few years with more factors to complete and meet which has been challenging for the team.
- The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. Trusts that can demonstrate they have achieved all the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.
- The safety actions and overall compliance were summarised as detailed in the report. The maternity service at SFT is declaring compliance with 5 out of the 10 safety actions.
- AK noted that demonstrating compliance is a big task and complex. However, the team believe the evidence reflects a story over the last 18 months, taking into consideration the new leadership team, significant staffing challenges and keeping up with the complexity and change of managing maternity services.

The team are very optimistic of continued improvement in the Women and Newborn division.

- The team went through each of the safety actions and the improvements in detail. AK acknowledged that there needed to be more of a focus on detail. AK also referenced the information that has been shared at Board level and noted that this needs to be more focused going forward and there also needs to be attention on sharing useful information externally too.
- AK noted that the department is still paper heavy and to evidence compliance with safety action 2 there was a lot of paper-based evidence to work through.

Discussion:
The Board discussed Maternity Continuity of Carer (MCOC) noting that this had been discussed previously and the ability to move ahead with the model based on the current workforce has determined that rollout was suspended in the Trust. EJ noted that this had been discussed previously both at CGC and Board and that maternity staffing had been discussed as part of the safer staffing review.

The Board discussed the heightened expectations for maternity reporting at Board level and JD explained that conversations with the Maternity Improvement Advisor (MIA) had included requests for clarity around this ask. It was noted that NHSEI and the MIA expect the divisional management team to present at Board.

SH acknowledged that the heightened reporting and expectation in maternity was in response to significant challenges in maternity departments as a result of public investigations. However, SH noted that this has resulted in disparate ways in which these have been responded to across the NHS and expressed that this process of reporting may not enable focus on the key issues that require more attention.

SH reflected on the gaps in the detail that had been alluded to and suggested that it would be helpful to understand what this process has meant for learning for the department and what can be done differently. AK explained that she would need to discuss with colleagues and work through to understand this.

TB asked the team if the service was safe. AK assured the Board that the gaps in detail as part of the CNST return were mainly technicalities and it was felt by the whole team that the service had greatly improved upon safety measures in the last 18 months ago. RH thanked AK for the update and asked where the evidence was to support the improvement in safety. JD explained that the maternity dashboard is included in the IPR every month which would highlight concerns around c sections and still births which have not flagged any issues. JD further explained that safety improvements around processes, assessment and review of serious incidents and the ratio of midwives to patients have also been undertaken.

AK, JC and HB left the meeting.

TB1 12/1/3.2 **Patient Experience Q1 and Q2 – deferred to March**

TB1 12/1/3.3 **Learning from Death Report Q2**

PC presented the report to provide assurance that the Trust is learning from deaths and making improvements. The following key points were highlighted:

- There is no change to the Quarter 2 position. However, there is continued concern that mortality indices are out with the expected range.
- The SHMI (Summary Hospital Level Mortality Indicator) sits within expected range and HSMR (Hospital Standardised Mortality Ratios) sits outside expected range.
- PC noted that in a previous meeting there had been a query from Stacey around assurance due to operational pressures. The team did review the crude mortality rates for the last quarter and noted that in December 2022, 93 people died but in 2017 96 people died. It is acknowledged that some of the variants in this data relate to the severity of the flu season. The team have also reviewed three months of data looking at the exact cause of death and no themes have arisen, particularly in relation to those around access.
- Nationally, there has been an increase in cardiovascular deaths in the last few years and there is work to look at this.

Discussion
TB noted that she and SH had visited clinical coding last week and currently there is not much progress in terms of clearing the backlog. TB asked if there was any way to clear backlog and recruit more people. PC noted that the team have prioritised coding of those who have died but it is the denominator which is the problem and this could be explored further.

EJ explained that there had been a conversation about coding at F&P Committee and additional resource is a challenge as there is no mutual aid available. This problem is not just isolated to SFT. However, the Chief Information Officer had highlighted the apprentice development and succession planning as a medium to long term solution. NG explained that the challenge with recruitment currently is that coders must be onsite and are unable to work from home (WFH). Other, more digitally mature systems in other Trusts allow for staff to WFH where required. PC explained that coding is a highly skilled job and therefore it does take time to train people to do it well. The implementation of a new EPR (Electronic Patient Record) will hopefully help the automation of data.

The Board noted that there would be a further update at March's Board meeting.

TB1 12/1/3.4 **Director of Infection Prevention and Control 6 Monthly Report**

JD presented the report which highlighted the Trust's performance regarding Infection, Prevention and Control (IPC) in the last 6 months.

- JD noted that for the first time the report includes data benchmarking against other local and regional Trusts. Overall, SFT's position is favourable.
- The recent IPC challenges have been discussed at length, including the three respiratory challenges experienced in November and December. In terms of managing the risks, patients were separated from each other but did mean that men and women were sometimes placed together to ensure infection control measures. A Duty of Candour letter has been completed in relation to this. The Trust maintained the cohorting of patients to keep them apart and the local director of public health has commended the Trust on this.
- In terms of Covid, there have been 14 outbreaks affecting inpatient area but SFT was not an outlier.

Discussion:
EJ praised JD and the team noting that the fact SFT continues to be a good performer is attributed to JD's leadership and the rest of the team efforts.

TB1 12/1/4 **PEOPLE AND CULTURE**

TB1 12/1/4.1 **People Plan**

MW presented the report which provided the Board with an update on SFT's People Plan.

- MW referred to the breadth of papers included in the meeting pack which reflected the streams of work underway but also the national templates and tools to help make sense of the work required and apply them to the needs of Salisbury.
- The Long-Term People Plan at SFT contains actions which will support the delivery of the four pillars of the NHS People Plan and will begin to embed the seven elements of Our People Promise and the People Plan.
- Each one of the 7 pillars of the people promise needs a long-term plan and some of this is included in the detail of the report. However, it is acknowledged that the team need to turn this into digestible information or a useful infographic.
- This work outlines the Trust's intent to become an outstanding employer and align to the Trust's strategic objectives around people.
- These plans will culturally initiate considerable change. There are some key areas of focus including education, support, and development for international recruits.
- In terms of our current people practices there are limited economies of scale in a Trust this size and so we are leading the collaboration with colleagues in the Acute Hospital Alliance (AHA) to looking at where we might align/ share people services.
- MW asked the Board to be assured about the Trust's ambition and note the breadth and ideas behind the annual workplan to achieve the required impact and staff experience outcomes.

Discussion:
MvB referred to the turnover of staff, noting that this impact could make it difficult to update working practices as new staff require time, additional training. MvB also referred to Freedom to Speak Up (FTSU) suggesting this should be described as the last means of feedback if all other methods have been exhausted or are not possible. The Board discussed that feedback is about daily interaction with staff and that there needed to be more reactive feedback in the organisation. MW noted that quarterly Pulse Surveys ensure regular monitoring and do indicate where staff feel that they're being listened to.

EJ acknowledged the hard work that had gone into the long-term plan and that a digestible version is required for staff to understand. EJ noted the work described around Equality, Diversity, and Inclusion, highlighting that not all the protected characteristics had been mentioned. EJ noted the importance of respecting and acknowledging the diversity of the aging workforce.

TB summarised that the Board were content that there is now a plan which will evolve over time. It is important from a communication perspective that the report was adjusted for a broader audience.

DBu noted that the key message to get across is that there is now a plan where there has not been before.

RH noted that the paper suggests that the Board is being asked to approve the plan. RH asked for the aspirations or tangible benefits from the plan and the next steps. MW noted that there was a detailed workplan within the annual plan. Progress will report through the People Plan work via the People and Culture Committee.

LT referred to the digestible version and suggested the new Associate Director of Strategy, Tony Mears, would be able to support.

Decision
The Board approved the SFT Long Term People Plan.

TB1 12/1/4.2 **Health and Safety Quarterly Report Q3**

MW presented the Health and Safety report which had been prepared by the Trusts Health and Safety Manager. The following key points were highlighted to the Board:

- There is now a full governance route for Health and Safety. There is an agreed schedule of work and operational managers are sighted on what is expected of them.
- The H&S team is undertaking further work to identify and understand the actual impact of work-related lost time injuries.
- There is now a strong and useful relationship with the estates team which ensures collaborative working across the two departments.

Discussion:

LT referred to the issues on estates and highlighted the good work to understanding the current risk profile across the Trust. LT noted that it would be useful to triangulate estates and health and safety reports to the Board so they are aligned with their quarterly updates. **ACTION: TR/BJ (Troy Ready/ Brian Johnson)** **TR/ BJ**

EJ highlighted the opportunity to learn from the work that BJ has already achieved in estates. MW noted that this is in hand.

RH commented that he was pleased to see that the Trust reported near misses as well as accidents, noting that this is critical information and culturally people are often disinclined to report near misses. RH noted that to truly value H&S information the Board needs to support a culture of people owning up to mistakes.

MW reported that a full time Head of Occupational Health had just started in the Trust who would also be supporting the health and safety work.

TB1 12/1/4.3 **Annual Medical Education Performance Report**

PC presented the report which had been through the OD&P management Board, noting that the report provided assurance and awareness of the state of medical education at SFT.

PC noted that despite pressures of the last two years, junior medical staff are receiving and reporting a good experience. The number of red flags in surgery are related to national training concerns. The Trust has had quality assurance visits from Health Education England and the medical school, both of which have been positive. Moving forward there is an understanding that there needs to be more focus on other staff groups that are not in modern training in order to ensure opportunities for development and training for a wider group of staff.

Discussion:
SH acknowledged the cost implication of taking on additional trainees but noted that it had been the right thing to do. The Board discussed the requirement to get deanery planning to align to strategic workforce planning as there is an understanding that whilst needed, they place additional pressure on existing staff. SH reported that a regional conversation was planned for the following week to understand how this could be managed better across the Southwest. ME noted that one of the areas of financial pressure is where the Trust is backfilling gaps so from that perspective taking on more trainees is a positive.

The Board highlighted the importance of education and training as valuable training experience leads to retention and from a reputational perspective, recruitment. PC explained that those more senior in their training are enticed to work in larger institutions where they essentially provide more specialist opportunities. The Board noted that moving HEE back into NHSEI will provide more control in aligning training and workforce needs. Alternative posts and training routes that are not HEE controlled will be a focus.

MvB asked for a timeline in terms of actions around improving the medical workforce and introducing new posts to support this workforce. The Board noted that PC has externally commissioned a piece of work to produce this and it will be available in the next month with a further understanding of how this will be implemented. This should come back in Quarter 1.

EJ referred to the strategic principles of the People Plan and queried if all this work should be aligned. PC explained that currently the Trust do not have a sufficient gap analysis of medical workforce, the model of care we need, and the requirement from other staff. This is a separate piece of work currently as the medical workforce is extremely complex and different in the way it is organised. However, it is acknowledged that how the Trust retains its staff should be consistent across all staff groups. JD suggested that as part of this work there needed to be an understanding of how advanced practice complements this work to inform an integrated team-based approach.

TB1 12/1/4.4 **Health Care Assistants Upgrade**

SH noted that this item had been removed from the agenda pending further work to come back to February's private Board.

TB1 12/1/5 **GOVERNANCE**

TB1 12/1/5.1 **Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance**

LT presented the report which provides the Board with the process and outcome for the annual EPRR assurance. LT advised that the documentation attached as part of the report includes the EPRR Assurance Report submitted as part of the EPRR assurance process and the final letter dated 15 December from the ICB confirming our compliance status as 'Fully compliant'.

Discussion:
RH commented that the Trust is fully compliant but asked how SFT benchmarks against other organisations. LT explained that SFT is in the top quartile in relation to other Trusts.

TB1 12/1/5.2 **Register of Seals – no new seals added since last report.**

It was noted that no new seals were added since the previous report to Board.

TB1 12/1/5.3 **Annual Review of Constitution**

This was deferred to March.

TB1 12/1/6 **CLOSING BUSINESS**

TB1 12/1/6.1 **Agreement of Principle Actions and Items for Escalation**

TB noted the key points from the meeting as follows:

- The executive received feedback about oversight in relation to theatres. Further thought was requested on how oversight and assurance can be demonstrated to the Board.
- The Board discussed the wording in relation to thrombolysis treatment and Stroke. The IPR will be checked for clarity to ensure wording reflects the current situation.
- The Board has had useful and details discussions about staffing and retention and the People Plan was approved.
- The Board had a useful update from the maternity team and feedback. The team have further learning to understand in terms of their gaps in the CNST return.
- It has been requested that the H&S report aligned to estates reporting at the Board going forward.

The key areas of escalation were noted.

TB1 12/1/6.2 **Any Other Business**

ME presented a report to the Board that had been supported at F&P Committee in December. The report outlined specific interim changes to the Standing Financial Instructions (SFIs) noting that the Trust is fast approaching the period where national pots of capital get redistributed. This places additional pressure on the procurement team. The short-term changes were detailed in the report and had been discussed in detail at F&P Committee.

Decision:
The Board approved the short-term changes to the SFIs whilst acknowledging that any chairman's action will require support from the chair, CEO and 2 x NEDs as set out in the constitution.

TB1 12/1/6.3 **Public Questions**

The Board acknowledged that a public question had been received. PC noted that the query had been in relation to Lean processes in the Trust. PC noted that he had explained that the Trust has, in conjunction with the other acute hospitals in the Bath and Northeast Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS), invested in the Operational Excellence programme developed by Theda care in North America.

The programme, named Improving Together within BSW, has been rolled out with the support of KPMG over the last 18 months. It incorporates Lean methodology and Improving Together combines bottom-up continuous improvement with an operational management system and organisational development programme. This encourages focus on a number of key priorities aligned to the Trust's Strategy and vision of an outstanding experience for our Population, People and Partners. Like the Virginia Mason Programme it has been implemented over the last decade in a number of healthcare institutions in The UK and Europe. Notably the programme has been embedded within Western Sussex Hospitals NHS Foundation Trust where it was considered fundamental to the success of the organisation and the delivery of a CQC

outstanding ratings within the Trust and subsequently in Brighton and Sussex University hospitals NHS Trust when it was rolled out following merger.

There were no further public questions.

TB1 12/1/6.4 **Date of Next Public Meeting**

Thursday 9th March 2023, Board Room, Salisbury NHS Foundation Trust

TB1 12/1/7 **RESOLUTION**

TB1 12/1/7.1 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

1	Deadline passed, Update required
2	Progress made, update required at next meeting
3	Completed
4	No progress made/ Deadline in future

Contact Kylie Nye, kylie.nye1@nhs.net for any issues or feedback

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 12/1/2.5 Integrated Performance Report (IPR) (M8)/ Theatre Activity	09/03/2023	**Peter Collins, PC Lisa Thomas, LT Stacey Hunter, SH**	The executive will come back with a suggestion on how to keep the Board sighted on theatre activity.		N	2
Trust Board Public	Sasha Grandfield	TB1 12/1/2.5 Integrated Performance Report (IPR) (M8)/ Stroke	09/03/2023	**Peter Collins, PC**	PC to check the IPR for clarity to ensure wording around Stroke and thrombolysis reflects the current situation.		N	2
Trust Board Public	Sasha Grandfield	TB1 12/1/4.2 Health and Safety Quarterly Report Q3	09/03/2023	**Troy Ready, TR Brian Johnson, BJ**	LT noted that it would be useful to triangulate estates and health and safety reports to the Board so they are aligned with their quarterly updates.	**The new dates for the two reports have been agreed and added to the cycle of business on March's agenda. Item closed**	Y	3

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	09 March 2023		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	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 1 AHA Programme Report			

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 and significant 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 in January 2023.

The report highlights:

- Key national communications for Board awareness and information.
- Level of sustained pressure resulting in continued high bed occupancy throughout the period.
- Year-end forecast
- Staff survey results
- Industrial action to date (impact) and preparation for junior doctors' strike in March
- BSW Integrated Care Systems escalation and information.

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) -	☐

Our Population

1.1 Operational Context

There is continued pressure across urgent care pathways coupled with ongoing high levels of people with a delayed discharge resulting in bed occupancy exceeding 95% during January and February. This creates significant challenges for our clinical teams in managing flow throughout the hospital and I know the Board will join me in thanking everyone for all their efforts to minimise the impact of this for patients.

Compared to December 2022 there have been improvements in the length of time most patients who need a hospital admission have waited to access a bed as the incidence of Influenzas, COVID and other respiratory viruses has reduced over the last 6 weeks.

Board members will have noted recognition for our teams' efforts in the BBC's NHS tracker which for quarter 3 demonstrated performance across a range of urgent and emergency indicators in the top 10 in England. Whilst we will not be complacent it is an opportunity to pause and be grateful to our frontline and leadership teams.

Our teams have worked equally hard in delivery of a reduction in the elective backlogs and are on track to meet the requirements to have no patients waiting over 78 weeks at the end of March 2023. The team have set themselves an internal stretch target of delivering this one month ahead of target i.e., by the end of February which I will be able to confirm at our meeting.

Progress against our key performance standards is detailed in the IPR for Board members and has been discussed in detail via the Board Committees with relevant escalation via their reports.

Our clinical, operational and EPRR teams have supported numerous days of Industrial Action in the ambulance service, Royal College of Nursing and the Chartered Society of Physiotherapists during the period. The planning and preparation are significant, and I am grateful to our strike committee members for their leadership which is critical in respect of managing safe services during strikes. Whilst the Royal College of Nursing has suspended their industrial action at the time of writing our planning effort has now switched to the British Medical Association (Junior Doctors) and HCSA (hospital doctors union) who have announced a 72hour continuous strike period for 13-16 March These strikes will be a significant challenge to trust staff and resources. This is concerning and I will ask the Medical Director to provide a verbal update on the position and preparation being undertaken.

I do want to acknowledge that whilst we were able to sustain urgent services and some of our planned work there were a number of patients who had to have their appointments rearranged because of the industrial action. The details of this can found below. I would like to apologise to people for any inconvenience this has caused.

Union	Date	Procedures cancelled	OP appointments
RCN	18th Jan	26	224
	19th Jan	25	262
	6th Feb	13	149
	7th Feb	5	35
		IP therapy interactions re-scheduled	
CSP	9th Feb	201	120

Our teams have continued to implement all elements of our Winter plan including sustaining an additional 24 beds at South Newton and utilising all the internal escalation capacity to support flow.
As work develops for next year's plan it is imperative that alongside our internal improvements, we can work with our system partners to reduce the number of people who are experiencing a delay in being discharged due to waiting for ongoing community health or social care capacity. The number of people this is affecting has not materially reduced throughout the year and has resulted in 25% of our beds being utilised for this purpose. This isn't sustainable going forwards.

The Chief Operating Officer and Chief Finance Officer will brief the Board about progress on next years plans in more detail at our meeting today.

1.2 Financial sustainability
The organisation continues to be financially challenged, driven by the demand for beds across urgent and emergency care pathways. As we near the end of the fiscal year we continue to collaborate with our partners within BSW to ensure the system meets its financial commitments for the year.

As we move into 2023/24 these financial and operational challenges will remain, with an expectation of efficiency, productivity, and cost reduction programmes greater than those seen since the beginning of the pandemic. This is a picture that is consistent with our partner BSW Trusts and those of surrounding systems. Work is underway within BSW to embed a financial recovery workstream, facilitating a transparent and aligned approach to prioritisation, risk, and principles relating to cost changes across the system.

2.0 Our People

2.1 Staffing
As a result of our Improving Together work, we have generated Staff Availability as a breakthrough objective. The driver metrics for this are a combination of high vacancy rates, poor retention of staff leading to high turnover and high levels of short-term absence, all of which result in the requirement for increased spend on agency staff to meet safe staffing and other service requirements.

A number of initiatives have been generated to improve the situation and meet the breakthrough objective goal to reduce agency spend towards the 3.7% target. These include an overhaul of recruitment processes shown through a PwC audit, which will improve onboarding, reduce time to hire and target attraction campaigns to meet hard to fill vacancies. A separate piece of work is capturing our social media profile to support attraction campaigns. Improvements to our Establishment Control mechanisms and the full roll out of E-Roster to manage staff rotas and generate improved data to understand shift patterns is also underway.

2.2 Retention of staff
Our ability to retain staff is key to the successful delivery of our new breakthrough objective. Work this month has focussed on the delivery of training interventions to enable staff to support conversations on wellbeing and career with our staff. The latter conversations focussed on those Nurses in the 45-55 age group, who will be considering future options because of pension changes and life decisions. Well-being champions have also been trained to support Line Managers in signposting staff to effective support where it is needed. Finally, we have invested in a pilot to provide local support for wards where absence

management has been difficult, identifying interventions to support staff back to work and identify longer term issues which may be affecting staff. Successful recruitment of a new Head of Occupational Health and additional staff is further supporting this activity.

2.3 Engagement

The January Pulse survey show positive improvements against the last Pulse (July 2022) which is encouraging. For example, staff reported that their ability to show initiative at work was up by 11%, that they felt their health and wellbeing was supported was up by 7% and recommending SFT as a place to work was up by 7.3%. Many other categories remained neutral with being well informed about changes and time passing quickly both down.

2.4 Staff survey

Today is the formal publication date for the annual staff survey results. The Staff Survey questions have for two years, since 2021, been aligned to the NHS People Promise.
The headline results shared to date are benchmarked against the other 65 acute providers who use Picker. The published results are out today which we will discuss in more detail next month. These will be benchmarked against all acute providers in England.

The survey was completed in October and November last year with a response rate (47.8%) slightly lower than the previous year (49.0%) but was above the average rate for comparable Picker trusts (46%).
We scored better than last year against most questions in the elements of:

- Your Job
- Your Team
- People in your Organisation
- Your Managers

We scored less well against our results last year in.

- Your Organisation
- Your Health and Wellbeing at Work – but better than other Picker Trusts.

The areas that need the most improvement include:

- Recommending the organisation as a place to work and receive treatment
- Addressing learning from errors and concerns
- Accessing development and receiving an appraisal
- Fair and equitable employer with colleagues from Black and minority ethnic backgrounds reporting they experience more harassment, bullying and abuse than white staff.

Further to the full results been published today, we will take the opportunity to share at next Board our “listening to action” response as we support the Divisions to host roundtables/ focus groups and understand the root cause of some of these results alongside the focus of 23/24 people plan
I know the Board will want to join me in thanking our colleagues who took time to complete the survey. This really helps us understand where we are getting it right for staff and where our continued focus for improvements needs to be.

2.5 Well Led Review

The FT Code of Governance sets out a requirement for an externally facilitated evaluation of an NHS FT Board at least every 3 years. This is supported by NHSI ‘Developmental reviews of leadership and governance using the well-led framework: guidance for NHS and NHS Foundation Trusts’ which recommends developmental reviews of leadership and

governance every 3 to 5 years. The last SFT externally facilitated review was May 2018. The review was planned for 2021 however, Covid delayed this process and the Board approved a deferral until 2022. The last CQC well-led inspection was November 2018.

A BSW AHA external well led developmental review tender process was successfully undertaken and the contract was awarded to Aqua (Advancing Quality Alliance). Aqua is an NHS Health and care quality improvement organisation working across the NHS, care providers and local authorities. An initial meeting between all three Acute Trusts and Aqua was held on 8th February. The agreed arrangement is for SFT's review to commence in April. This is expected to be at least a three-month process.

In addition to the core developmental review offer, the Trust has committed to a further 2 optional elements; external stakeholder interviews and pre CQC mentoring sessions to prepare the Board/Senior Team for assessment.

The Board welcomes this developmental review which will identify our leadership and governance strengths and provide areas for focussed improvement

3.0 Our Partnerships

3.1 National Communications

NHS E/I have selected our Acute Hospital Alliance as one of nine successful provider collaboratives to join the new Provider Collaborative Innovator scheme. The ambition of the scheme is to support and accelerate development of the collaboratives so that patients across the country benefit. We are delighted to have been selected and want to maximise the opportunities to be at the forefront of transforming services for the communities we serve.

3.2 BSW Integrated Care System

The BSW Integrated Care Board is progressing the partnership's work on key transformation programmes. Of note this includes the BSW Integrated Community Based Care Programme which present a significant opportunity to strengthen this provision for our communities. There is a tight timetable with new arrangements to be secured for April 2024. We are progressing work alongside other system partners which we will share with the Board during our private session due to the commercial confidentiality.

As part of the BSW response to the planning guidance and allocations the ICB is progressing work to on delivering the priorities and working towards a balanced financial position. There are significant challenges to work through which we will detail to Board via our operational and financial plan for 23/24.

3.3 Acute Hospital Alliance (AHA)

The programme of work led by AHA is progressing well and I have appended (Appendix 1) the detail for Board colleagues in the AHA programme report.

The first workshops for the 9 Provider Innovative sites will take place in April and I will feedback to the board the opportunities the programme may support us to accelerate and strengthen our AHA priorities.

3.4 Wiltshire Place

The joint committee has had an opportunity to respond to Wiltshire Councils draft Health and Wellbeing Strategy which outlines their priorities over the coming years based on the latest Joint Strategic Needs Assessment (JSNA)
Kate Blackburn our Director of Public Health delivered a session for SFT colleagues on the most recent JSNA which over 150 colleagues joined.

3.4 Other partnerships, communications and engagements

Salisbury in the news – The Trust has once again welcomed national and regional broadcasters onto site. ITV news covered the pressure on beds can be seen here (nhs-remains-under-significant-pressure-as-new-hospital-figures-released) and 5 news reported on A&E waiting times (Record number of people waiting more than 12 hours in A&E | 5 News).
More positively, the BBC recorded Dr James Haslam and our former Director of Nursing, Lorna Wilkinson for a special podcast reflecting on the hospital's response to the Novichok poisonings. This will be on BBC Sounds from 28th February. Dr Kate Jenkins also provided an interview on the impact of Novichok for BBC West. And finally, Jane Dickinson Deputy COO has also been on BBC Wiltshire discussing our positive national ranking for Emergency Department waits in January. A huge thank you to all the staff that both featured and supported the filming.
The hospital podcast series *The Cake* is now live on BBC Sounds in an abridged form and is being broadcast each week on BBC Wiltshire. Joe and Jayne supported this with a live interview.

Meeting of Board of Directors

Report Summary Sheet

Report Title	Acute Hospital Alliance Briefing, February 2023.					Agenda item	
Date of meeting	February / March 2023						
Purpose	Note X		Agree		Inform		Assure	
Author, contact for enquiries	Ben Irvine, Programme Director (ben.irvine@nhs.net)						
Appendices	Appendix 1. AHA Briefing						
This report was reviewed by	• Cara Charles-Barks, CEO RUH, Senior Responsible Owner • Kevin McNamara, CEO GWH • Stacey Hunter, CEO SFT						
Executive summary	This briefing provides an update on the activities of the Acute Hospital Alliance (AHA) in January and February 2023, as well as a description of priorities for the forthcoming period. Work of the AHA Committees in Common of the three Trusts, and the AHA Programme Executive is described. The following areas are covered in the briefing: 1. AHA selected to join National Provider Collaboratives Innovator programme 2023-2024. 2. Committees in Common Update 3. Programme Executive, Developing AHA 2023-2026 programme & Delivering Five Core Projects: i. Acute Clinical Services Strategy Development ii. Consistent Methodology for Staff Modelling iii. Open Book Finances & Use of Resources Assessments iv. Single Capital Priorities Plan v. EPR Alignment Programme 4. Further updates are provided on Programme Resources, Risks & Issues, Communications plans, the role of AHA in BSW Integrated Care System and the AHA Forward Meeting Cycle. The next AHA Board briefing will be issued in March 2023. For further information on the AHA Programme please contact Programme Director Ben Irvine (ben.irvine@nhs.net).						

Equality Impact Assessment	An AHA Programme Equality Impact Assessment [EIA] has been completed. The EIA will be refreshed as the three-year AHA Programme 2023-26 matures.							
Public and patient engagement	Our AHA Clinical Strategy work is closely linked with the BSW Care Model which has been through a significant public engagement exercise. Service users will be involved in service design activities as the AHA Clinical Strategy is implemented.							
Recommendation(s)	To note the AHA briefing.							
Risk (associated with the proposal / recommendation)	High		Medium		Low X		N/A	
Key risks	The development of the BSW Acute Hospital Alliance is in line with national policy and strategic direction on provider collaboration. The AHA Programme Executive, SRO and Programme Director identify and manage risks associated with programme delivery.							
Impact on quality	The AHA maintains a strong focus on quality and patient safety and assumes continuous focus on quality improvement – the Improving Together programme is one of the AHA core activities. The AHA clinical strategy and staffing methodology workstreams are designed to improve clinical service effectiveness, patient experience and quality. The corporate workstreams aim to deliver value for money, quality, and resilience of corporate services.							
Resource implications	A cost centre has been established at GWH to host the core AHA budget. SFIs are being developed by the Directors of Finance to maintain balance in financial contributions between the three Trusts.							
Conflicts of interest	None known.							
This report supports the delivery of the following BSW System Priorities:	☒ Improving the Health and Wellbeing of Our Population ☒ Developing Sustainable Communities ☒ Sustainable Secondary Care Services ☒ Transforming Care Across BSW ☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan							

Appendix One.

Acute Hospital Alliance, January - February 2023 Briefing

Introduction

This briefing provides an update on the activities of the Acute Hospital Alliance (AHA) in January and February 2023, as well as description of priorities for the forthcoming period. The following contents are included in each monthly briefing:

1. AHA and National Provider Collaboratives Innovator programme 2023-2024.
2. Committees in Common Update
3. Programme Executive Activities, Developing 2023-2026 programme; Delivering Five Core Projects;
4. Decisions Taken
5. AHA in BSW Integrated Care System
6. Resources Update
7. Risks & Issues
8. Communications
9. AHA Forward Meeting Cycle

1. AHA and National Provider Collaboratives Innovator scheme 2023-2024.

On 20th February, the Trusts were notified by NHS England that our BSW Acute Hospital Alliance has been selected as part of the first wave of a new national Provider Collaboratives Innovators Scheme. This is a significant achievement, with the AHA being the only bid chosen from the South-West with nearly 50 bids submitted across the country.

As part of the new scheme, NHS England has chosen nine collaboratives – one from each region – to help accelerate their development; being part of the first cohort is recognition of the work our teams have done so far, and our potential to collaborative further in the future.

We will now work closely with NHS England to co-design the support and expertise we consider would provide most value to deliver our locally agreed priorities for benefitting patients. This will enable us to increase equity for our population, through clinically and financially sustainable services, and continuing to improve what we do for the future.

Being part of the first cohort will provide further opportunities for staff at our three organisations to collaborate more closely together. It also means that our experience will help to improve future policy around collaboratives and collaboration.

We have held initial discussions with NHS England about how they can best support the development and impact of our partnership through this programme. Further details on the Innovator Scheme will be included in our monthly AHA Briefings.

2. Committees in Common: Update

The AHA Committees in Common (CIC) sets strategic direction and provides oversight of the AHA programme. The CIC has also arranged a series of away days to support AHA development, strengthening our collaborative work, better ensuring programme alignment within BSW, and relationship development within the ICS. The next of the series of CIC away days will be held in March while the next regular CIC meeting is planned for 21st April.

3. Programme Executive Activities

Executive leads from across the Trusts have continued *developing our 2023-2026 programme*. The programme includes both clinical and corporate services collaboration streams, with activities designed to enhance quality, reduce unwarranted variation, improve productivity and cost effectiveness. The proposed programme will be reviewed by the Executive at its meeting on 31st March.

Governance Review. The programme has commissioned a developmental governance review to ensure the AHA has strong governance arrangements in place as it embarks on the next phase of its work in the developing BSW and national Provider Collaborative landscape.

The Programme Executive has established an *AHA Joint Planning Steering Group*, meeting fortnightly, responsible for optimising the alignment of acute trust operational and strategic planning to support the BSW system.

Updates on the objectives, recent activities and next steps for each of the *five core AHA projects* follow.

Project One: Acute Clinical Services Strategy

- *CEO Sponsor:* Cara Charles-Barks, *Executive Lead*, Peter Collins, Chief Medical Officer, SFT; Programme Management, Alicia Wyer.

- *Objective:* Creation of a joined-up acute clinical services strategy to support realisation of the BSW care model. This project aims to support transformational change across our health and care system, so that as three acute hospitals we deliver excellent care and focus on the work that only we can do. The strategy will set a clear ambition for our services – for example to achieve at least upper-quartile performance against a group of measures, compared to similar services nationally.

- *Recent Activities:* A working group meets fortnightly and has organised a series of Acute Alliance Clinical Summit sessions to bring together clinical leaders from the three Trusts as well as other BSW Partners. January & February saw completion of a *Clinical Service Collaboration Framework* and launch of the planned *Programme of Specialty Deep Dives* – including Ophthalmology, Oral Surgery, ENT, Pharmacy, Dermatology and Gynae-Oncology. A series of briefing sessions with specialty leads and teams has begun. Initial workshop sessions have been held by Pharmacy colleagues. On 26th January our *Clinical Strategy Programme Board* held its second session, chaired by Peter Collins, CMO SFT. The

group will oversee the strategy implementation, including *Specialty Deep Dives*. It will ensure service transformation, performance improvement and financial sustainability are each appropriately reflected.

- *Next Steps:* On 15th March the *Clinical Strategy Programme Board* holds its next session. The Programme team has confirmed resource requirements to support clinical strategy implementation. Trust leads are considering sourcing strategy. The Programme team is working with BSW & acute business intelligence leads to create specialty data packs – these will be used to identify areas for significant performance improvement focus.

- *Forthcoming Milestones:* Summit 4: The fourth summit on 25th May will be hosted by GWH and will focus on learning from the specialties / services and teams involved in piloting the *Clinical Services Collaboration Framework*.

Project Two: Consistent Methodology for Staff Modelling

- *CEO Sponsor:* Kevin McNamara, *Executive Leads:* Melanie Whitfield, Chief People Officer, SFT & Antonia Lynch, Chief Nursing Officer, RUH; Programme Management, Alicia Wyer

- *Objectives:* This project is closely linked to our Clinical Strategy work. Over the next three years its objectives are:
  - To achieve safe staffing levels across the AHA supported by agreed principles and variance.
  - To deliver best in class patient outcomes. Creating an environment where staff feel psychologically safe, supported, developed and have sufficient resource to do their job.
  - To encourage new staff models designed to support delivery of Clinical Strategy and BSW Care Model.
  - Finally, to achieve financially sustainable high-quality services.

- *Recent Activities*: A small working group has continued to meet weekly to drive the project and its four workstreams – Nursing, Midwifery, AHPs, & Medical Staffing. The AHA Executive held a workshop session on 27th January to review initial recommendations for each staffing group. A detailed report on inpatient nursing was introduced by the three Chief Nurses. The report described a consistent, evidence-based approach to nursing staffing designed to ensure a high standard of care across the AHA and inform the best use of resources.

- *Next Steps:* Departments and staffing groups not included in phase 1 (including Emergency Department, Paediatrics, Theatres, Outpatients, and Advanced Care Practitioners) will be reviewed in 2023-2024. The team will develop a *multi-professional service line workforce methodology* to support new models of care envisaged in the BSW Clinical Strategy. The Chief Nurses plan to create an AHA Nursing and Midwifery Workforce committee to shape the strategy and vision for Nursing and Midwifery across the AHA. The group's remit may include:
  - Developing a nursing workforce fit for the future; Nursing within new and emerging Health and Social Care models; Workforce sustainability; Development of new roles; Clinical career pathway for nursing and midwifery excellence.

- *Milestone: End January 2023* – Phase 1, Risk-based, prioritised and phased investment plan for nursing has been completed and is included in the annual planning exercise. Phases 2 and 3 will be completed in 2023-24 and are expected to inform planning rounds for the next three financial years.

Project Three: Open Book Finances & Use of Resources Assessments

- *CEO Sponsor:* Kevin McNamara, *Executive Lead:* Mark Ellis, Chief Finance Officer, SFT

- *Objectives:*
  - First, creation of an 'Open Book' BSW ICS Finance report. To understand the collective risk of the three Trusts, looking ahead proactively to plan mitigations. To demonstrate partnership working in instigating mitigating actions and a collective approach to risk.
  - Second, Use of Resources (UOR) assessments, to allow AHA to prioritise and systematically identify opportunities for collective improvement; Identify opportunities for learning and best practice to be shared amongst the alliance to deliver improvements; and to support the development of the Acute Alliance Clinical strategy.

- *Recent Activities:* BSW ICS Finance report completed and circulated for months nine & ten; Initial high-level Use of Resources Assessment (UOR) drafted for all three Acute Hospitals; Pilots: Urology, Dermatology, Oral & Maxillofacial, UOR assessments completed. Meeting held in early February to ensure appropriate connection is drawn between AHA Clinical Strategy implementation programme and the Use of Resources work.

- *Next Steps:* Working closely with the Clinical Strategy programme team, finalise programme of deep dives for 2023/24 based on UOR assessment. Secure analytical resources to enable ongoing Use of Resources project delivery.

- *Milestones:* Confirmation of Deep Dives Programme for 2023-2024 – Anticipated February-March 2023. Monthly open book finance reporting.

Project Four: Single Capital Priorities Plan

- *CEO Sponsor:* Stacey Hunter, *Executive Lead:* Simon Wade, Chief Finance Officer, GWH

- *Objective/ Vision:* Project aims for AHA Trusts to:
  - Work together to maximise available capital resources into BSW/ AHA by having a coherent, strategic plan for capital investment within the AHA
  - Create a workstream-based approach to prioritisation that balances different types of capital investment.
  - Consistently advocate for each-others' schemes and the collective capital development priorities.

    - Establish a focused capital strategy development framework including clear principles guiding how we will collectively respond to national requests for funding.
    - Confirm a coherent plan working towards net zero carbon sustainability standards across AHA.

- *Recent Activities:* Launch sessions were held in early January. Later in January and February capital programme data submissions were made, collated and initial analysis completed, with planned schemes being categorised into five workstreams: Strategic Redevelopment, Backlog Maintenance, Medical Equipment, Diagnostics, Digital). A *Strategic Capital Group*, chaired by Simon Wade, has been established to oversee the ongoing development of capital programme through 2023-2024.

- *Next Steps:* 24th February will see the AHA Executive hold a capital prioritisation session. In March/ April the Committee in Common will consider recommendations, leading to confirmation of priorities.

- *Milestones:*
    - March/ April: Committee in Common agrees 5-year AHA wide capital strategy.

Project Five: EPR Alignment Programme

- *CEO Sponsor:* Stacey Hunter, *Executive Lead:* Jon Westbrook, Chief Medical Officer, GWH

- *Objective:* Procurement and deployment of a single EPR platform. The programme will provide a common digital platform between the Trusts that will enable standardised care pathways, mutual aid models, single consistent data flows and economies of scale. Through close alignment with the Clinical Strategy Programme the EPR Programme aims to optimise care, minimise variation, improve clinical outcomes, and level-up digital maturity across the three trusts.

- *Recent Activities:*
    - Programme management and Oversight. Clinical Design Authority, EPR Steering Group and EPR Programme Board established and meeting regularly.
    - *Procurement*. Having been selected as preferred bidder in early January, contract negotiations continued through January and February with Cerner. The procurement exercise to secure a Data Migration and Archiving partner has continued.
    - *Full Business Case (FBC) Production*. Drafting of FBC is nearing completion.
    - *Stakeholder briefings*. A series of briefings on the benefits and anticipated costs of the FBC has continued.
    - *Budget*. *December's* Programme Executive saw consideration and approval of budget proposals for Q4 2022-23 and 2023-2024. The funding request was subsequently submitted to Trust Boards for consideration and approval in January. Following approval, recruitment to priority roles has begun.

- *Next Steps:*
    - *February, March* – confirmation of capital availability and phasing.
    - *February, March* - Continue benefits analysis and development to support FBC.
    - *March* – Briefing sessions for Trust Board sub-committees.

  - *March 2023* – Finalisation of FBC.
  - *March 2023* – SRO and EPR Finance lead secure ICS letter of endorsement.

- *Milestones:*
  - *April 2023* – FBC to Trust Boards and ICB Board for consideration. Then passed to SW Region.
  - NHSE FBC approval anticipated in August 2023
  - Go-live plans for each Trust will be determined during contract negotiations with the suppliers.

Other Programme Activities

- People Services Programme – collaboration opportunity scoping work has continued led by the three Chief People Officers.
- Corporate Programme – Finance team: progress continues to be made in procurement collaboration. The team is focused on delivering the 2022-23 programme (year-end forecast on-plan at £5m) and defining priorities for the 2023-24 programme – target £4.9m.

4. Significant AHA Decisions Taken – January
   - Project 2: Staffing Methodology. Nursing report recommendations approved.
   - Joint Planning Steering Group Terms of Reference approved.
   - Clinical Strategy Programme Board Terms of Reference approved.

5. AHA in BSW Integrated Care System

The AHA aims to contribute to system stability, modelling the benefits of collaboration. With strong relationships between Trust leadership teams built over the past years, the AHA continues to play a full role as an effective provider collaborative, maximising opportunities to work together at scale to the benefit of the population we serve.

6. Resources Update

The Acute Alliance has a small core team in-post. The AHA Programme is funded by equal contributions from the three Trusts. Posts are hosted by all three Trusts. The AHA Virtual Clinical teams work (eg Dermatology and Ophthalmology) also receives programme and project management support from the ICB Strategy & Transformation Directorate – acute commissioning team. During the period covered by this report:

- Resource requirements to deliver the AHA clinical strategy programme as well as the enabling capital, staffing methodology, and use of resources assessment enabling projects have been re-affirmed. Leads from the three Trusts have been planning how to ensure sufficient resources are made available to support agreed AHA priority work; this is likely to include opportunities for Trust staff to lead or take part in collaborative project teams.
- As described in section 3 above, resource requirements for the next phase of the EPR programme have been approved.

7. Risks & Issues

A range of risks and issues continue to be managed by the programme team. A risk register is held centrally, risk management responses are reviewed monthly, with significant items being reported to the Programme Executive. No new and significant risks have emerged in this reporting period. The following risks & issues were reported to the Programme Executive over the last three months.

1. *Capacity constraint; delay to delivery:* The programme's current and emerging work programme will require further resource to support delivery. *Response*: A detailed resource plan is in place. In the current financially constrained operating environment, leads from the three Trusts are planning how to ensure sufficient resources are made available to support agreed AHA priority work.

2. *Leadership Transition in BSW*. Establishment of ICB leadership team, Executive and ICB Board, and developing operating model creates some destabilisation. *Response*: Core AHA team and Trust executive leads are working to develop effective partnership relationships with ICB executive team. Maintain focus on effective delivery by AHA, contributing to system stability and sustainability, modelling positive impact of collaboration. Involve ICB executives in key activities. AHA leads to engage effectively as partners in BSW Integrated Care System development.

3. [Project 5] Access to EPR Funding restricted (Capital & Revenue). *Response*: CIC support will be required over next three months to ensure required funds are secured. £21m capital support has been confirmed by NHSE – N.B. match funding is required, and a process is underway to identify required funding [Refer *AHA Project 4 – Single Capital Priorities Plan*].

4. [Project 2] *Staffing Methodology*.: The clinical staffing establishment baseline work has potential cost implications. *Response*: The team has developed a draft investment decision timeline that assumes risk-based phasing of investment will be required over 2-5 years. Initial nursing workforce outputs were reviewed by the Programme Executive on 27th January and are included in Trust workforce plans for 2023-24 budget.

8. Communications

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

- *Monthly Board Briefings*, a *Monthly Newsletter* for wider dissemination through Trusts and BSW, and a monthly *AHA Highlight Report* – for CIC and Programme Executive.
- A series of *videos on our five priority projects* involving Trust leads are in production.

A week-by-week stakeholder communications plan is also in place designed to maintain an effective overview of communication activities across the whole programme.

9. AHA Forward Meeting Cycle

Table one below sets out the dates of our CIC meetings, Programme Executive and Clinical Summits for 2023. A detailed meeting planner, providing a clear view of key decision points and milestones has been developed by the programme team and will be shared via the Programme Executive and Committees in Common.

Table 1. Forward Meeting Cycle: Key Dates

AHA Committee in Common Dates 2023				
17th February	21st April	23rd June	18th August	20th October

AHA Programme Executive Dates 2023											
27th January	24th Feb	31st March	28th April	26th May	30th June	28th July	25th August	29th Sept	27th October	24th Nov	29th Dec

AHA Clinical Summit Dates 2023		
1st March	25th May	28th September

Finally, the next AHA Board briefing will be issued in March 2023.

Close

Drafted by Programme Director, Ben Irvine

22nd February 2023

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	9th March 2023		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	28th February 2023
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 28th February 2023. The report both provides assurance and identifies areas where further assurance has been sought and / or is required.

Key Items for Escalation

Key information / issues / risks / positive care to escalate to the Board are as follows:

- Following on from discussion at the December CGC, a deep dive has been undertaken and was presented to the committee on the electronic discharge summary (EDS) backlog. A first stage review has been undertaken which has identified that there is a low risk of harm and that some of the gaps in EDS are due to either process or recording issues. Approximately 5% of the EDS' (for patients in hospital more than 24 hours) need further analysis and this is being led by the Head of Clinical Effectiveness on behalf of the Chief Medical Officer. A timeline to come back to CGC has been agreed with earlier escalation if required.
- The discussion about the Integrated Performance Report section confirmed that there has been some improvement in quality metrics despite the ongoing operational pressures, including the impact of industrial action. The progress is partly due to increase in available care hours per patient day (CHPPD) following successful recruitment of approximately 100 healthcare support workers. Concern was raised that Grade 2 pressure ulcers have increased in month and the continued focus on education and fundamentals of care was noted. Alongside the discussion relating to diagnostic performance challenges at F&P, the committee asked for assurance that any harms relating to delays in diagnosis were being reviewed and acted on. Assurance was provided from the CMO that prioritisation continued to be undertaken by senior clinicians. It was also noted that planning was well advanced in relation to medical staff industrial action and a further update would come to Board.

- The risk report was presented with assurance provided that the uploading of the backlog of Datix incidents had been completed and that this was because of the corporate risk team being at full capacity. A key risk, as discussed in the IPR related to delays to treatment.
- Despite the current operational pressures, patient experience continues to be mainly positive with complaint numbers reduced despite an increase in patient numbers. The committee also noted high satisfaction levels with an increase in compliments. The national patient survey key findings were considered alongside the plan in place to address feedback. Whilst the Trust is the same as other Trusts in 45 of the 47 questions, there were 2 questions where the Trust were rated worse than others. These areas of concern related to hydration and noise at night. The new roles being implemented and the recruitment plan will aid in addressing the focus required on fundamentals of care.
- The quarterly maternity report was presented. Whilst safety metrics remain positive, the ongoing challenges due to midwifery shortages were noted. Focus on the maternity incentive scheme and meeting the Ockenden requirements were outlined and these will be escalated to Board for discussion at March Board. The Director of Midwifery also reported on the national maternity survey, noting that SFT scored in the top 20% of Trusts on 15 questions and in the bottom 20% of Trusts on 5 questions out of a total of 59. Areas for improvement action are in train.
- Quarterly reports were presented on safeguarding adults and children and research. All gave good assurance.
- The annual report for 2022/3 was provided in relation to Human Tissue Authority (HTA) inspection of Stem Cell and Post Mortem licences. For both areas, the HTA had confirmed that following reparative action, the Trust remained fully licensed. The Director of Corporate Governance was thanked for her leadership of this work.
- The second Divisional presentation was given, this time by the Medicine Division. It was positive to note that the Divisional triumvirate had been involved in preparing for the meeting. Information was provided in relation to how governance had been improved and how learning was being shared through a new forum. Areas for improvement, for example Duty of Candour, have been identified and the revised governance is enabling better focus on this. Training is happening across the Division in relation to governance.
- The upward report from Clinical Management Board (CMB) was presented. It had been a very full meeting with a strong focus on safety. It was escalated that cataract surgery had been paused due to an issue with one of the machines involved in the procedure. Assurance was provided that there had been no harm to patients and as a result of the investigation a change had been made which has enabled surgery to recommence. Assurance was also provided that the relevant authorities had been informed and that whilst surgery had been paused for 6 weeks, the 78 week wait trajectory would not be adversely affected by this.
- Both Governor observers confirmed that there had been good scrutiny at the meeting, including a focus on some challenging issues.

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

CLASSIFICATION: please select

Report to:	Trust Board	Agenda item:	2.2
Date of meeting:	9th March		

Report tile:	Escalation report from Finance and Performance Committee		Meeting Date	28th Feb 2022
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Prepared by:	Debbie Beaven, Non-Executive Director			
Executive Sponsor: (presenting)	Debbie Beaven, Non-Executive Director			

Recommendation:

The Board is asked to note the discussion points and approvals contained below.

Executive Summary:

Supply of CT Equipment, Maintenance, and Turnkey Works.

The Committee considered the proposal for a 2-year fixed price contract for equipment including 10 years for the associated maintenance with a total contract value of £6m.

The Committee explored the level of priority for this investment, it is in the draft capital plan, but the Trust was hopeful it would be funded through the national diagnostic funding streams. It comes with a £100k cost pressure. The response was that this is of the highest priority, given the “end of life” status of the existing equipment, which fails regularly and detrimentally impacts productive and patient pathways.

The Committee agreed to commend the spend to Board (paper will be submitted) for approval on the basis that it is a “must do” with a positive impact on DM01 in the medium/long term. A bid for national capital funding will be made and may be retrospectively applied if the Board approves the expenditure this year. The company have confirmed they can provide a Vesting Certification to evidence the transfer of ownership and allow the money to be spent compliantly.

Surgical Robot Business Case

The Committee considered the proposal to invest in new surgical robotic capability, with a capital cost of c£1.2m and annual running costs for maintenance and consumables of £170k Yr2 to £275k Yr7, with additional training costs totalling £210k over 2 years. The running costs are an additional cost pressure in the short term.

The driver for this investment is to ensure we can recruit talent to meet our patient needs, where in a rapidly changing surgical landscape, candidates want to be where robotic surgery is happening. Without it there is a cost risk of approx. £268k pa from vacancies and agency backfills. During the training phase it may have a negative impact on productivity and the Committee asked that this be minimised and mitigated effectively.

The Committee was given assurance that this was already part of the strategy, with the urgency coming from the opportunity to gain a discount by purchasing alongside GWH. There was acknowledgement that

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

discounts may still be negotiated if this opportunity is missed, but the Executive team were fully supportive and see this as an opportunity to catch up with other Trusts and make it core to our clinical offering.

There are 2 potential sources of funding; the business case is based on using charitable funds, however there was some discomfort around whether this should be funding through the charity if it is core and part of our strategy. The opposing view is that there is precedent and it is exactly what the charitable funds are for. There is a potential for some funding through regional additional capital, however this was not confirmed at the time of the meeting.

The Committee asked in commending this proposal to the Board that the paper be updated with the source of funding confirmed.

Chair – post meeting reflection: it would be helpful to track where we make decisions that add cost pressure for next year.

Integrated Performance Report

Themes haven't materially changed with challenges and performance consistent to previous months, the committee noted the following changes in performance:

- Improvement in the 28-day Cancer standard
- DM01 – Echo and Cardiology now in a steady state but recognising there is a need to review the clinical prioritisation and processes linked to outpatients as to whether demand can be managed differently.
- MRI – most challenged position, with a workshop planned with the aim of thinking differently to balance demand and capacity.

Operational Plan 23/24

The Committee heard that the 2 key challenge are Improving Length of stay and reducing turnover of staff, the key discussion points included:

- The plan is still in draft form with a number of elements still being developed – particularly around the money and triangulation to improvements required/transformation schemes.
- Length of stay (LoS), with the particular need to reduce the number of beds open – which is considered a system priority and linked to the number of patients waiting for onward care/assessment as well as improvements SFT need to make for pathway 0 and pathway 1 patients.
- The current modelling doesn't include the system ambition of a 50% reduction in beds (c60 beds) by the end of the year. This is currently being modelled and dialogue with Wiltshire Place is ongoing to understand the feasibility and plans to improve – it is expected further versions of the plan to come to Board will include some ambition about improvements.
- There is still work to be done on the transformative projects and milestones, to demonstrate their impact operationally and financially in driving sustainable services and financial performance.
- Reducing the turnover of staff, which is for us to improve. Recruiting and retaining staff remains a key issue with many initiatives in place. We need to evaluate what is working.

Financial Plan 23/24

There was an acknowledgement that there is still a lot to do to land the plan, ahead of the submission deadline of 30th March and that the Board has limited time to be assured around the rigor and credibility of the plan. There is likely to be a need an extraordinary F&P meeting (with an open invite to all Board members) around the middle of March to consider the plan, as it's state of triangulation, detail and challenge from ICB evolves. The Board will need to consider delegating authority to F&P (or CEO, FD, Trust Chair and

Chair of F&P) to approve the final plan at the end of the month before submission. The expectation is that many of the plan principles and assumptions can be agreed at the Board meeting on 9th March.

The key challenges remain:

- Operational as above
  - 4% efficiency savings and the level of confidence that this is achievable, together with the divisional drive and accountability to "improve together" to explore and deliver efficiency opportunities. There are clearly identified opportunities however the pace and operational pressures are the biggest risk to delivery.
  - A potential further push to reduce costs by another £10m as a result of a £35m hole at ICB which the acutes have been asked to find.
  - Leadership capacity and stretch, to focus on SFT's challenges and deliver improvements as well as support the ICB with some members spending 1-2 days per week in "system" work.

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

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	09 March 2023		

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:	Stacey Hunter Chief Executive Officer			
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.

Escalation Summary:

The Trust Management Committee was held on February 22nd and was a full committee this month following the Senior Leadership Meeting being held last month.

In addition to the standard escalation reports which the Board receive assurance from via the IPR and the Board committee reports, TMC received presentations from the four clinical division teams on their progress against the 23/24 operational plans.

TMC members had the opportunity to review the plans against the national planning guidance and the contributions to our Improving Together breakthrough objectives, strategic initiatives, and vision metrics. The teams presented their activity assumptions, cost improvement plans, performance trajectories and their delivery risk factors.

The Divisions had made a good start and all recognised that there is more work needed as we progress towards the final plan. The key focus for each Division over the next period is summarised below:

Medicine:

- Workforce plans to deliver reduction in agency and premium rate spend
- Detailed plans to reduce length of stay and bed occupancy
- Review of opportunities to increase productivity in Cardiology and Respiratory elective activity

- Progress CIP plans

Surgery:

- Same Day Emergency Care Pathways
- Recovery performance trajectories for Endoscopy and Audiology (contribute to DMO1 standard)
- Outpatients follow up reduction
- Continued review of elective and day case activity plans for all specialities focusing on realising productivity and efficiency benefits

CSFS:

- Recovery trajectories for the 6-week diagnostic standard (DM01)
- Staff availability
- Spinal therapy provision (new national standards)
- Medicines reconciliation
- Time to first outpatient appointment
- Further CIP plans

Women's and New-borns:

- Improve retention rates across Midwifery
- Reduce time to first appointment in Gynaecology
- Productivity in elective activity to increase overall day case and IP trajectories
- Recovery Gynaecology cancer performance
- Continue to progress improvements aligned to the Ockenden requirements, Saving Babies lives and their plans in place to respond to their CQC priorities.
- Respond to the national single maternity improvement plan (due to be published March)

The committee considered the following business cases:

1)Proposal to transition locally employed doctors to the 2016 Contract.

When the trust transitioned junior doctors to a new national contract in August 2016 this did not include locally employed doctors (LED)
The business case detailed a proposal for 38 LEDs to be transitioned to the 2016 contract to improve recruitment and retention, promote fairness and remove pay disparity between doctors on the same grade.
The financial implications were detailed and do not represent any additional cost for the organisation and the details of how this will be implemented were outlined clearly within the case. **TMC approved this business case**

2)Surgical Robot Business Case

TMC reviewed a business case to purchase a surgical robot in line the Acute Hospital Alliance robotic strategy (agreed April 2022).
The case detailed the drivers, the national and local context which demonstrates evidence of accelerated uptake of robotic surgery in DGHs and the opportunities for patients to have access to robotic surgery in their local area. The business case appraised the relevant features of two well established commercially available robotic systems and detailed the preferred option for

TMCs consideration. **Following a comprehensive discussion TMC members supported recommending the preferred option to the Finance and Performance Committee.**

3)Digital Pathology Business Case

This case proposed investment in Digital Pathology Systems part funded by the NHSE/I Diagnostics Digital Capabilities Programme as part of the Southern Counties Pathology Network (South 6).
The case will support the department to transition from a manual slide process, reporting slides under a microscope to a digitalised system. The proposal detailed improvements in productivity, efficiency and effectiveness which will reduce costs and improve turnaround times ensuring the best possible service for patients.
The case detailed that the Trust has been granted 1.73m capital over three years to support this (this was approved by Trust Board in Q3) with the focus now on approval on the ongoing revenue costs over the next 7 years. **TMC supported the case.**

Other business for TMC included approval of a paper detailing principles to improve space utilisation and oversight of the sterile services quarter 3 report.

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) -	☐

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	9th March 2023		

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 & care: Clinical Governance Committee • Workforce: People & Culture Committee			
Prepared by:	Louise Drayton, Performance and Capacity Lead Amanda Hardie, Head of Performance			
Executive Sponsor (presenting):	Mark Ellis, Director of Finance			
Appendices (list if applicable):	Not applicable			

Recommendation:
The Trust Board are asked to note the Trust's performance for Month 10 (January 2023)

Executive Summary:
The Total RTT Waiting list size position at the end of January stood at 25,132 an increase of 228 from December (24,904). This has resulted in a deterioration from plan, but this needs to be put into the context of a higher than expected number of clock starts in month, the impact of limiting General Anaesthetic procedures in the DSU for the first two weeks of January to support flow, the pressures from non-elective demand, and the impact of the industrial action which resulted in cancellation of circa 2,000 appointments. The average wait to first outpatient appointment decreased slightly between December and January but remains high. This is somewhat reassuring in that there has been a slight reduction despite the significant number of appointments that had to be cancelled owing to the industrial action in January, which would serve to increase patients waiting times. The Trust continues to have success in ensuring there are no waits over 104 weeks and remains on schedule to deliver the target of zero waits over 78 weeks one month early (by the end of February). Work to reduce the number of patient falls continues as a key focus of the "Improving Together" programme, with a January position of 8.1 falls per 1000 bed days against a target of 7. There were 5 falls in January with harm ratings of moderate or above. Lying and Standing blood pressure compliance has improved significantly over the year to date. Over

400 members of staff have received falls training thus far.

The improvement against the 4-hour standard performance target continued in January with a rise to 75.7%. There was a noticeable decrease in Type 1 attendances (SFT Main Emergency Department) at 3686, the lowest monthly number in the last 12 months. The decrease may be explained by the system wide introduction of the Care Coordination centre whose primary focus is on reducing unnecessary conveyances of patients to Emergency Departments, or from patient choice due to industrial action.
M10 saw an improvement in Ambulance Handover performance compared with M9 although the number of patients waiting over 30 mins to offload remains high at 21.4%. The main driver for improvement has been delivered by the concerted efforts of the ED, Hospital Ambulance Liaison Officer (HALO) and patient flow teams to ensure ambulances are offloaded as quickly as possible into suitable locations, particularly on days that the ambulance service was affected by Industrial action.

Overall performance against the 6-week Diagnostic standard has improved marginally in M10 compared to M9 but remains low. Cardiology Echo has significantly improved with zero breaches. Areas that continue to report high numbers of breaches are MRI and Ultrasound. Workforce capacity remains the largest constraint impacting DM01 performance.

The Trusts Two Week Wait performance in January was 80.3%. This is a slight improvement on our December position although challenges remain within Skin and Lower GI. The primary reason for breaches in both areas is inadequate outpatient capacity. The 28-day Faster Diagnosis (FDS) Performance for the trust in January was 75.4% demonstrating continued success against this cancer waiting times standard, achieving the 75% standard for 10 out of the last 11 months. Performance against the 62 Day Cancer standard for January was at 76.7% which continues to be below target. The predominant reason for the breaches was delays in diagnostic timeframes. The remainder were due to a mixture of patients delaying their own pathways, complex cases and inconclusive diagnostic results.

The proportion of patients arriving on the Stroke Unit within 4 hours was below target at 33%. This is largely due to the impact of high bed occupancy trust-wide which affects the timely availability of beds on the stroke unit. Additionally, this affected the percentage of stroke patients receiving a CT within one hour of arrival (42%).

There has been an increase in the number of patients moved more than once (2.7%), largely linked to the number of Infection Prevention Control (IPC) incidences which increases the number of moves patients may experience.

The Trust reported 50 hospital acquired category 2 pressure ulcers in January which was the highest number in the financial year. A new PU investigation process is being implemented; learning has been identified and actions undertaken for teaching on wards with areas of concern.

Agency spend remains high at 8%, significantly above the 3.7% target, with the highest demand for nursing staff. This is due to a combination of high vacancy rates, high staff turnover and high levels of short-term absence, resulting in the requirement for agency staff to meet safe staffing and other service requirements.

In January the Trust recorded an in-month control total deficit of £2.921m against an original target of £1.459m - an adverse variance of £1.462m. The year-to-date control total deficit is £15.582m compared to the original plan of £9.840m. Pay costs increased in-month by £0.6m driven by an increase in bank and agency costs, including bank incentive costs. Non-pay costs fell by £0.4m mainly driven by Purchase of Healthcare in prior months. 'Pass through' non-pay costs continue to run in excess of those planned for and now account for 60% of costs above plan.

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

Integrated Performance Report

January 2023

Summary

January 2023

The Total RTT Waiting list size position at the end of January stood at 25,132 an increase of 228 from December (24,904). This has resulted in a deterioration from plan, but this needs to be put into the context of higher than expected number of clock starts in month, the impact of limiting General Anaesthetic procedures in the DSU for the first two weeks of January to support flow, the pressures from non-elective demand, and the impact of the industrial action which resulted in cancellation of circa 2,000 appointments.
The average wait to first outpatient appointment decreased slightly between December and January but remains high. This is somewhat reassuring in that there has been a slight reduction despite the significant number of appointments that had to be cancelled owing to the industrial action in January, which would serve to increase patients waiting times. The Trust continues to have success in ensuring there are no waits over 104 weeks and remains on schedule to deliver the target of zero waits over 78 weeks one month early (by the end of February).

Work to reduce the number of patient falls continues as a key focus of the "Improving Together" programme, with a January position of 8.1 falls per 1000 bed days against a target of 7. There were 5 falls in January with harm ratings of moderate or above. Lying and Standing blood pressure compliance has improved significantly over the year to date. Over 400 members of staff have received falls training thus far.
The improvement against the 4-hour standard performance target continued in January with a rise to 75.7%. There was a noticeable decrease in Type 1 attendances (SFT Main Emergency Department) at 3686, the lowest monthly number in the last 12 months. The decrease may be explained by the system wide introduction of the Care Coordination centre whose primary focus is on reducing unnecessary conveyances of patients to Emergency Departments, or from patient choice due to industrial action.

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What we are measuring – our Strategic Priorities

Improving the health and well being of the Population we serve

Working through Partnerships to transform and integrate our services

Supporting our People to make Salisbury NHS Foundation Trust the Best Place to Work

Our focus – Breakthrough Objectives and Strategic Initiatives

Strategic Initiatives	Breakthrough Objectives
Delivering the NHS People Promise	Reducing Falls in hospital
Improving Together	Reducing the number of patients in hospital with no criteria to reside
Improving health and reducing health inequalities	Reducing time to first outpatient appointment
Digital Care	Elective Recovery Programme

What is an Integrated Performance Report (IPR)?

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives that are set as part of the recently updated strategy. It is divided into three sections (Quality of care, access and outcomes, People and Finance and Use of Resources) which contain the following within them:

Key Term	Definition
Breakthrough Objective	Area of focus for the whole organisation for the next 12-18 months. We are striving for an improvement of 30%+ in these metrics over this period.
Key Performance Indicator	Key metric that is monitored as part of NHS National Operating Framework for 2022/23 and heavily relates to improving patient care and increasing positive outcomes.
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to analyse worsening performance, or achievement celebrated if performing is improving.
Non-alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Business Rules - Driver Metrics

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
1	Driver does not meet target for a single month	Performance outside of expected range for a single month	Give Structured Verbal Update	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
2	Driver does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Prepare Countermeasure Summary	Showing signs of continued difficulty meeting the target and need understanding of root cause.
3	Driver meets or exceeds target for a single month	Performance outside of expected range for a single month	Share top contributing reason	Showing early signs of improvement but not yet sustained
4	Driver meets or exceeds target for 2 or more months in a row	Performing above target for multiple months in a row	Share success and move on	Showing signs of continued improvement but not yet assured that the target will always be met
5	Driver meets or exceeds target for 4 or more months in a row	Performing above target for a sustained length of time	Consider swapping out for a Concerning Watch metric/increase target of Driver	Assess Watch metrics and consider switching out this high performing Driver metric for an underperforming Watch metric, or increasing target of Driver metric
6	**Driver is orange**	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
7	Driver is grey	Performance is in line with expectations (no special cause)	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
8	**Driver is blue**	Performance outside of expected range in a positive /improving direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes

Business Rules - Watch Metrics

Rule No	Rule	What It means	Suggested Action	Rationale
9	Watch has one point out of control limits – **orange**	Concerning performance	Share top contributors and move on	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
10	Watch has 2 out of 3 points low – **orange**	Worsening performance	Give Structured Verbal Update (includes top contributors)	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
11	Watch has 4 points below mean or 4 points deteriorating - **orange**	Worsening performance	Consider: - Upgrading to a Driver and which driver to downgrade to a watch (include on Slide 4)	**SPC logic** – Row of orange dots means special cause variation causing adverse performance. Discussion required around whether this requires promotion to driver and replace current focus.
12	Watch has one point out of control limits - **blue**	Improving performance, not yet sustained	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
13	Watch has 2 out of 3 points high - **blue**	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
14	Watch has 6 points above mean or 6 points increasing - **blue**	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
15	Watch is **grey** (no special cause)	Performance is as expected	Do not discuss	**SPC logic** – nothing special is going on, performance is within normal variation

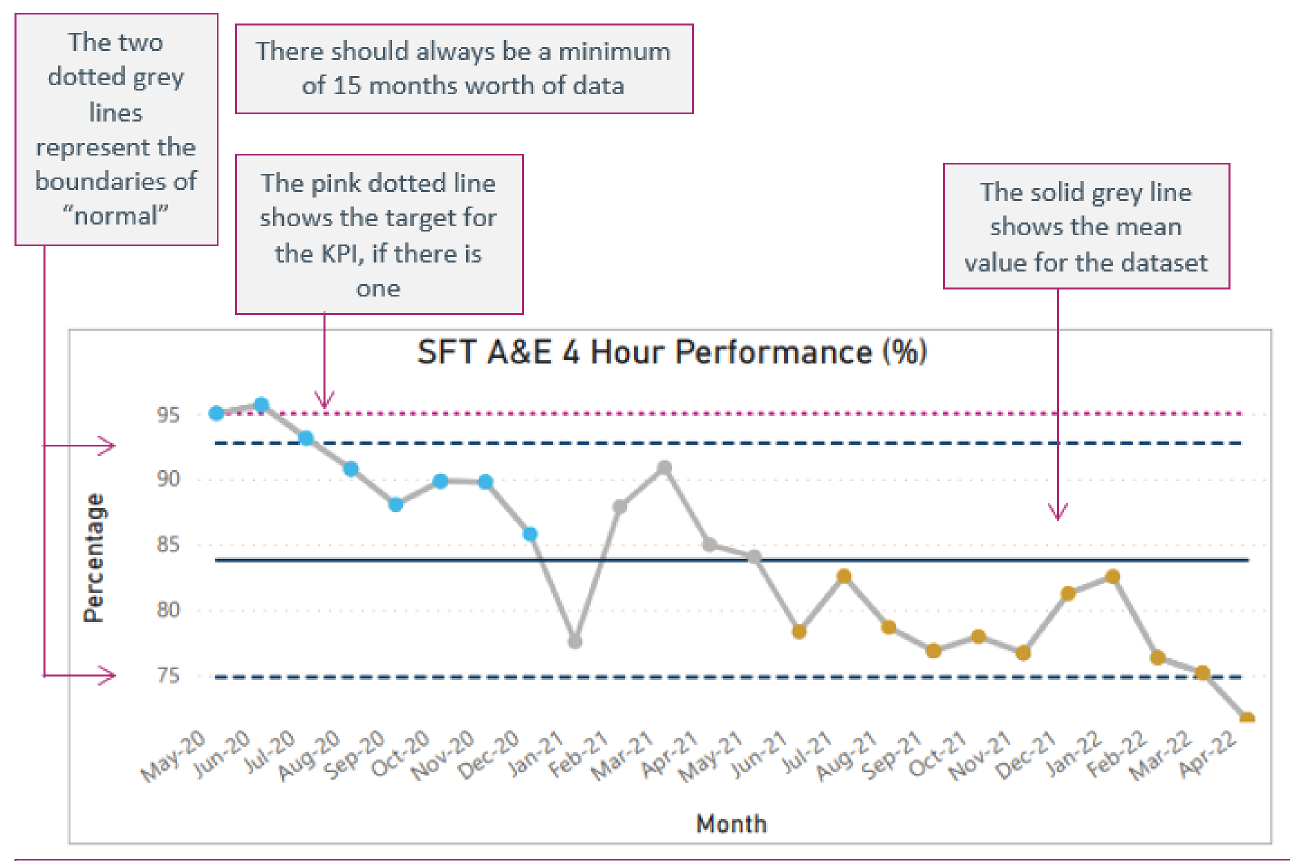
Business Rules - Statutory/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level.

Whether or not a metric has met its target each month will be indicated by a tick or cross icon in the "Target Met This Month?" column. The number to the right of that indicates how many months in a row the metric has **NOT** met its target for. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Different actions are suggested depending on how many months the target has not been met for.
These metrics are assessed against their improvement target, or their national target where no improvement target exists.

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
16	Mandatory does not meet target for a single month	Performance outside of expected range for a single month	Note performance Give structured verbal update by exception	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
17	Mandatory does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Give structured verbal update, agree if counter measure summary required	Showing signs of continued difficulty meeting the target and need understanding of root cause.
18	Mandatory does not meet target for 4 or more months in a row	Performing below improvement target for a sustained length of time	Consider applying improvement target	Showing signs of continued difficulty meeting the target despite understanding of root cause. Current performance known and acknowledged.
19	Mandatory with improvement target meets or exceeds target for 4 or more months in a row	Performing above improvement target for a sustained length of time	Consider increase target of Mandatory	Assess Mandatory metrics and ensure performance culture is maintained.
20	Mandatory is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 16-17 above and act accordingly	Mandatory metrics are being deliberately monitored and therefore SPC rules are not strict enough for monthly performance assurance purposes

Reading a Statistical Process Control (SPC) Chart



Blue markers indicate that there has been a marked improvement in performance, meeting Business Rules 1-3

Orange markers indicate that there has been a marked decline in performance, meeting Business Rules 4-6

Grey markers show normal behaviour with no significant cause for variation

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

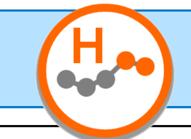
Population

Partnerships

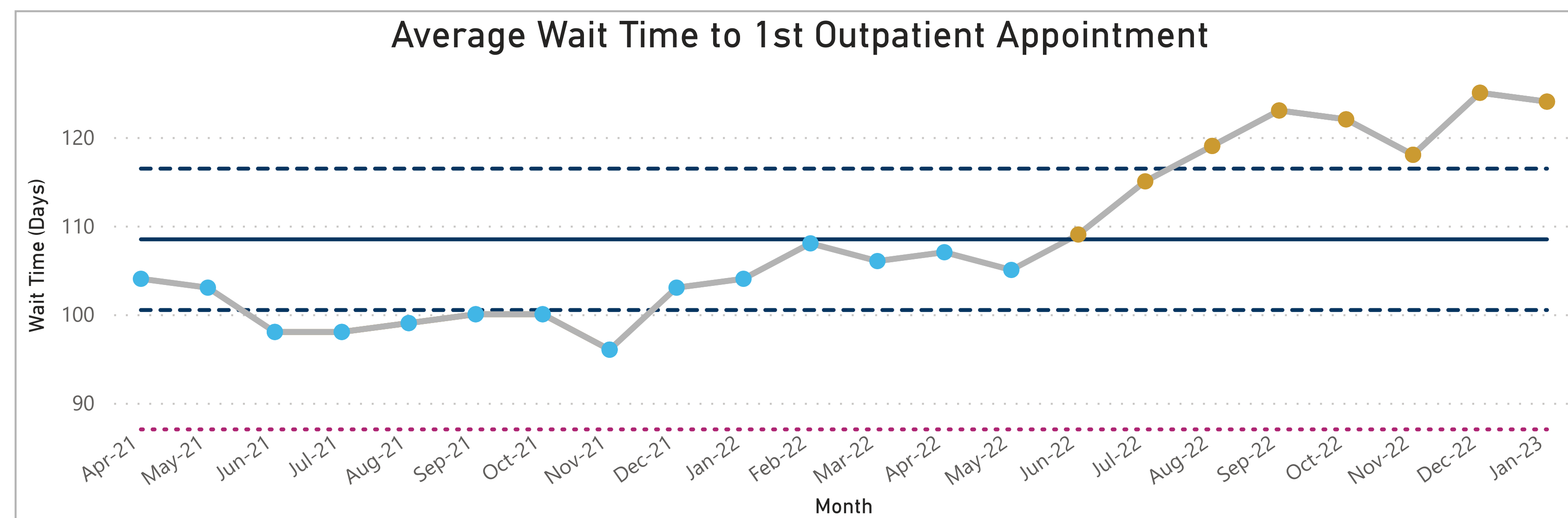
People

Reducing Patient Waiting Times

Target 87 days



Breakthrough Objective



We are driving this measure because...

SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% RTT 18wk elective treatment target since October 21.

A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18 week RTT target at risk.

It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

Understanding the performance:

The performance data shows an improved position reversing the deterioration of the previous two months. This is not entirely unexpected given the Christmas and New Year period which sees a reduction in new referrals (which serve to lower the average wait), alongside a reduced number of appointments offered owing the holiday period, resulting in longer average waits for that period.

This however, is somewhat more reassuring in that there has been a reduction despite the significant number of OPD appointments that had to be cancelled owing to the NMC industrial action in January, which would serve to increase patients waiting times. Staffing and operational pressures continue to challenge a number of specialties, resulting in steady increases in the number of longer waits specifically over 52-week waits which are driving up the overall average waiting time. The Trust continues to focus on seeing patients in line with clinical need, referral type, e.g. Cancer 2week wait and Urgent referrals, and by longest wait, in line with NHSE requirements.

The Trust continues to have success in ensuring there are no >104-week waits and is focussing on delivering the year-end target of zero 78ww, for which the Trust remains on schedule to deliver this 1 month early (by the end of February), with all patients having TCIs before the end of the month.

Actions (SMART):

Trust progress against long waiting patients including those awaiting 1st Appointment to continue to be monitored weekly and to be reported to the CEO and COO via weekly summary updates.

Patients to continue to be booked in line with NHSE recommendations, with weekly validation of long waiting patients.

Support given to Divisions to better understand and map demand and capacity in preparation for 2023/24 planning round.

Draft options plan for Dermatology has been completed and submitted for consideration.

Risks and mitigations:

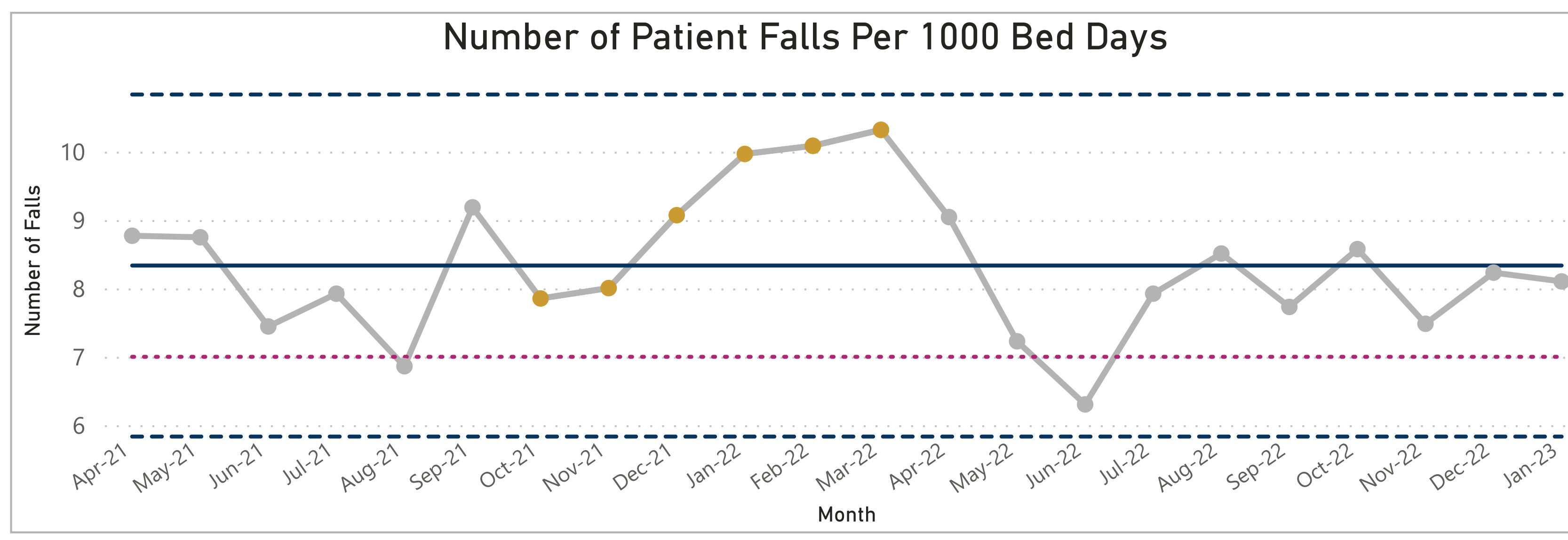
Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality/pathway level, however the performance team are supporting this work with the Divisions and specialities. Resource limitations at both DMT and Speciality level have been raised and a paper proposing enhanced Divisional structures has been drafted to be discussed at TMC.

Staffing pressures exist across a number of specialities not least Dermatology which present a potential individual speciality pressure into next financial year. The Division of surgery is drafting a set of possible proposals for consideration by the Executive Team.

Reducing Patient Harm

Target 7

Breakthrough Objective



We are driving this measure because...

Falls are the most frequent adverse event reported in hospital. The Trust continues to report a high level of falls per 1000 bed days with a significant spike over the last 12 months to 10.2 falls per 1000 bed days during the COVID-19 pandemic. The average nationwide falls data shows a rate of 6.7 falls per 1000 bed days and so this spike in combination with the increasing trend of all falls within SFT, is a concern which requires concentrated effort to address and improve.

Understanding the performance:

Overall falls for January 2023 as 8.1 per 1000 bed days against the local target of 7 (20% reduction from Strategy 2021/22). Performance has been slightly variable over the last 6 months.

There were 5 falls in January with harm ratings of moderate or above with only 1 of these reported as a fall with major harm.

Lying and Standing BP compliance has improved slightly from 52% in December '22; this is comparative to 6% in February '22 when data started to be collected.

Over 400 members of staff have received training thus far; the strategy suggests that 95% of ward staff should receive formal training.

Actions (SMART):

- Research suggests that introducing Bay Watch and falls huddles post patient falls could reduce falls by 50%. Roll out will continue with a target of all wards having the knowledge and skills by August 2023. Farley ward have seen a reduction in falls by 33% in Q3 2022/23 compared with Q2.
- Post falls huddles were introduced to Pitton and Farley wards at the end of December as part of the Improving Together programme.
- Lying and standing BP compliance has steadily improved with ward audits once a month. Training has changed to indicate why it is important and what to do when a patient has a positive result.
- Implementation of study day for ward staff currently being scoped, with the intention for this to be made available by Q2 2023/24
- A flow diagram of "What to do if postural hypotension is recognised" has been developed by the by the falls group and will be presented to PSSG in January '23.

An alert has been added to the POET system to remind staff to complete lying and standing BP.

Risks and mitigations:

- The Trust has had both high staff vacancy rates and capacity issues along with high rates of Infection Control challenges that may have had an impact on patients' ability to be cared for in the right place by the correct staff.

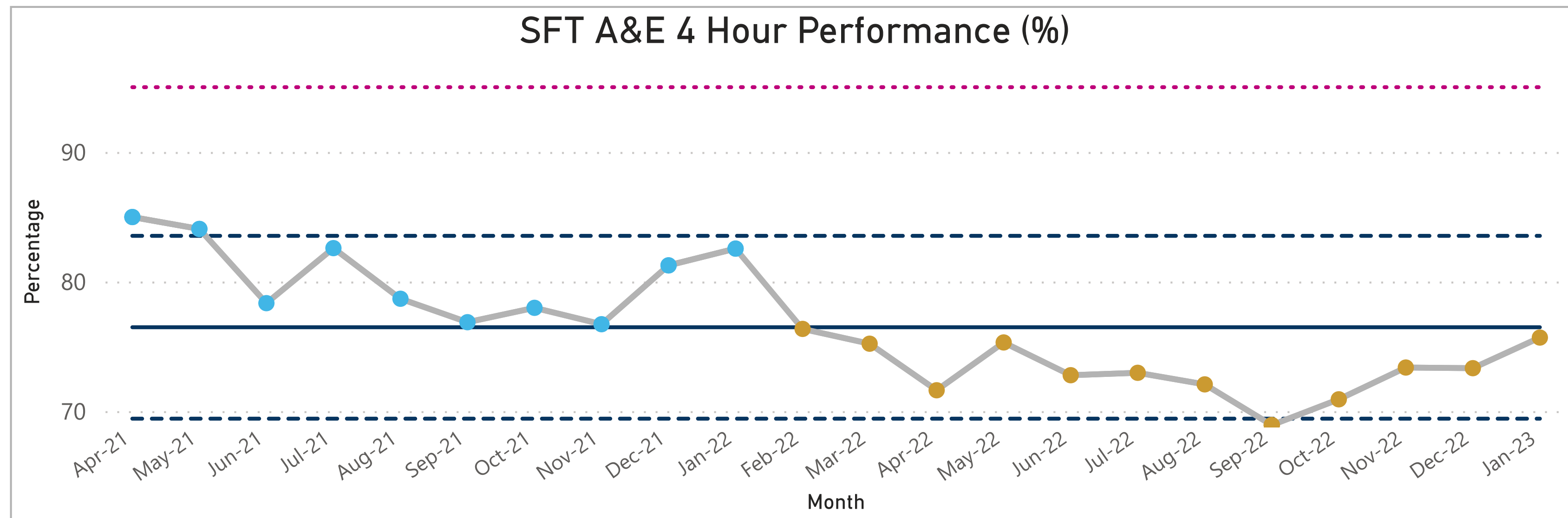
- Wards need to have full bay watch training prior to roll out. There have been some significant challenges with full buy-in from all members of the MDT. However, roll out will continue with a target of all wards having the knowledge and skills by August 2023.

- Taking of lying and standing BP is lengthy and sometimes difficult though should be part of the admission process. Dedicated training to be provided to AMU staff over January '23 (95% target).

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month: 75.7%

Attendances: 5863

>12 hrs in ED Breaches: 77

Understanding the performance:

The improvement against the 4-hour standard performance target resumed in M10 with a 2.5% increase in month after remaining static in M9. There was a noticeable decrease in attendances in M10 of 976 which equates to c.32 per day. This decrease was made up of 487 in ED, of which 392 were Type 3, and 489 at the Walk in Centre. The decrease may be explained by the system wide introduction of the Care Coordination centre whose primary focus is on reducing conveyances of Type 3/4 patients to ED's. There has been a steady increase in conversion rate for emergency admissions via ED since M8. The conversion rate has risen each month from 25.2% M8 to 26.9% in M9 and finally 28.7% in M10. However, when compared to admission numbers they have remained fairly static – 1064 in M8, 1115 M9 and 1050 in M10. This supports the narrative that the fluctuations in attendances are in the Type 3/4 patients who should primarily be treated in the community. Following the large spike in the number of patients waiting >12 hours in the Emergency department in M9 to 201, the numbers decreased to 77 in M10.
Flow out of the department has remained challenged with only an average 14.05% of patients being discharged before midday. This leads to a lack of movement out of ED in the mornings.

Actions (SMART):

The ED tracker role has now been confirmed to start in Month 11. This is a new role and will be vital in keeping accurate records of patients journeys and assisting the medical teams, in tracking outstanding investigations and bed allocations to increase 4-hour performance and coding.

A further 8 staff attending triage training in M11, this will help contribute to a reduction in time to initial assessment, supports the implementation of Streaming and forms part of the divisional driver metrics through "Improving Together".

A planned visit to look at SDEC "village" model at the John Radcliffe Hospital took place in M10. The findings have supported the project management board in pulling together an action plan/vision re the implementation of a SDEC Village at Salisbury.

Next target of protecting 4 AMU ambulatory Trolly spaces from escalation to be agreed and worked towards in M11. This will help support the DTA to Admission divisional driver metric.

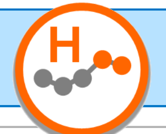
Risks and mitigations:

Nursing staffing vacancies remain a high at 16.03 (includes 6.45 Winter uplift) whole time equivalent (WTE) B5 Nurses, with a further 11.04 WTE HCA's. A rolling advert is out to recruit both qualified and unqualified Nursing, with an ED recruitment day planned for Month 12.

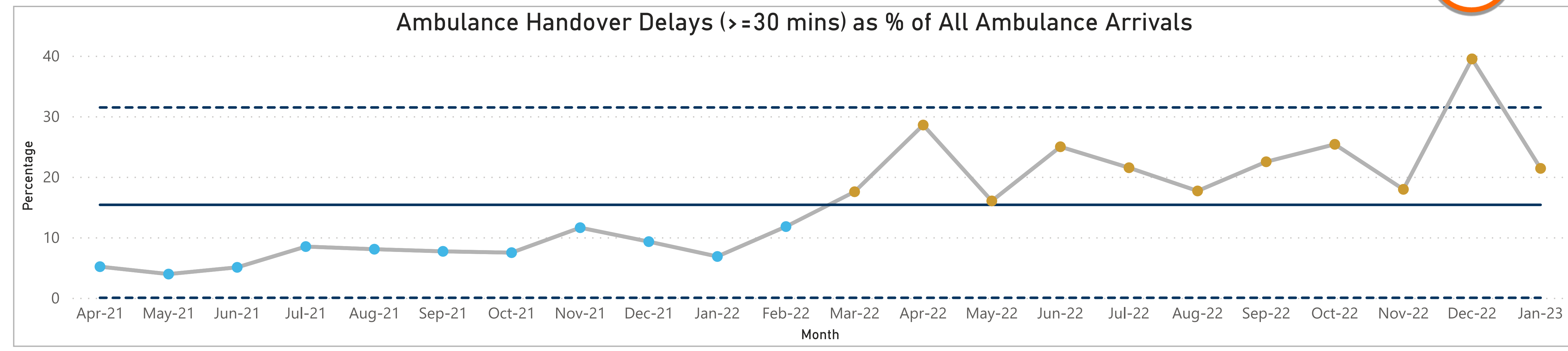
Within the medical workforce there remains 4.0 WTE (40%) gaps in the Middle Grade rotas and 2.6 WTE Consultants. Overseas junior doctors recruited in M7/8 have commenced with shadow shifts over Months 9-11. This will support filling the middle grade gaps to bolster increased senior decision making in the department from M12.

Flow out of the Emergency Department continues to impact 4 and 12-hour performance targets, with high bed occupancy levels continue across the Trust resulting in limited capacity to see and treat patients. Escalation areas such as Paediatric ED and Interventional Radiology are used as required, dependent on staffing.

Ambulance Handover Delays



National Key Performance Indicators



Understanding the performance:

M10 saw a significant improvement in Ambulance handover performance with 20.59% (Validated) patients waiting over 30 mins to offload an improvement of 18.88% on M9. There was a slight decrease in arrivals of 1054 compared to 1115 in M9, this equates to 1.9 ambulances less per day in M10. The main driver for improvement has been delivered by the concerted efforts of the ED, Hospital Ambulance Liaison Officer (HALO) and patient flow teams to ensure ambulances are offloaded as quickly as possible into suitable locations. This performance has been further supported by the improvements in Time to initial assessment and the time between DTA and admission. The breakdown in performance for each time period are:

- 232 ambulances off loaded between 15 and 30 minutes.
- 134 ambulances between 30 and 60 minutes.
- 130 ambulances off loaded over 1 hour.

Actions (SMART):

A further 8 staff attending triage training in M11, this will help contribute to a reduction in time to initial assessment, supports the implementation of Streaming and forms part of the divisional driver metrics through "Improving Together". This will help to create more capacity within ED to facilitate faster offloads and treatment of patients.

The ED tracker role will start in Month 11. This new role will work with the Hospital Ambulance Liaison Officer (HALO), Nurse & Consultant in charge to eliminate delays and track patients through the ED Journey to ensure actions are done correctly and efficiently. They will also link in with the clinical site team and wards to facilitate transfers

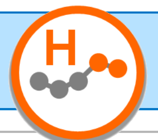
Emergency Department Escalation Levels (EDEL) launched and embedded within the trust to accurately articulate the ED pressures at a given time and give clear actions for both ED and the Trust to support.

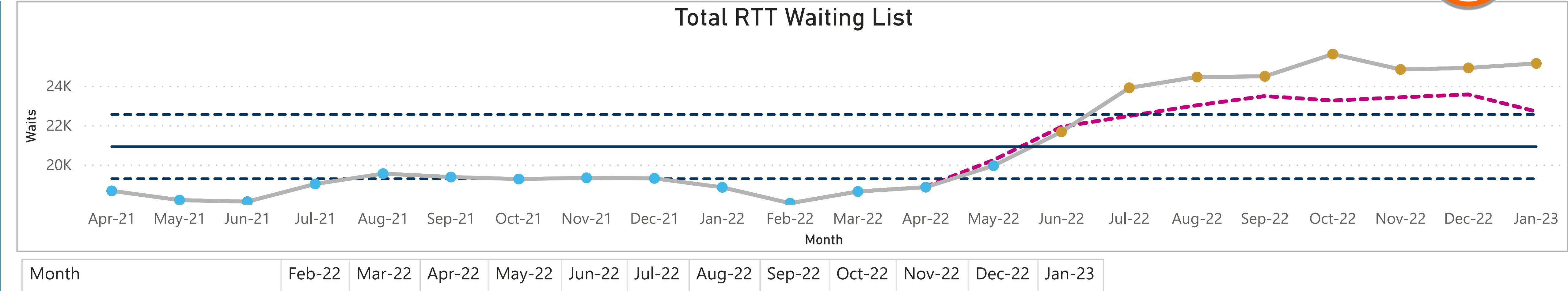
Risks and mitigations:

- High bed occupancy and staffing challenges evident across the Trust, resulting in poor flow out of the Emergency Department remains the biggest challenge in being able to offload ambulances in a timely manner. The introduction of a discharge lounge has proved beneficial to generating earlier flow with the trust supporting decompression of ED.
- Respiratory conditions (Flu A, Covid and RSV) continue to pose challenges in offloading patients. This is due to the requirement for patients to go to a suitable area both in and post ED of either a cohort bay or side room to ensure isolation processes are followed. This slows the flow out of ED whilst these areas are identified.
- Industrial Action for both the Ambulance Service and Nursing Staff negatively impact on flow/performance with less staff able to facilitate timely offloads, treatment and discharges; mitigating actions to minimise risk remain ongoing.
- Collaborative working continues with between SWAST (South West Ambulance Service) partners and the SFT HALO to mitigate risk by cohorting of patients waiting to off-load in order to release crews. Whilst in use, patients within the cohort area remain ambulance holds as the area is staffed by SWAST Paramedics.

National Key Performance Indicators

Total Elective Waiting List (Referral to Treatment)





Month	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Longest Waiting Patient (Weeks)	116	116	120	99	99	95	98	94	95	87	83	85

Understanding the performance:

The Total RTT Waiting list size position at the end of January stood at 25,132 an increase of 228 from December (24,904). This has resulted in a deterioration from plan with the Trust now being 2,441 behind plan (a deterioration of 1,093 in month).

This, however, needs to be put into the context of a higher than expected number of clock starts in month, and the second highest YTD, the decision to limit GA operating through DSU for the first two weeks of January to support flow and the pressures from non-elective demand, and most telling the impact of the industrial action by the NMC, which resulted in circa 2,000 appointments being cancelled.

Actions (SMART):

SFT remains behind plan and it is clear that the post-covid assumptions made in the original annual planning have not been reflected by both the activity delivered and against the number of referrals received. Indeed the number of new clock starts has been consistently higher than anticipated, which has been exacerbated by winter pressures and industrial action.
The largest proportion of the waiting lists sits within the non-admitted pathways. There remain a number of specialities that have remained below their current YTD average, including a number of specialities with considerable operational and staffing pressures. However, there remains a need to better understand the demand and capacity by specialty, which is currently being developed by the Performance and BI teams, and is supporting the planning round for 2023/24 to support achievement of national requirements, and ensure specialities are best placed to meet the referral demand being experienced.

Given that there is more industrial action planned by the NMC, and expected junior doctor industrial action in March, there will be further requirement for large number of cancellations of both admitted and non-admitted activity, which as a result will preclude SFT meeting its year-end trajectory.

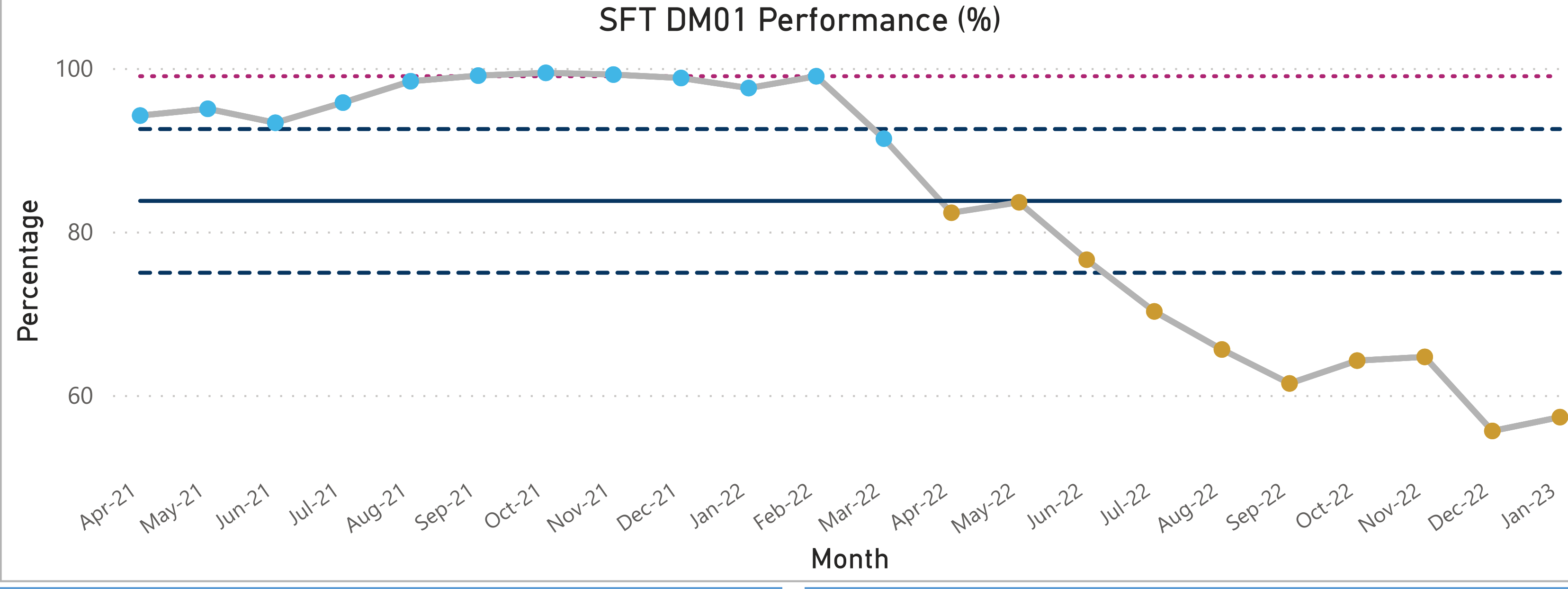
Risks and mitigations:

The risk of non-achievement of plan is heightened by series of industrial action days from Jan and scheduled into March. Whilst mitigations are in place, the volume of activity affected cannot be entirely mitigated and recovered in the remaining 2 months of 2022/23. In addition non-elective flow has continued to place significant pressure on the elective programme. The use of DSU continues to mitigate safety for non-elective activity, but leaves a reduced number of options to mitigate the resulting impact on the Trust's waiting list volume. However, all activity is assessed for suitability for most appropriate modal delivery and moved to a safe alternative setting where possible.
New ways of working across the two theatre footprints have been and continue to be developed and signed off to maximise outputs through different ways of utilising the estate, not least to help mitigate the impact upon DSU, with new Standard Operating Procedures providing a greater forward view and transparency in planning and delivering lists during ongoing periods of escalation.
In the absence of the OPD Improvement Board, an OPD summit has been scheduled for March to review OPD Delivery and assess what areas of focus are required going into 23/24 to address growing demand and increase activity across the specialties.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 57.3%

Waiting List Volume: 3283

MRI	53.7%	CT	100.0%
US	43.9%	DEXA	100.0%
Audio	63.5%	Cardio	100.0%
Neuro	100.0%	Colon	62.6%
Flexi Sig	66.3%	Gastro	90.7%

Understanding the performance:

Overall DM01 performance has improved in M10 compared to M9 (from 55.16% to 57.3%). This represents a reduction in breaches from 2695 to 2372. There has also been a further decline in total waiting list size of 516.

The reducing waiting list exacerbates the number of breaches and reduces the performance increase. Areas that continue to report high numbers of breaches are MRI (569 reduction from 616), USS (1598 reduction from 1795), Audiology (66 reduction from 81) and Endoscopy (139 reduction from 199). Cardiology Echo has significantly improved and first the first time in year has reported zero breaches.

The largest constraint impacting DM01 performance remains as workforce capacity.

Actions (SMART):

1) Delay with USS insource arrangement (continued slow start but some capacity online during M11)
2) Increase overbooking to USS list to mitigate some of 4% DNA rate
3) Continue with agency backfill and incentivised overtime rates in Radiology to increase weekend scanning provision
4) 23/24 trajectory completed for submission by Performance Lead - paper to F&P 28/2/23

Risks and mitigations:

Possible power supply issues to MRI1 being monitored by Estates (no downtime in M11 at time of writing IPR)

RCN strikes M11 and M12 will impact endoscopy capacity

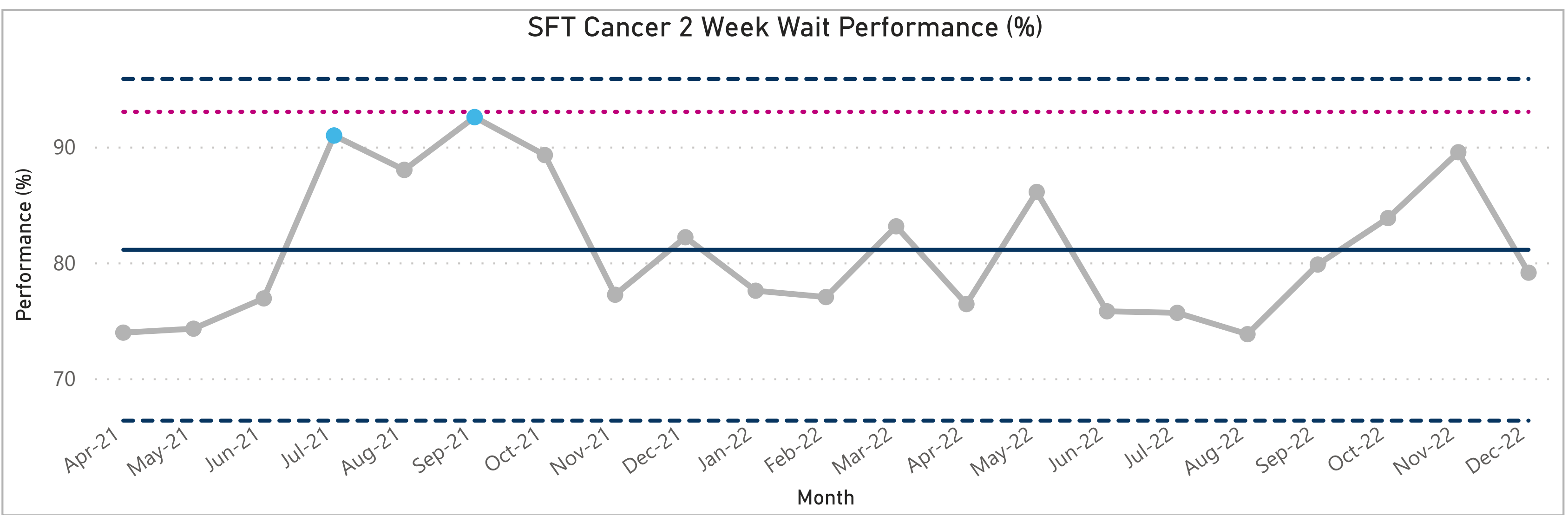
Echocardiography, Radiography and Sonography remain dependent on high volume of agency/locum/overtime staffing to maintain capacity. Recruitment ongoing.

Admin resource within Radiology and Endoscopy experiencing some reourcing issues which is challenging for booking and overall booking efficiency (further constrained by postal strikes etc. Recruitment plans in place.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	79.1%	735	929	194
Two Week Wait Breast Symptomatic Standard:	87.0%	20	23	3

Understanding the performance:

The Trusts 2WW performance in January was 80.3%. This is a slight improvement on our December position although challenges remain within Skin and Lower GI as anticipated from the challenges outlined in the previous month's IPR. There was a total of 98 2WW Skin breaches in January with 87 of them being attributed to inadequate outpatient capacity. The average wait for a 2WW suspected skin cancer appointment was 14.5 days. There are continued challenges within 2WW Lower GI with a total of 68 breaches in January with 41 of these being attributed to outpatient capacity with an average wait of 14.3 days for the first 2WW lower GI appointment.

Actions (SMART):

Colorectal 2ww Capacity:
The Performance team have provided each service with their demand and capacity for 2WW alongside the Cancer trajectories for PTL numbers. Cancer services have met with the team and agreed the trajectories however we are awaiting final sign off on the 2WW Demand and Capacity work.

Skin 2ww Capacity:
The Performance team have provided each service with their demand and capacity for 2WW alongside the Cancer trajectories for PTL numbers. Cancer Services have met with each of the specialties and agreed the trajectories however we are awaiting final sign off on the 2WW Demand and Capacity work.

Risks and mitigations:

RCN Strikes: There was disruption in January due to the RCN Strikes within the organisation. This involved challenges within Endoscopy. Assurances from Endoscopy that the further planned RCN Strikes should be supported by weekend work in March.

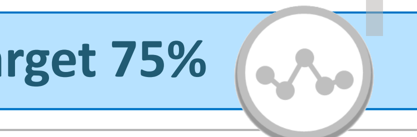
Pathway Improvement: The Weekly Cancer Improvement Group has been taken on by Performance Team alongside Cancer Services. This will support with engagement from DMT with work streams feeding in from Cancer PTL Meeting and onto Cancer Board. The BPTP Milestones are being used alongside the CQUIN data submitted to measure the success of the current pathways

Colorectal Pathway: Endoscopy capacity should be BAU by February as endoscopy nurse on phased return. New 2WW Colorectal referral form finalised and uploaded for GP Practices to access. Pathways shared with Wessex Cancer Alliance to ensure streamlined process for practices within Hampshire.

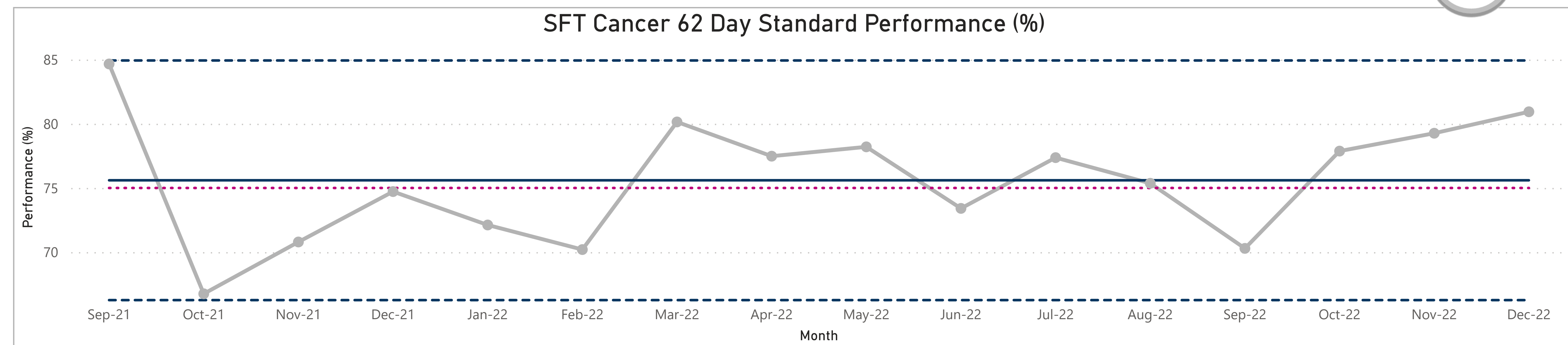
Skin Pathway: The Surgical division are currently undertaking an audit of synapsis advice and guidance to 2WW uptake. Provisional discussions around GP education for tele-dermatology to help with patient flow into the Trust. There us currently a lack of dermatology cover for advice and guidance for medical tele-dermatology. This action is currently being monitored by CIG.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%



National Key Performance Indicators



Understanding the performance:

The 28-day Faster Diagnosis (FDS) Performance for the trust in January was 75.4% and we are having continued success against this cancer waiting times standard. Our performance is solidified by the over performance of the Breast team in being able to provide a benign diagnosis within 28 days of referral with a 96.6% success rate as well as the Skin team in their ability to offer a decision to treat within 28 days with a success rate of 97.7%.

We have successfully achieved this target for 10 of the last 11 months which is a fantastic achievement. However, we are still seeing challenges with this target in Urology and Gynaecology with an average wait of 35 days and 32 days respectively. The main breach reasons for Urology involved patients requiring multiple diagnostic tests which held up our ability to reassure patients and administrative delays to benign results letters being sent. For Gynaecology the main breach themes were around administrative delays to benign results letters and capacity delay reasons for diagnostics.

Actions (SMART):

Urology have implemented the new CNS-led triage system which enables patients to be triaged to diagnostic as quickly as possible. As a result, the average wait to first OPA is 1-3 days. However, challenges still exist within the diagnostic element of the pathway. We are currently trialling a new Prostate Biopsy process with the Urology Navigator and Central Booking team and surgical DMT are identifying additional capacity to support with backlog. Cancer Services have been working with Radiology to highlight MpMRI to be reported on 9 days from request. Challenge identified with demand and capacity planning with prostate biopsies due to their being no designated cancer 2ww slots to map future capacity against, this has been raised with the Surgical DMT and is being monitored CIG.

Gynaecology Pathway:

The additional 2WW Capacity has enabled Gynaecology to bring their average wait time down to 5.4 days for the first appointment in January but challenges remain within the diagnostic side of the pathway. The new CNS will facilitate straight to CT requesting which will reduce the days from request to report. New Navigator will support the use of the benign template letter which will enable patients to be reassured sooner. Scope for a potential clinic to be held after MDT for breaking bad news to ensure no delay for patients post-MDT.

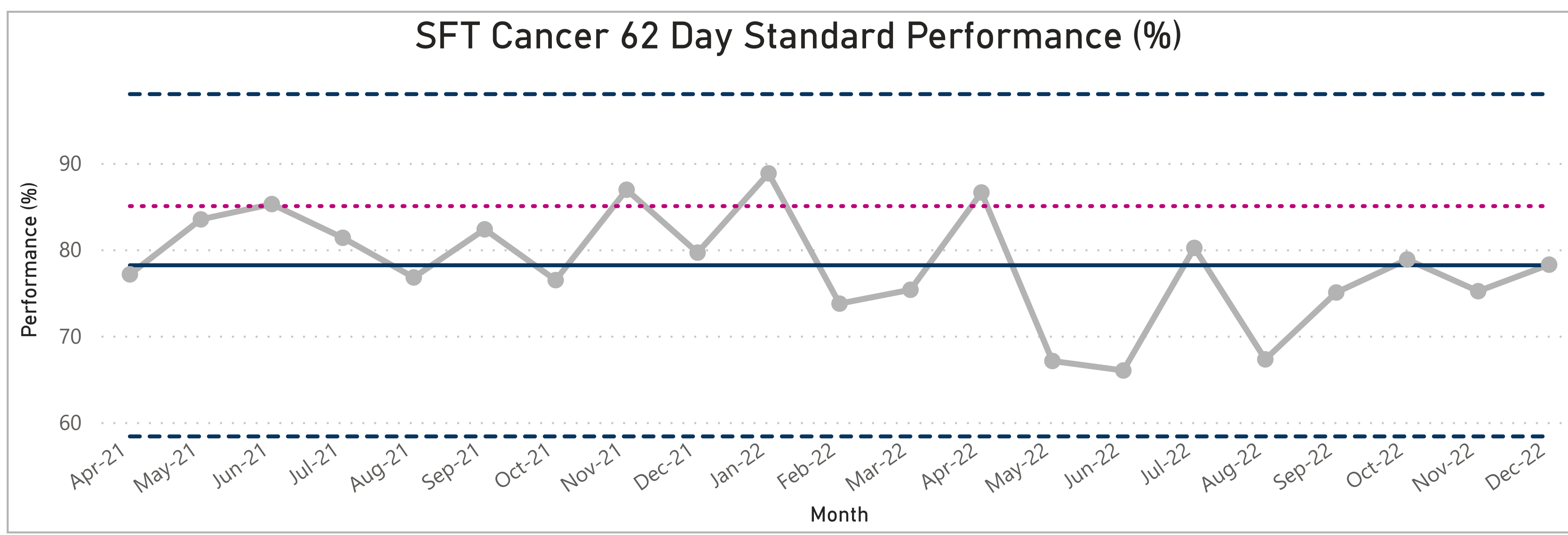
Risks and mitigations:

- Consultant Histopathologist appointed and likely start date during Q1 of 23/24, to provide resilience to breast cancer histology reporting (currently have single point of failure) and will allow for some reporting to be brought back 'in house' and reduce some reliance on outsourcing of histology reporting
- Anticipate further appointment of Consultant Histopathologist late Q1 23/24 in post during Q3 23/24 – to bring the Trust to full establishment for Consultant Histopathologists. Will serve to bring back some of the work to inhouse, thus improving control on turnaround times and an ability to reduce.
- US capacity to increase by +3k scans over next 6m, restore waiting list to < 6 weeks
- MRI capacity potential to increase via CDC collaboration by circa 40 scans per week from April – dependent on estate work at the Trust to facilitate
- CT capacity and waiting times are well within 6 weeks currently and anticipate aiming to reduce waiting time for patients on 62-day pathway to below 7 days from request for a CT scan
- Additional reporting capacity now online to increase reporting capacity by up to 200 (100 plain film, 100 CT/MRI) reports per week – anticipate reporting backlog will be stabilised and within 14 days by end of March for routine tests.
- Ambition to reduce all 2WW reporting to under 7 days within Q1 of 23/24

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	78.2%	49	62
62 Day Screening:	82.1%	12	14

Understanding the performance:

Our 62d Performance for January was at 76.7% which is a drop from December this was due to several breaches outlined below:
Urology – 7 Breaches
Colorectal - 4 Breaches
Upper GI - 2 Breaches
Head and Neck – 1 Breach
Breast – 1 Breach
Skin – 1 Breach
Gynaecology – 1 Breach
Lung – 1 Breach

The main themes around the breaches were delays in diagnostic timeframes with 11 of our 18 breaches due to this reason. Two patients breaches were due to delaying their own pathways, and the remaider a mixture of complex cases and inconclusive diagnostic results making up the remainder of the breach reasons.

Actions (SMART):

Prostate Bx Capacity:
The process for Prostate Biopsy booking has been reviewed and a new process has been implemented between the Urology Cancer Navigator and Central booking which involves identifying potential prostate biopsy candidates as well as screening of biopsy forms by the Urology CNS prior to being booked for all 2WW and Surveillance Prostate Biopsies. However, there are current challenges in February with limited amounts of kit, which there is a backlog on order for Procurement.

RCN Strikes:
There was disruption due to the RCN Strikes within the organisation. Plans being worked up by surgical division to minimise the disruption for diagnostics and surgeries during the next planned RCN Strikes in March.

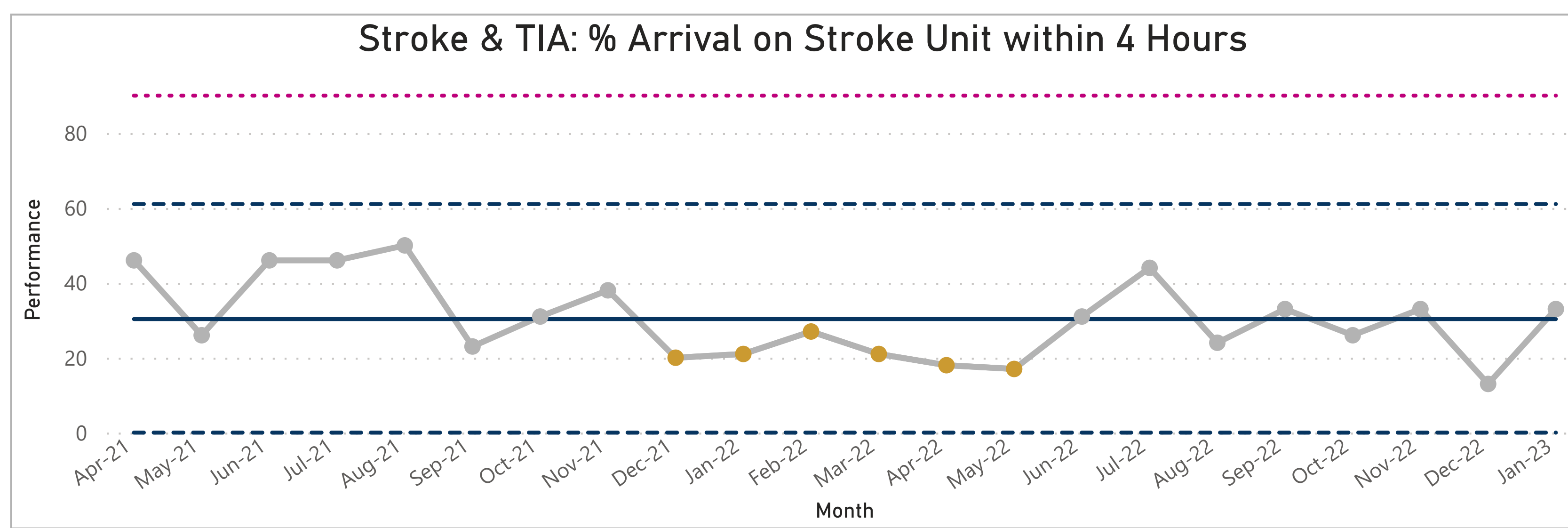
Risks and mitigations:

Chemotherapy at SFT:
Principal pharmacist has started within the organisation and it is anticipated being back to BAU for Pharmacy by March 2023. Awaiting final training for the Chemo nursing team which should be completed by June / September respectively.

Trajectory against performance standards:
As part of the CIG each speciality has been asked to complete a piece of work on their trajectory against the performance standards with the support of the Cancer Services. This has been completed and signed off as per CIG and Cancer Delivery Group and these trajectories will be submitted with our planning for 23/24. Cancer Services to look at potential trajectory for success against the 62d Pathway which is currently ongoing and is expected to be completed by April 23.
Histopathology / Radiology:
As above the service improvement should support the diagnostic pathways for Cancer Services for patients with increased capacity for scanning and additional histopathology capacity to support the services.

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

Fyear	Q1	Q2	Q3	Q4
2019-2020	B	B	B	Not Reported
2020-2021	Not Reported	Not Reported	Not Reported	Not Reported
2021-2022	C	C	C	C
2022-2023	D	C		

Understanding the performance:

The national target for arrival on Stroke Unit within 4 hours is 90%. January 2023 performance was 33% (an increase in comparison with December 2022 performance of 13%); this is mainly due to direct admissions to the stroke unit via GP referrals. The length of stay (LOS) for patients on the stroke unit increased slightly from December, with December having an average LOS of 17 and January LOS at 20. This was due to some long stay patients being discharged. The impact of high bed occupancy trust-wide has had an impact on timely availability of beds on the stroke unit.

Organisational bed pressures had led to more general medicine patients being out-lied to stroke beds which limits the beds available to stroke patients.

Staffing vacancies for Farley Ward remain high (Jan 7.37 vacancies). We have two new Band 5s joining the team, one starting in February and one in March. Throughout January there were several occasions where staff were moved to support other wards due to a lack of staff across the division. This, along with additional escalation beds open, reduced skill mix and number of staff trained to manage stroke patients and able to be released to see patients in the emergency department (ED). This ward has also been supporting escalation areas such as South Newton and Breamore Ward.

Actions (SMART):

1. Simulation training to be implemented to increase staff understanding and ability to recognise stroke symptoms. This will ensure timely transfer of priority patients from ED staff, date to be confirmed during ED/Stroke management meeting on 24th Feb 2023.

2.Prioritisation of bed moves out of Farley to facilitate stroke patients transferring is ongoing. This action includes identification of patients which are suitable to move off the ward daily, such as medical non stroke patients or patients that no longer need therapy input. This will feed into improving together daily huddle and to discuss issues with delayed transfers and how this can be improved. The use of the GP assessment room is also discussed daily to see if patients are appropriate to be seen there rather than waiting in ED.

3.Meeting with Stroke and ED Management teams is scheduled for 24th Feb 2023 to facilitate development of a working group to discuss actions to improve patient transfers within 4 hours from the decision to admit to admission to the stroke unit monthly.

Risks and mitigations:

Hyperacute stroke patients are at currently risk of worsening outcomes without access to specialist care in the appropriate time frame, which increases length of stay. To help mitigate, monthly meetings to discuss: progress of stroke patients arriving on the stroke unit within 4 hours; arising issues of transferring patients off the ward that will impact on our target; and any staffing issues. These meetings will enable us to facilitate bed moves when a potential stroke patient has been identified in the ED more promptly when bed capacity allows.
Risk of significant staffing shortages, particularly during periods of significant operational pressures whereby stroke nurses are moved to support other clinical areas. An increase of staff sickness since the beginning of December has an impact on Stroke Services' ability to receive patients from ED, especially those that are thrombolysed. The service is hoping to be able to protect staff going forward by recognising stroke as an acute ward. However, bed managers will only move staff from the stroke unit as a last resort to help protect our staffing levels where possible.
Bed allocation remains a significant risk in the context of the trust's operational position. The service hopes to ensure adequate allocation of beds for stroke patients to improve transfer time as well as improve identification of patients suitable for transfer to medical wards to allow allocation for stroke patients going forward, though this is not achievable at present.

Maternity

Are We Safe?

01/01/2023 <- Reporting Month (Input the first of the REPORTING month)

	SFT Assurance Dashboard	Guidance	Standard	RAG Target 2021-22 Q4	RAG rating: Red	RAG rating: Green	Improvement Direction	Rolling 6 months: Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			NA	>= 2	= 0	Down	0	0	0	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP) per 1,000 Live (reg) Births	ONS	3.8 per 1000 live births	NA	>= 3.9	<= 3.7	Down	0.0	0.0	0.0	0.0	0.0	0.0	0
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	NA	>= 2.8	<= 2.6	Down	0.0	0.0	0.0	0.0	0.0	0.0	0
	Medical termination over 24 +0 registered			NA	NA	NA	Down	0	0	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths per 100,000 Maternal Deaths	ONS	9.1 per 100,000 women who delivered	NA	>= 9.2	<= 9	Down		0.0	0.0	0.0	0.0	0.0	0
	Number of women requiring admission to ITU	6 month SFT rolling		NA	>= 2	= 0	Down	0	0	0	0	0	0	0
Insight	Number or Datix incidents - moderate or above	6 month SFT rolling		1	>= 2	= 0	Down	6	2	1	2	1	1	2
	Datix incidents moderate harm(not SI)	6 month SFT rolling		1	>= 2	= 0	Down	5	2	1	2	0	1	2
	Datix incidence SII	6 month SFT rolling		0	>= 1	= 0	Down	1	0	0	0	1	0	0
	HSIB referrals	6 month SFT rolling		0	>= 1	= 0	Down	2	1	0	0	1	0	1
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		0	>= 1	= 0	Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		0	>= 1	= 0	Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover	RCOG guidence		40	<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR+	1.26	1.32	>= 1.29	<= 1.26	Down	1.33	1.35	1.33	1.29	1.31	1.31	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			NA	>= 1	NA	Down	19.64	19.65	18.84	18.84	19.96	20.9	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	100	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		NA	>= 2	= 0	Down	1	1	1	0	1	1	1
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	100	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		NA	>= 2	= 0	Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		22	NA	>= 22	Up	21	31	10	26	10	31	22
	Service user feedback : Number of Complaints	6 month SFT rolling		1	>= 2	<= 1	Down	4	2	1	2	2	1	2
	Number of SOX	6 month SFT rolling		6	NA	>= 6	Up	2	7	4	7	3	3	4
Assurance	Progress in achievement of 10 safety actions(CNST)	NHSR	10	NA	<= 5	>= 10	Up	5	5	6	7	5	5	6
	Training compliance - MDT PROMPT %	NHSR	90%	NA	<= 84	>= 90	Up	77	77	82	93	91	91	NA

Understanding the performance:

Midwifery vacancies remain high impacting midwife to birth ratio. Using bank and agency midwives to cover shortfall alongside use of nurses.
Some impact on vacancies from recruitment into specialist midwifery roles, these promotions have led to vacant posts in clinical areas.

Prompt (obsetric emergencies) training compliance over 90% however when subdivided into categories compliance < 88% in some workforce groups showing overall non-compliance with this safety action in accordance with Maternity Incentive Scheme (year 4).

Actions (SMART):

Midwifery staffing vacancies remain a Driver for Improving Together (IT) which ensures action and around recruitment and retention.

Continue to monitor midwifery staffing vacancy as an IT driver and continue to access OD and P support with recruitment and retention.

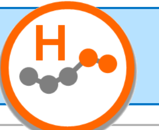
To continue with training session on fetal heart monitoring and Prompt (obstetric emergencies) to maintain/achieve compliance with safety action.

Multi-disciplinary team meeting arranged to review CNST safety actions achieved in 2022 and formulate plan for 2023

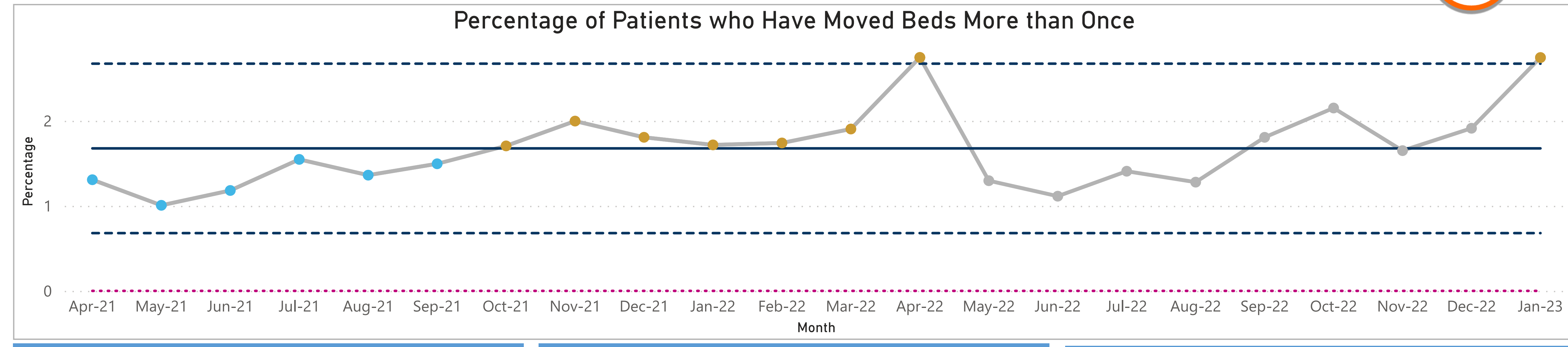
Risks and Mitigations:

Staffing – Targeted recruitment drive in progress and increase in international recruitment. 6 international midwives now in Salisbury being supported in practice to achieve OSCE and entry onto NMC register filling a midwifery vacancy. Supporting a return to practice (RtP) midwife .

Patients Who Have Moved Beds More Than Once



Are We Safe?



Understanding the performance:

This month has seen a significant increase in the percentage of patients moved more than once in January 2023, in comparison to the previous months. There has been an increase in the number of Infection Prevention Control (IPC) incidences, and this has increased the total number of moves patients may experience.

To accommodate patient needs in clinical specialty when the hospital is full requires prioritisation and movement.

Work is ongoing to promote the use of the discharge lounge, but there have been periods where the use of the discharge lounge has been used as an escalation area. The discharge lounge allows for early release of beds to non-elective admissions in the day to support the reduction in moving patients at the end of their journey to ensure that patients are placed within their correct speciality area.

Actions (SMART):

Work is ongoing to promote the use of the discharge lounge, but there have been periods where the use of the discharge lounge has been used as an escalation area. The discharge lounge allows for early release of beds to non-elective admissions in the day to support the reduction in moving patients at the end of their journey and ensure that patients are placed within their correct speciality area.

It continues to be a priority for all divisions to ensure that the patients receive their treatment in the appropriate speciality area.

The work with the E-whiteboards to identify the patients moves continues and aims to minimise total moves per patient and allow of an opportunity to improve the patient experience.

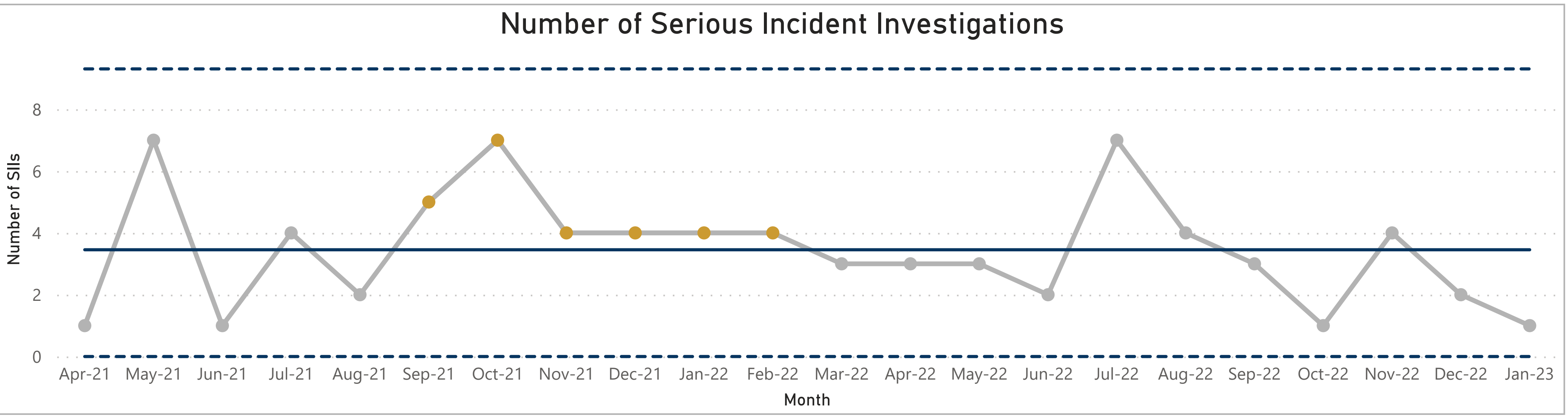
Risks and mitigations:

Staffing has been challenging throughout this period across the MDT, Site Team and admin which has impacted the patient experience.

Work continues with E-Whiteboards at ward level and the provider to improve.

Aiming to reduce the escalation areas throughout the trust footprint.

Incidents



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance:

There was one Serious Incident Investigation (SII) commissioned for review in January: SII 542- Contaminated IV giving set used in theatre

Actions (SMART):

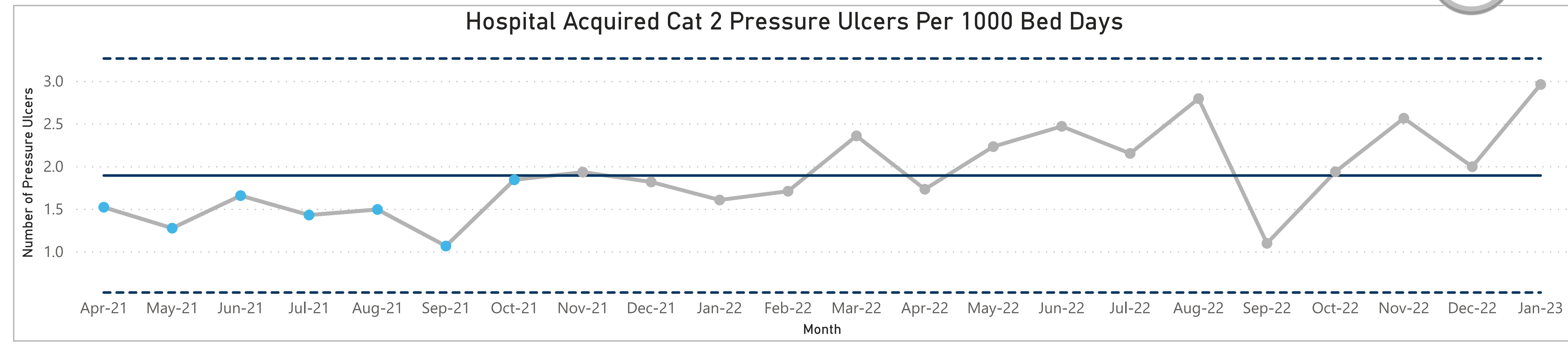
- Following the commissioning of an SII the incident will be investigated as per Trust protocol.
- The current time frame set for the completion of these reports is 60 working days.

Risks and mitigations:

- Once an incident has been identified and a 72 hour report completed, it will be established as to whether there are immediate safety actions that need to be implemented or escalated immediately.
- On completion of the report, learning will be cascaded through the Intranet, Clinical Governance sessions, patient safety steering group and dissemination to staff via area leads.
- Recommendations and action plans will be completed as per set target dates.

Pressure Ulcers

Are We Safe?



Understanding the performance:

- 50 hospital acquired pressure injuries were confirmed in January, this is the highest we have seen in this financial year.
- 3 hospital acquired device replated pressure injuries were noted, SWARM investigations and appropriate actions are being implemented.
- No hospital acquired PU 3 or 4s have been reported.
- 37 pressure ulcer were noted on admission.

Actions (SMART):

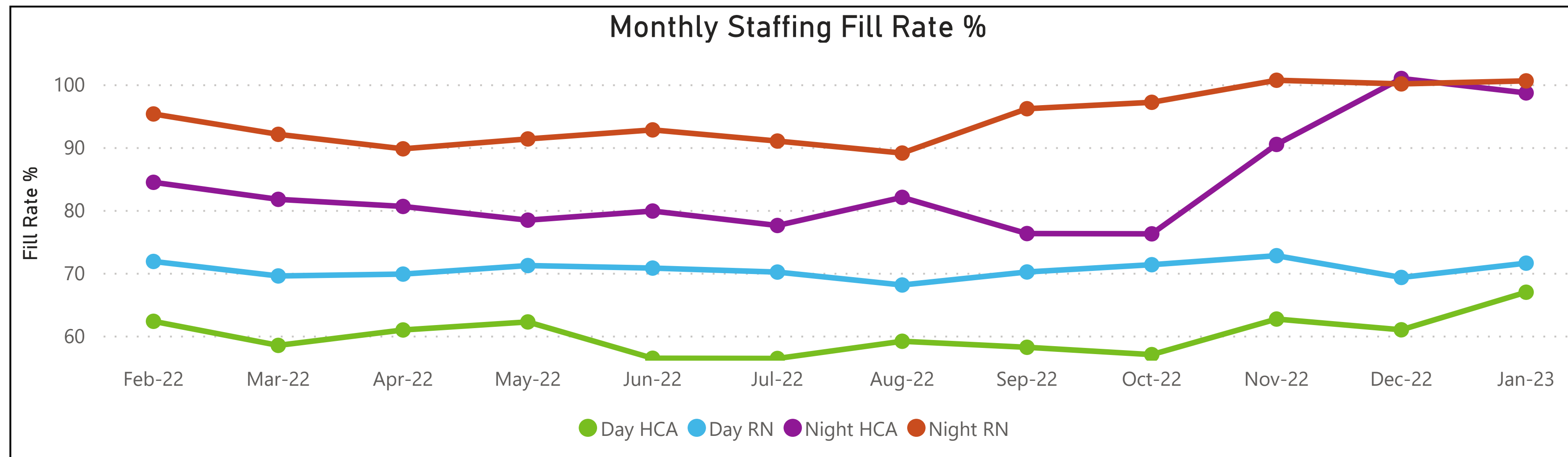
- New Hospital acquired PU investigation process being implemented; there has been good engagement from ward leads with the SWARM investigations and actions. Learning has been identified and actions undertaken for teaching on wards with areas of concern.
- Electronic datix validation on Lorenzo has completed testing and is now live. All validation for patients in December will be completed in duplicate on Lorenzo and on excel spreadsheet to ensure the data collected for monthly PU figures is accurate.
- All staff to be reminded to include as much information as possible when referring patients. This will minimise the number of inappropriate referrals which can delay reviews.
- Ward leads to ensure that their staff have completed medical photography training and are competent in taking required images and uploading to PACS.

Risks and mitigations:

- The Tissue Viability team have appointed 2 new CNS's who are in being trained in their new roles. Please be aware that reviews may take longer while this training is undertaken.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	98%	104%	87%	126%
Britford	87%	100%	95%	119%
Chilmark	88%	95%	75%	80%
Downton	111%	138%	104%	164%
Farley	83%	96%	67%	112%
Hospice	92%	101%	87%	116%
Longford	83%	121%	89%	104%
Maternity	88%	92%		
NICU	107%	101%	67%	
Odstock	102%	87%	101%	101%
Pembroke	95%	102%	90%	153%
Pitton	101%	129%	85%	139%
Radnor	89%	94%	58%	90%
Sarum	88%	104%	84%	
Spire	94%	128%	89%	120%
Tisbury	78%	95%	72%	119%
Whiteparish	135%	146%	88%	132%

Understanding the performance:

All 4 markers show an improvement in month. HCA is driven by the improvement in HCA recruitment and the Allocation on Arrival shifts for the night which have a good uptake.

Night shift remains the highest shift fill both for RN and HCAs, due to the unsocial hours rate and popular amongst temporary staff and often fits around childcare requirements.

Clinical Hours per Patient Day (CHPPD) is 7.9 in month, 7.4 when ICU/NICU are excluded – this is an improvement on the previous month

Actions (SMART):

Increase hourly rate of pay for Band 2 staff to top of scale (from 01/12/22) - complete
Review of all Band 2/Band 3 job descriptions with view of regrading Band 2 to Band 3 with effect from New Year – ongoing work towards implementation.
Review of all current vacancies by Division - complete.
Development of non-clinical support role (Band 2)– anticipate start date in March – will be undertaken as pilot across 5-6 wards managed by matron.
Winter bank incentive scheme in place – super-enhanced reviewed and being extended to avoid TNS fill and approval will be driven by red staffing levels
Understand impact of agency usage from requirements for RMNs
All actions being monitored as part of exec-led weekly winter planning meets.

Risks and mitigations:

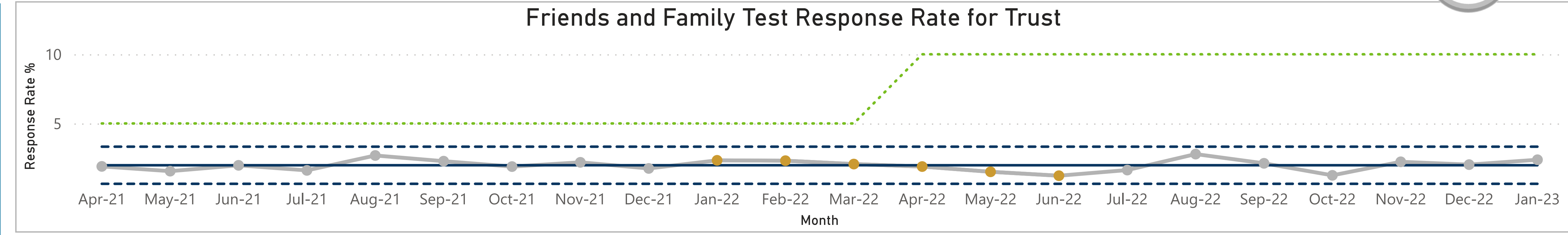
Risks to this work include:
Ongoing high turnover rate for RN and HCAs (risk)

National and international recruitments (mitigation)

Twice monthly HCA inductions (mitigation)

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
FFT Response Rate - A&E	0.1%	0.0%	0.2%	0.0%	0.2%	0.1%	0.3%	0.4%	0.3%	1.1%	0.3%	0.8%
FFT Response Rate - Day Case	5.3%	5.0%	4.8%	4.6%	3.3%	4.6%	8.9%	6.8%	3.1%	2.5%	1.4%	0.3%
FFT Response Rate - Inpatient	9.5%	7.1%	5.7%	7.1%	6.8%	7.5%	10.9%	11.5%	5.2%	10.5%	5.7%	11.8%
FFT Response Rate - Maternity	2.5%	5.9%	11.5%	0.9%	0.4%	1.6%	7.8%	1.1%	1.2%	0.0%	2.6%	2.2%
FFT Response Rate - Outpatient	1.6%	1.6%	1.3%	0.8%	0.6%	0.9%	1.5%	0.9%	0.9%	1.6%	2.0%	2.0%

Understanding the performance:

FFT responses have increased again this month. Staff are still being encouraged and reminded to offer FFT through the PALS outreach services although we appreciate that this sole method of obtaining response will inevitably mean fluctuations in activity consequent to pressures.

It is noted that in the last few months the average responses of patients who are satisfied with the service they received, have dropped from 99% to 96% but this has improved again in the last two months.

Actions (SMART):

Long-term action: Securing a provider to gather patient feedback vis SMS will be key to moving towards achievement of our objectives under the Improving Together Programme over the next 6-12months:

Aims:
- Increase overall response rates to FFT
- Diverse methods for completion (including, online, SMS, over the phone)
- Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
- Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard
- Opportunity to align our processes in FFT across the ICS

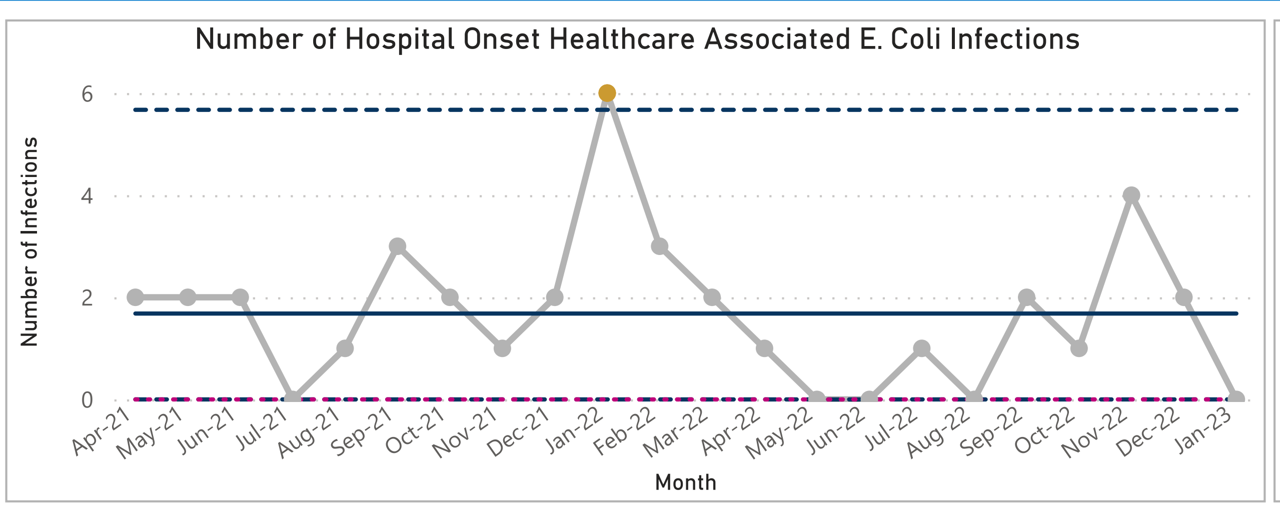
Risks and mitigations:

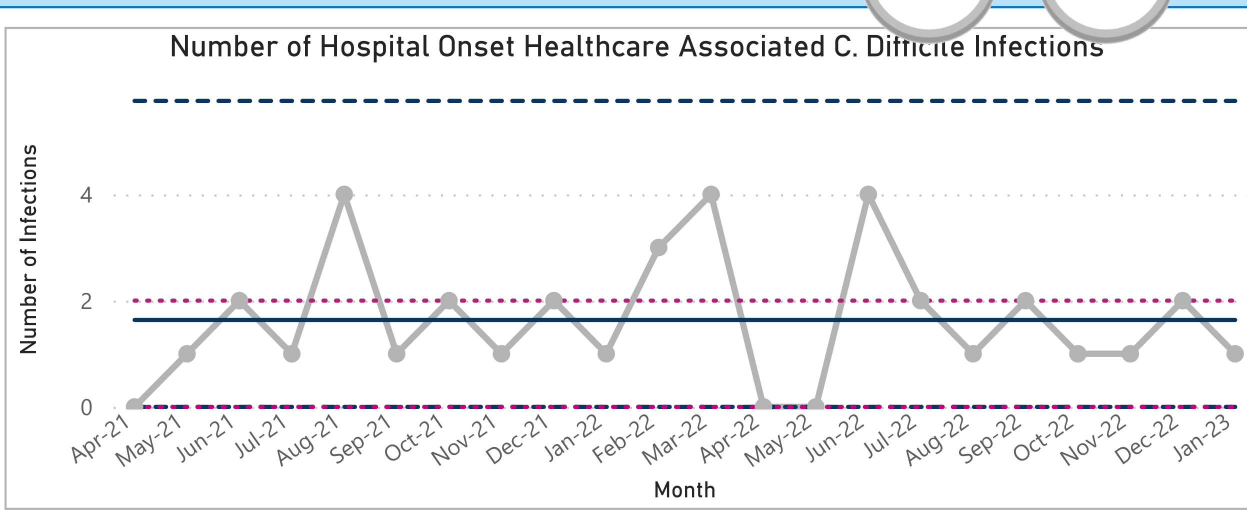
Continued low response rate, due to limited methods for accessibility and the reliance on staff to promote completion of a physical card, this is directly impacted when there are staff shortages and operational pressures. The current method requires manual input and theming, which there is limited resource to undertake. Theming on a large scale is near impossible without the usual of manual approaches - this makes presenting accurate data for the Trust difficult to assure.

Implementation of the new IT solution to increase response rates and improve analysis is now likely to be delayed from Autumn 2022 to early in the New Year of 2023. A revised implementation timescale is currently being worked through with CPPG and the related Work Package Groups.

Infection Control

Are We Safe?





Year	2021-2022	2022-2023
MSSA Bacteraemia Infections: Hospital Onset	12	6
MRSA Bacteraemia Infections: Hospital Onset	0	0

Understanding the performance:

There have been no hospital onset healthcare associated reportable E.coli bacteraemia infections and one hospital onset healthcare associated reportable C.difficile case this month.

As previously reported, we have exceeded set trajectories for reportable healthcare associated C.difficile cases for 2022/23 (total now 26 cases).

The Infection Control Nurses (ICNs) have undertaken targeted ward visits and utilise educational opportunities with different staff groups.

Actions (SMART):

-Decision made to progress with the agreed process and extend roll out across the clinical divisions during Q4 22/23.
-Ongoing action associated with completion of required case investigations by clinical areas to identify good practice and any new learning. SFT IP&C team facilitate this process so that areas take ownership and progress any actions or identified learning (including sharing good practice). It remains the responsibility of the ward/area/department lead and division to complete this.
-Ongoing feedback required from clinical areas at monthly 'Share & Learn' meeting to enable agreement of actions moving forward from any themes/trends identified from all cases. January 2023 meeting was held with variable attendance by ward/area leads to feedback information.
-Involvement with BSW collaborative workstreams related to IPC and Gram-Negative Bloodstream Infections (GNBSIs). Any feedback communicated from the sessions to identified individuals in the organisation is to be shared at the Trust's Infection Prevention & Control Working Group (IPCWG) as part of a standing agenda item. The next meeting is scheduled for February 2023, with attendance by the Infection Control Doctor agreed.

Risks and mitigations:

Exceptional workload for IPC nursing team including managing new COVID-19 outbreaks, continued respiratory illnesses and increased diarrhoea activity within the hospital, impacting on ability to focus on other HCAI prevention work.

Ongoing nursing vacancy within the IPC team which has delayed the ability for the service to undertake additional educational activities and policy practice reviews. Secondment plan for position was due to commence in January 2023 but has been delayed until February 2023.

An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes and Trust exceeding all agreed trajectories.
Variable staffing levels continually reported by clinical areas affecting ability to facilitate learning in ward environment.
Delays with return of completed case investigation documentation by relevant clinical areas, therefore unable to identify evidence of learning.
Limited evidence of IPC practice assurance provided by the clinical divisions due to ongoing operational challenges and workload pressures for teams.

Mortality

Are We Safe?

Metric Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Crude Mortality	63	76	62	68	69	65	64	79	94	86	84	84	88	84	77	88	82	73	75	77
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	100	102	100	101	102	102	103	106	105	101	104	107	109	109	111	112	113			
HSMR Trust	111	108	109	108	108	109	110	110	113	113	109	111	116	115	117	118	119			
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	98	100	101	101	101	102	102	102	102	104	105	107	106	106	106	106	106			
SHMI Trust	103	105	106	106	106	107	107	107	107	108	109	111	110	110	110	111	111			

Please note: The data has been supplied by Telstra Health UK (Dr Foster) and a 2-month lag has been applied to the HSMR figures to allow for coding. It should be noted that 'expected' ranges are based on the 95% confidence intervals applied by Dr Foster, however the published SHMI figures from NHS Digital are based on 98% confidence intervals. This intended to be a more sensitive indicator in order to provide the trust with an early warning for potential areas to review.

Key:* *Red = Statistically higher than expected

Understanding the performance:

Mortality statistical models compare across all acute hospital trusts (the majority of which will not contain hospice services), therefore the number of expected deaths at Salisbury NHS Foundation Trust is likely to sit above expected levels.

The Summary Hospital-level Mortality Indictor (SHMI) for the 12-month rolling period of September 2021 to August 2022 for Salisbury District Hospital is 106.98.

The HSMR for the 12-month rolling period of September 2021 to August 2022 for Salisbury District Hospital is 113.4.

Actions (SMART):

N/A

Risks and mitigations:

The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting.

A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend in order to help us to interpret and analyse our mortality data and identify variations in specific disease groups.

Where alerts are generated, these are discussed
and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
RTT Incomplete Pathways: Total 52 week waits	448	549	578	555	0		Special Cause Improving - Run Below Mean	✗	1
Cancer 2 Week Wait Breast Performance	96.7%	96.1%	87.0%		90%		Special Cause Improving - Run Above Mean	✗	1
Cancer 62 Day Screening Performance	84.6%	85.7%	82.1%		90%		Special Cause Improving - Run Above Mean	✗	4
% of Inpatients Undergoing VTE Risk Assessment	98.7%	%	98.7%		95%		Special Cause Concerning - Two Out of Three Low	✓	0
Total Number of Compliments Received	47	12	68				Special Cause Concerning - Run Below Mean		
Trust Performance RTT %	65.2%	61.8%	64.8%		92%		Special Cause Concerning - Run Below Mean	✗	22
Ambulance Handovers 30-<60 mins	164	148	152				Special Cause Concerning - Run Above Mean		
DM01 Waiting List Volume	6688	6071	5555				Special Cause Concerning - Run Above Mean		
ED 12 Hour Breaches (Arrival to Departure)	72	201	77		0		Special Cause Concerning - Run Above Mean	✗	22
Proportion of patients spending more than 12 hours in an emergency department	1.7%	4.8%	2.1%				Special Cause Concerning - Run Above Mean		
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	29.0%	22.0%	42.0%				Special Cause Concerning - Above Upper Control Limit		
Average Patients with No Criteria to Reside	146	171	172	35			Special Cause Concerning - Above Upper Control Limit	✗	22
Ambulance Handovers 60+ mins	131	281	136		0		Common Cause Variation	✗	22
Average hours lost to Ambulance Handover delays per day	14	34	14		0		Common Cause Variation	✗	22
Mixed Sex Accommodation Breaches	14	22	9	0	0		Common Cause Variation	✗	5
Stroke & TIA: % CT'd within 1 hour	50.0%	50.0%	42.0%		50%		Common Cause Variation	✗	1
Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	459	335	816	150	0		Common Cause Variation	✗	22
Total Number of Complaints Received	19	11	9		0		Common Cause Variation	✗	8

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance:

Metrics in relation to length of time in the Emergency Department, Ambulance handover delays and Diagnostic and elective waiting lists continue to alert. Details on actions and risks in relation to these are detailed on the relevant slides earlier in the report. Occupancy levels in the Trust remain high, with a high number of beds occupied with patients no longer requiring an acute bed.

Performance against the Two week wait standard for suspected Breast Cancer dipped in January due to a high number of referrals from the mobile Breast screening vans in the area throughout M7-9. Consequently, there was a 40% increase in number of cancers detected compared to the same period in 2021. In January a total of 28 Breast Screening cancers were treated which saw an average treatment date of 64 days, just over the 62-day standard.

Actions (SMART):

Actions focus around developing further Same Day Emergency Care Pathways to reduce the number of patients requiring admission to bedded areas and ensure patients on emergency pathways receive prompt diagnostics and treatment. Length of stay reduction schemes are being developed by Divisions aimed at reducing length of stay and thereby reducing occupancy levels with the aim of being able to move patients more quickly from the emergency department to inpatient areas.

Risks and Mitigations:

Staffing risks remain high in terms of availability and vacancy, focused work continues with improvement beginning to show in the care hours per patient per day measure (CHPPD), but this remains vulnerable with higher than desired turnover rates.

Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Arrivals	1144	1049	1057				Special Cause Improving - Two Out of Three Low		
Ambulance Handovers 15-<30 mins	328	225	268				Common Cause Variation		
Cancer 31 Day Performance Overall	97.9%	90.7%	97.0%		96%		Common Cause Variation	✓	0
ED Attendances	6131	6839	5863				Common Cause Variation		
Neonatal Deaths Per 1000 Live Births	0	0	0		0		Special Cause Improving - Run Below Mean	✓	0
Number of High Harm Falls in Hospital	0	0	0	0	0		Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 2	38	31	46				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 3	0	0	0				Special Cause Improving - Run Below Mean		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0				Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 104 week waits	0	0	0	0	0		Special Cause Improving - Run Below Mean	✓	0
RTT Incomplete Pathways: Total 78 week waits	6	8	7	10	0		Special Cause Improving - Below Lower Control Limit	✓	0
Serious Incident Investigations	4	2	1				Common Cause Variation		
Stillbirths Per 1000 Total Births	0	0	13				Common Cause Variation		
Total Incidents (All Grading) per 1000 Bed Days	59	55	51				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

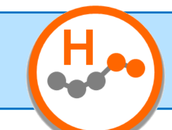
Population

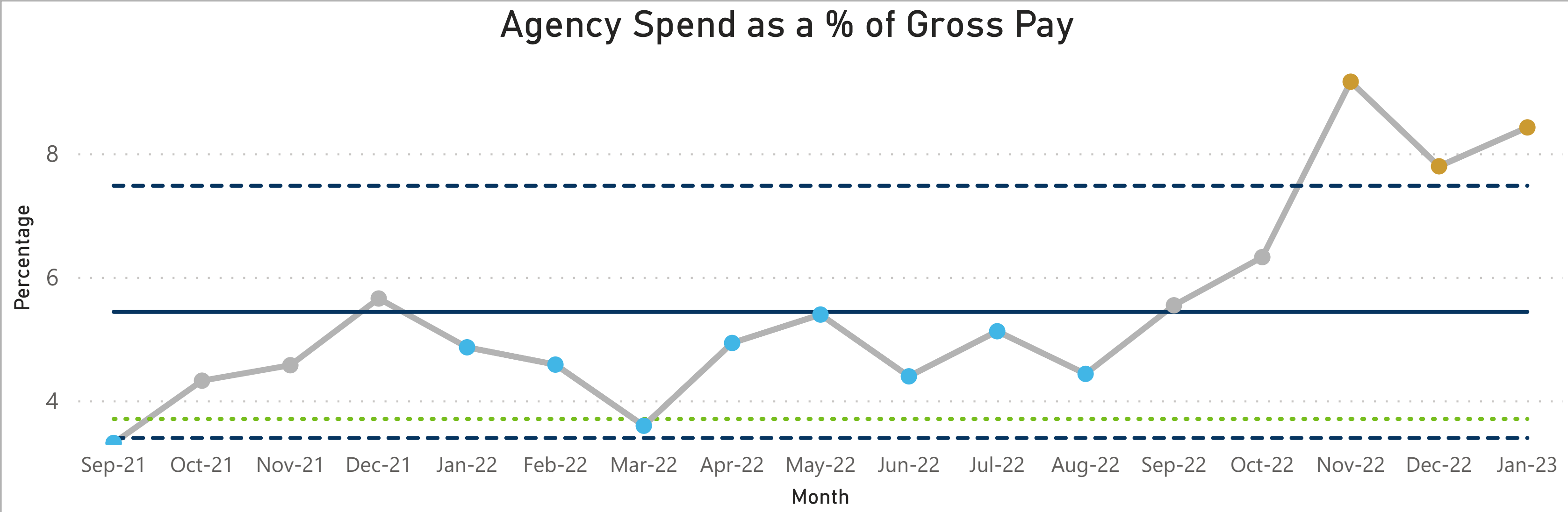
Partnerships

People

Staffing Availability

Target 3.7%





We are driving this measure because...

Understanding the performance:

Poor staff availability, which increases agency spend is a combination of high vacancy rates, poor retention of staff leading to high turnover and high levels of short term absence, resulting in the requirement for agency staff to meet safe staffing and other service requirements.

The trends against turnover, vacancies and absence have been rising since Apr 22 resulting in increased agency spend as a proportion of the pay bill. January data shows agency spend above 8% of the pay bill, by some margin in excess of the 3.7% target.

This month's data shows a rise for January, with Medicine responsible for a little over 50% of agency spend. Across the Trust, nursing staff are proportionally the highest demanders of Agency support.

Actions (SMART):

Establishment Control: The e-roster and ESR project will deliver establishment control through oversight of organisational design, improve visibility of vacancies across the Trust and improve workforce productivity. Benefits will be assessed against agreed project metrics, reporting initially in Jun 23. Further e-roster roll out commences against an agreed schedule from Apr 23.

Recruitment Services: The Starters Project implements the six recommendations from PwC audit to improve onboarding, reducing time to hire and targeting attraction campaigns to meet hard to fill vacancies. Project timelines have been agreed with the first progress report due in Mar 23.

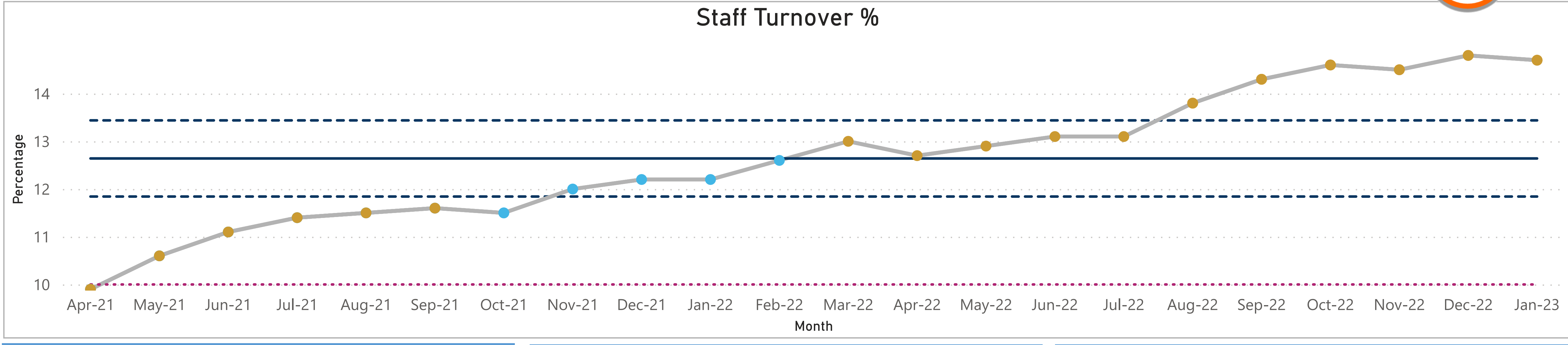
Absence Management: Direct support to line mangers to support absence management is being provided as a pilot, reporting in Apr 23, if successful this model will be rolled out further with the aim of reducing short-term sickness absence from its current rate to 3.5%.

Risks and mitigations:

Workforce - Turnover

Target 10%

People



Understanding the performance:

All Divisions remain red against the Trust 10% target.
In January, 24.05 (FTE) left the Trust, with 67.86 (FTE) staff starting work. This has reduced the rolling average to 14.68% this month and represents a net inflow of 43.81 (FTE). This is an expected increase, as discussed last month, the Christmas period tends to see more staff leaving before the break and starters waiting until the New Year to begin work.

Surgery have the lowest turnover rate this month, with Women and Newborn the highest at 20%.

Exit data remains incomplete. This month 30% of staff conducted an exit survey, a 10% improvement from last month. Nearly 20% of leavers indicated that they would remain within the NHS.

Reasons for leaving this month were more varied, with no dominant theme, although one third of staff cited better reward/promotion and moving to education/training.

Actions (SMART):

Work is ongoing to analyse Staff Survey data. This work will be complete by mid March, ready to support targeted Divisional interventions in April.

Initial stakeholder meeting for the 'Movers and Leavers' project has confirmed project benefits, and examined the relationship with ESR improvements driven through the e-Rostering/ESR project. The delivery of improved procedures for exit interviews and data collection is one of the key benefits.

HR Business Partners (HRBPs) will continue to support Divisional Line managers deliver appraisals and career conversations. All those RN in the 45-55 age group will have had a career conversation before 31 Mar 23.

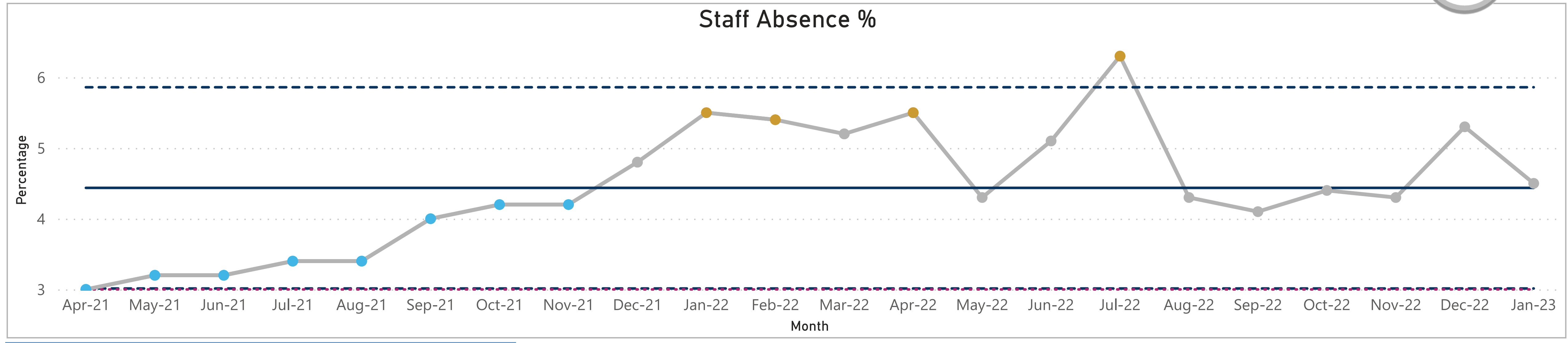
Risks and mitigations:

The ability to reduce the number of patients not meeting the criteria to reside is a significant risk both in terms of elective and non elective pathways. Additional beds have been opened at South Newton to provide additional capacity.

Workforce - Sickness

Target 3%

People



Understanding the performance:

Sickness absence has reduced to 4.5% in January, with the highest impact in Surgery and Medicine Divisions. Only the Corporate area sits below a 4% threshold at 3.75% and is graded amber against the target of 3%.

Figures for Dec and Jan are slightly lower overall than the same period last year with additional clinical services being the staff group with the highest absence rate (7.71%) in Jan 23.

Short term absence through sickness accounted for 3,303 lost FTE days in Jan, with more than half being due to Cold, Cough, Flu, Infectious Disease, and Gastro-intestinal problems. 1,041 days were lost to mental health illness.

Actions (SMART):

Recruitment has commenced against the BC agreed to recruit a member of staff to conduct a pilot to support Divisional and Line Managers with Absence Management and wellbeing conversations. The intent is to prove the concept of direct support to management to improve visibility and action on long-term absence cases and, in conjunction with the 26 wellbeing ambassadors, deliver wellbeing conversations to all staff by 31 Mar 23. Interventions will be targeted against areas with significant backlogs.

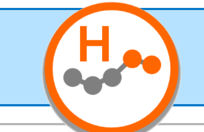
An absence management workshop took place in Jan 23, which identified several areas where improvements could be made to policy, processes and management of absence cases. These ideas will be refined with the aim of introducing improvements in Apr 23.

Risks and mitigations:

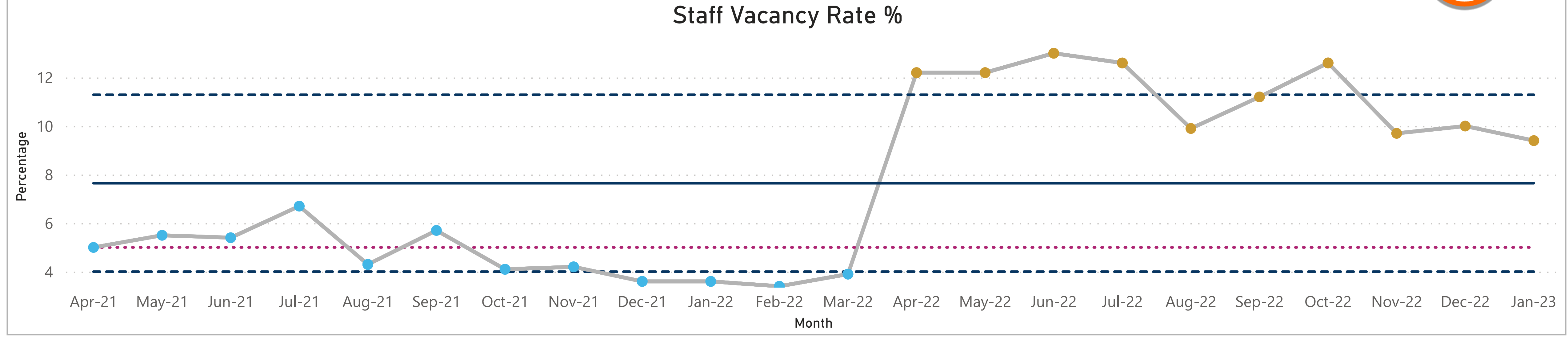
Corporate Risk – Delivery of Occupational Health (OH) service
OH staffing has improved. A Band 7 lead, combined with increased counselling and physio hours are required. Delivery of a health intelligence capability is planned for Summer 23.

Corporate Risk – Sustainable Workforce
Absence management actions are not effective. AD HR Ops is now producing a targeted plan to reduce absence case work numbers.

Workforce - Vacancies



People



Understanding the performance:

January saw an improved vacancy rate sitting at 9.44%, the lowest rate since the increase to establishment numbers in Apr 22. Starters this month amounted to 67.68 (FTE). In addition, the Bank staff numbers saw an increase by 42 workers to the admin bank.

Data shows that Nursing staff have the highest vacancy numbers at 134 FTE and theatres have the highest departmental rate at 82 FTE.

The impact of targeted campaigns for admin and other support staff has made a difference to vacancy rates in these areas, although pressure must be maintained in all high volume/lower band areas of the Trust.

Actions (SMART):

The 'starters' project, highlighted by a PwC audit has begun. This seeks to improve onboarding processes, with delivery against medium term project plan benefits complete by Jun 23.

Throughout December, an assessment of social media platform presence has been conducted, changes identified in that analysis will be put into place in Jan 23, with results assessed in Mar 23.

HRBPs have analysed data made available through improvements to reporting to identify specific vacancies that can be targeted through campaigns supported by recruiting and retention premia. Pharmacy is one area of examination.

Risks and mitigations:

Corporate Risk – Sustainable Workforce:
Resourcing Plans delivered.

Implementation of PWC 'overhauling recruitment' recommendations to generate more efficient processes.

Recruitment campaigns are being refreshed.

Communication of single version of recruiting picture across the Trust.

Creation of career pathways and improved career structures to better advertise roles and opportunities.

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	86.6%	86.9%	85.8%	90.0%			Special Cause Improving - Run Above Mean	✗	22
Non-Medical Appraisal Rate %	65.5%	63.8%	63.9%	86.0%			Special Cause Concerning - Below Lower Control Limit	✗	22

Watch Metrics: Alerting Narrative

People

Understanding the performance:

Ineffective management of appraisals remains an area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff. January data sees no change to the average of 64% completion rates. The impact this has on staff is identified in recent staff survey results Trust wide, adding to Turnover numbers. Surgery and Medicine division remain the worst divisional performers at 55.6 and 61.0% respectively, however, this month the overall average was reduced by a worsening number of completed appraisals from the Corporate area.

Actions (SMART):

A simplified process for appraisals has been agreed and once rolled out, will be measured over a four month period to assess the impact on completion rates.

Delivery of the Trust's leadership programmes:
Aspiring leaders (Bands 4-6) programme starts with the first cohort of 20 managers in Feb 23.
Transformational Leadership Programme (Bands 7-8+) first cohort of 20 from Mar 23.
Management workshops including managing appraisals and time management modules are being increased for 2023
Line Managers breakfast sessions have been re-instigated to support those line mangers who need help and guidance on delivery of appraisals to staff, pointing out training courses where required.

Risks and Mitigations:

Corporate Risk - Sustainable Workforce.

Retention Mitigations – Appraisal Project, Development and Delivery of Leadership Training Modules for line managers.

Watch Metrics: Non-Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	90.8%	90.6%	90.2%	90.0%	85%		Special Cause Improving - Run Above Mean	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

Population

Partnerships

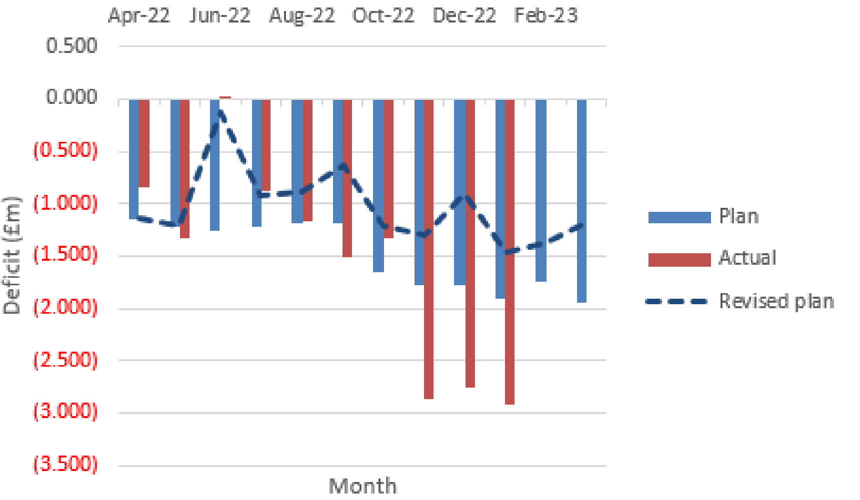
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	Jan '23 In Month			Jan '23 YTD			22-23 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,946	22,094	148	220,115	222,311	2,196	260,775
Other Clinical Income	714	1,218	504	7,142	9,284	2,142	8,573
Other Income (excl Donations)	2,797	3,312	515	28,852	34,133	5,281	34,540
Total income	**25,457**	**26,623**	**1,166**	**256,110**	**265,728**	**9,619**	**303,888**
Operating Expenditure							
Pay	(16,912)	(18,475)	(1,564)	(168,669)	(175,150)	(6,481)	(199,429)
Non Pay	(8,281)	(10,003)	(1,722)	(80,513)	(90,277)	(9,764)	(96,646)
Total Expenditure	**(25,193)**	**(28,479)**	**(3,286)**	**(249,182)**	**(265,426)**	**(16,245)**	**(296,075)**
EBITDA	**264**	**(1,856)**	**(2,120)**	**6,928**	**302**	**(6,626)**	**7,813**
Financing Costs (incl Depreciation)	(1,723)	(1,065)	658	(16,768)	(15,883)	885	(20,213)
NHSI Control Total	**(1,459)**	**(2,921)**	**(1,462)**	**(9,840)**	**(15,582)**	**(5,742)**	**(12,400)**
Add: impact of donated assets	(68)	685	753	(680)	388	1,068	(816)
Add: gains/(losses) on transfers by absorption	0	(329)	(329)	0	(329)	(329)	
Surplus/(Deficit)	**(1,527)**	**(2,566)**	**(1,039)**	**(10,520)**	**(15,523)**	**(5,003)**	**(13,216)**
NHSI Control Total including BSW ICB support	**(426)**	**(1,888)**	**(1,462)**	**493**	**(5,248)**	**(5,742)**	**0**



Understanding the performance:

In month 10 the Trust recorded an in month control total deficit of £2.921m against an original target of £1.459m - an adverse variance of £1.462m. The YTD control total deficit is £15.582m compared to the original plan of £9.840m. When the full year £12.400m ICB funding is taken into account (£10.333m at month 10) the deficit is adjusted to £5.248m against a surplus of £0.493m.

Pay costs increased in month by £0.6m driven by an increase in bank and agency costs, including bank incentive costs. Non pay costs fell by £0.4m mainly driven by Purchase of Healthcare in prior months. 'Pass through' non pay costs continue to run in excess of those planned for and now account for 60% of costs above plan. Financing charges reduced by £0.5m in month due to the capital charges relating to the Day Surgery unit being extended in line with the District Valuer's recommendations.

Actions (SMART):

Agreement was reached on the distribution of the BSW ICB planned surplus and £12.4m was paid to SFT in October.

People workstreams are focusing on retention of staff, with the uplift of all Band 2s to the top of scale with effect from 1 December. A review of HCA roles that fulfill clinical competencies and can be regraded to Band 3 has been concluded with the expectation that this is effective from January 2023.

The BSW-wide procurement 2022/23 workplan levers the ICS spending power to mitigate the impact of inflation.

Risks and mitigations:

Pressure on emergency care pathways which results in increased costs associated with the Trust's bed base, reductions of elective inpatient care and premium costs of bank and agency to cover vacancies and unavailability.

The requirement for the provision of additional beds at South Newton would represent a financial risk to the Trust if unfunded.

The Trust has a forecast delivery of £9.7m efficiency savings split 50:50 between recurrent and non-recurrent schemes. This signals a significant risk if further recurrent efficiencies are not identified.

A revised forecast of £6.4m deficit was approved by the Trust Board in early January and work is ongoing with the ICS to identify potential mitigations.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	January'23 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	9,004	8,507	(497)
Day Case	16,811	16,201	(610)
Elective inpatients	11,125	11,489	364
Excluded Drugs & Devices (inc Lucentis)	18,500	20,171	1,671
Non Elective inpatients	58,701	60,781	2,080
Other	75,541	75,702	161
Outpatients	30,433	29,460	(973)
TOTAL	220,115	222,311	2,196

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	130,454	132,257	1,803
Dorset ICB	21,880	21,789	(91)
Hampshire, Southampton & IOW ICB inc Portsmouth	17,841	17,841	-
Specialist Services	32,073	33,702	1,629
Other	17,867	16,722	(1,145)
TOTAL	220,115	222,311	2,196

Month on Month Income Analysis

Income (£m): 18.000 – 25.000; Apr-22 to Mar-23; Actual, Plan, 21-22 Actual

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	59,159	61,082	1,923	57,165	3,917
Day case	19,274	18,513	(761)	17,165	1,348
Elective	2,772	2,749	(23)	2,324	425
Non Elective	24,177	22,237	(1,940)	23,514	(1,277)
Outpatients	211,651	211,292	(359)	224,654	(13,362)

Understanding the performance:

The Trust is ahead of the Clinical income plan year to date due to BSW ICB ERF, pay award and South Newton additional beds funding and overperformance on Channel Islands spinal patients and additional Cystic Fibrosis patients and drugs. NHS England Specialised services continues to overperform on cost and volume high cost drugs and devices which is being offset by the transfer of the Genetics service with an income reduction of £0.6m per month. Dorset ICB income has been adjusted for the agreement on the Sleep service.

A&E activity was higher in December than in November with less attendances at the A&E department but circa 840 attendances more at the Walk in centre in month. Day case activity in December was 353 less cases than in November with less activity undertaken in General Surgery (111 cases) and Plastic Surgery (90 cases) but exceeded the plan by 81 cases. Activity in Elective inpatients was above plan in month by 54 cases mainly within Trauma and Orthopaedics and Plastic Surgery. Non Elective activity was higher than in November by 32 cases and above plan mainly within medical specialties. Outpatient activity was understandably lower than in November but above planned levels.

Actions (SMART):

The BSW ICB contract has been signed by both parties and the reamining contracts with NHS England.

The NHS England contracts require updating for the inclusion of agreed quality schedules, final agreement on the finance and information schedules and the removal of public health aspects within the HIV contract which were not part of the contract tender.

Risks and mitigations:

The BSW ERF funding has now been confirmed at £2,150k and is higher than originally planned.

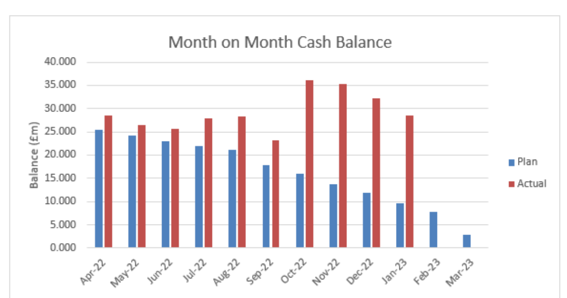
£900k funding has been agreed for 14 South Newton beds and discussions are ongoing on the additional fuding for a further 10 beds.

Cash Position & Capital Programme

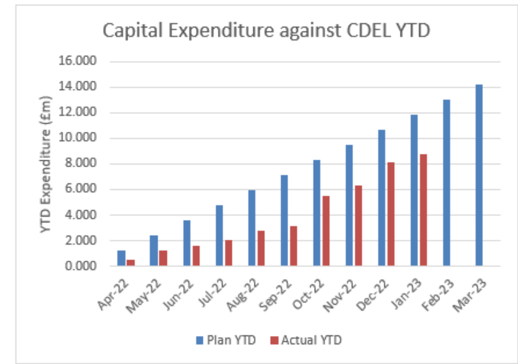
Capital Spend: (amber) **Cash & Working:** (green)

Finance and Use of Resources

	Closing Balance March 2022 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,939	9,017	1,078
Debtors	14,296	21,989	7,693
Cash	33,447	28,512	(4,935)
TOTAL CURRENT ASSETS	**55,682**	**59,518**	**3,836**
Creditors	(46,637)	(51,624)	(4,987)
Borrowings	(1,102)	(1,265)	(163)
Provisions	(1,235)	(906)	329
TOTAL CURRENT LIABILITIES	**(48,974)**	**(53,795)**	**(4,821)**
TOTAL WORKING CAPITAL	**6,708**	**5,723**	**(985)**



Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Jan-23	**6,700**	4,509	766	198	1,427
Dec-22	**8,474**	6,286	425	439	1,324
Nov-22	**7,152**	4,929	781	291	1,151
Movement vs prev mth	*(1,774)*	*(1,777)*	*341*	*(241)*	*103*



Schemes	Annual Plan £000s	January'23 YTD Plan £000s	January'23 YTD Actual £000s	January'23 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	3,684	3,070	1,319	1,751
Building projects	3,048	2,540	2,771	(231)
IM&T	3,828	3,190	2,388	802
Medical Equipment	4,072	2,710	1,330	1,380
Other	425	354	313	41
Total CDEL schemes	**15,057**	**11,864**	**8,121**	**3,743**
National Funding				
TIF - New ward	*2,048*	*472*	*472*	0
Pathology LIMS	*682*	*100*	*100*	0
MRI Acceleration Upgrades	*178*	*120*	*120*	0
Total National Funding	**2,908**	**692**	**692**	0
GRAND TOTAL	**17,965**	**12,556**	**8,813**	**3,743**

Understanding the performance:

Capital expenditure is significantly behind plan, c30% year to date, particularly within Medical Equipment and Building schemes. Forecast expenditure by capital sub group is reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. The forecast includes the refurbishment of the Douglas Arter Centre as part of the decant for the additional ward scheme together with further agreed investment in medical equipment and building schemes. TIF funding for the new ward (£14m) hs now been formally agreed with £2.048m in 22/23. A further £2.726m of additional funding has been confirmed for nationally funded capital schemes.

The improvement in the cash position, following the receipt of the BSW ICB funding, mitigates any risk to the cash balance for the remainder of the financial year. It is anticipated that the cash balance will reduce markedly by year end due to capital expenditure within the last few months of the year.

Actions (SMART):

A further £300k BSW capital allocation has been confirmed and this is expected to be required for Digital schemes.

The capital plan has been reviewed in the context of known supply chain restraints. Alternative projects initially planned for 2023/24 which can be brought forward to 2022/23 have been identified to mitigate the risk of further slippage.

Risks and mitigations:

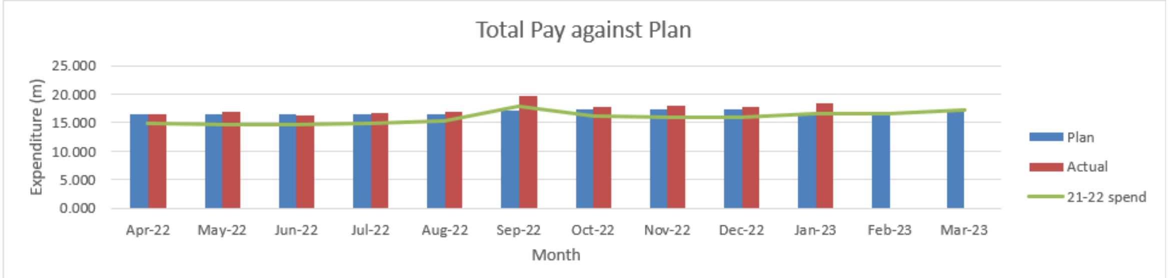
Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

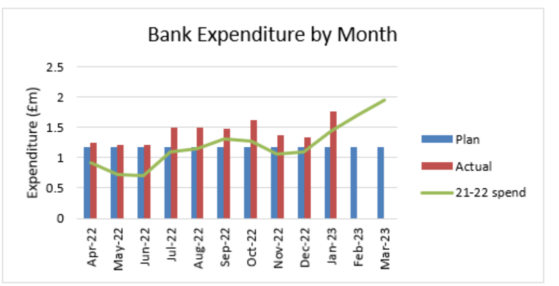
The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available.

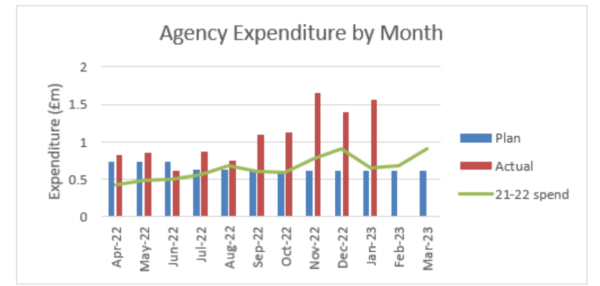
Workforce and Agency Spend

Pay:

Finance and Use of Resources







	January'23 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	149,273	149,543	269
Pay - Bank	11,905	14,237	2,333
Pay - Agency	6,501	10,717	4,216
Other (eg. Apprenticeship Levy)	990	653	(337)
TOTAL	**168,669**	**175,150**	**6,481**
Medical Staff	44,490	45,516	1,026
Nursing	40,045	45,598	5,553
Support to Nursing	12,190	14,205	2,015
Other Clinical Staff	27,631	25,328	(2,303)
Infrastructure staff	43,323	43,850	527
Other (eg. Apprenticeship Levy)	990	653	(337)
TOTAL	**168,669**	**175,150**	**6,481**

	January'23		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	472.6	(18.1)
Nursing	1,103.6	1,119.3	15.7
Support to Nursing	515.1	615.1	99.9
Other Clinical Staff	689.8	601.1	(88.7)
Infrastructure staff	1,461.1	1,403.7	(57.4)
TOTAL	**4,260.2**	**4,211.6**	**(48.6)**

Understanding the performance:

Pay expenditure increased by £649k in month 10, excluding pay award arrears in September, the highest of the year. This was driven by higher patient acuity and mental health nursing support in month with the escalated bed base continuing to drive the demand for temporary staffing at a premium cost. This is compounded by sustained turnover in excess of 14% against a target of 10%. Bank costs were the highest monthly spend this year to date and Agency costs have increased in month to the second highest monthly level. Bank costs include the bank holiday enhancements for Christmas and New Year (£42k) and the bank incentive scheme effective from 30th December 2022 (£80k). Bank and Agency costs were driven by expenditure within Medicine division and reflect higher patient acuity and mental health nursing support specifically on Whiteparish, Durrington, Spire and Pitton. This alongside a reduction in the use of high cost agency Thornbury shifts although there has been overall increase in total agency shifts in month due to additional beds at South Newton and escalation areas open. Pay savings target is £5.9m YTD, against which total achieved pay savings YTD are £3.1m - an adverse variance of £2.8m, with £0.3m recurrent delivery and £2.8m relating to non-recurrent savings from vacancies.

Actions (SMART):

Detailed actions on the response to the Trust's workforce challenges are set out in the People section of the IPR. These focus on recruitment, retention, and a focused review of short term sick leave.

Risks and mitigations:

Retention initiatives over and above those assumed as part of the winter forecast are in train to mitigate workforce gaps. Although in the longer term these would offset the need for high cost agency, in the short term it is likely that the Trust will require both.

Further Industrial action in March is expected to adversely impact on costs to mitigate and to disrupt patient pathways.

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Breakthrough Objective	% Beds Occupied	Site Team	Lisa Thomas	Medium
Breakthrough Objective	Staffing Availability	Oracle	Melanie Whitfield	Medium
Breakthrough Objective	Total Patient Falls per 1000 Bed Days	DATIX Team	Judy Dyos	Medium
Breakthrough Objective	Wait time to first OPA (non-admitted)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	% of patients moved more than once	Trust Data Warehouse	Judy Dyos	High
Narrative	C Difficile Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	High
Narrative	Cancer 2 Week Wait Performance	Cancer Services	Lisa Thomas	High
Narrative	Cancer 28 Day Faster Diagnosis Standard	Cancer Services	Lisa Thomas	High
Narrative	Cancer 62 Day Standard Performance	Cancer Services	Lisa Thomas	High
Narrative	Cat 2 Pressure Ulcers per 1000 Bed Days	DATIX Team	Judy Dyos	High
Narrative	DM01 Performance	Trust Data Warehouse	Lisa Thomas	High
Narrative	E Coli Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	High
Narrative	ED 4 Hour Performance	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Friends and Family Test Response Rate - All Trust	Trust Data Warehouse	Judy Dyos	High
Narrative	Staff Sickness Absence %	Health Roster	Melanie Whitfield	High
Narrative	Staff Turnover	ESR	Melanie Whitfield	High
Narrative	Stroke & TIA: % Arrival on Stroke Unit within 4 hours	Trust Data Warehouse	Peter Collins	High
Narrative	Total Ambulance Handover Delays	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Total Waiting List	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Vacancies	ESR	Melanie Whitfield	High

Data Sources: Watch Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	Ambulance Arrivals	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Ambulance Handovers 15-<30 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 30-<60 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 60+ mins	SWAST AR119 report	Lisa Thomas	High
Watch	Average hours lost to Ambulance Handover delays per day	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Average Patients with No Criteria to Reside	e-whiteboards via Trust Data Warehouse	Lisa Thomas	Medium
Watch	Cancer 2 Week Wait Breast Breaches	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Num	Cancer Services	Lisa Thomas	High
Watch	DM01 Waiting List Volume	Trust Data Warehouse	Lisa Thomas	High
Watch	ED 12 Hour Breaches (Arrival to Departure)	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Watch	ED Attendances	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	MSSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	High
Watch	RTT Incomplete Pathways: Total 104 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 52 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 78 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Stroke & TIA: % Bedside Swallow Assessment within 4 hours	Trust Data Warehouse	Peter Collins	High
Watch	Stroke & TIA: % CT'd within 1 hour	Trust Data Warehouse	Peter Collins	High

Data Sources: Watch Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	% of Inpatients Undergoing VTE Risk Assessment	Quality Team	Peter Collins	High
Watch	% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	DATIX Team	Judy Dyos	Medium
Watch	Cancer 31 Day Performance Overall	Cancer Services	Lisa Thomas	High
Watch	Mandatory Training Rate %	MLE	Melanie Whitfield	High
Watch	Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Mixed Sex Accommodation Breaches	Site Team	Judy Dyos	Low
Watch	Neonatal Deaths Per 1000 Live Births	E3 Maternity System	Peter Collins	High
Watch	Non-Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Number of High Harm Falls in Hospital	DATIX Team	Judy Dyos	Medium
Watch	Pressure Ulcers Hospital Acquired Cat 2	DATIX Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 3	DATIX Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 4	DATIX Team	Judy Dyos	High
Watch	Proportion of patients spending more than 12 hours in an emergency department	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Serious Incident Investigations	DATIX Team	Judy Dyos	Medium
Watch	Stillbirths Per 1000 Total Births	E3 Maternity System	Peter Collins	High
Watch	Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	e-whiteboards	Lisa Thomas	Medium
Watch	Total Incidents (All Grading) per 1000 Bed Days	DATIX Team	Judy Dyos	High
Watch	Total Number of Complaints Received	PALS Team	Judy Dyos	High
Watch	Total Number of Compliments Received	PALS Team	Judy Dyos	High
Watch	Trust Performance RTT %	Lorenzo via Trust Data Warehouse	Lisa Thomas	High

Data Sources: Other Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Cancer 2 Week Wait Breaches	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Den	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Num	Cancer Services	Lisa Thomas	High
Other	DM01 Performance: Audio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Cardio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Colon	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: CT	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: DEXA	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Flexi Sig	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Gastro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: MRI	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Neuro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: US	Trust Data Warehouse	Lisa Thomas	High
Other	Longest Waiting Patient (Weeks)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Other	Day HCA	Health Roster	Melanie Whitfield	High
Other	Day RN	Health Roster	Melanie Whitfield	High
Other	Night HCA	Health Roster	Melanie Whitfield	High
Other	Night RN	Health Roster	Melanie Whitfield	High

Data Sources: Other Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Maternity: Compliance with supernumery status of the LW coordinator %	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Coroner Red 28 made directly to trust	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX incidents moderate harm (not SII)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX incidents SII	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX relating to workforce	Maternity Dept	Judy Dyos	Medium
Other	Maternity: HSIB referrals	Maternity Dept	Judy Dyos	Medium
Other	Maternity: HSIB/NHSR/CQC or other organisation with a concern or request	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Midwifery vacancy rate	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Minimum safe staffing in maternity services; Obstetric cover	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Minimum to birth ratio	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of DATIX incidents - moderate or above	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of SOX	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of times maternity unit on divert	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of women requiring admission to ITU	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Progress in achievement of 10 safety actions (CNST)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Provision of 1 to 1 care in established labour (%)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Service user feedback: number of complaints	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Service user feedback: number of compliments	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Training compliance - MDT Prompt %	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Medical termination over 24+0 registered	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of Maternal Deaths	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of neonatal deaths (0-28 days)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of stillbirths (>+24 weeks excl TOP)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	SSNAP Case Ascertainment Audit	Stroke Team	Peter Collins	High

Data Sources: Other Metrics (3)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Crude Mortality	Medical Examiners	Peter Collins	High
Other	FFT Response Rate - A&E	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Day Case	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Inpatient	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Maternity	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Outpatient	Trust Data Warehouse	Judy Dyos	High
Other	HSMR Trust	Telstra Health	Peter Collins	High
Other	MRSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	High
Other	Never Events	DATIX Team	Judy Dyos	Medium
Other	SHMI Trust	Telstra Health	Peter Collins	High

Data Sources: Other Metrics (4)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Add: impact of donated assets	Finance Division	Mark Ellis	High
Other	Financing Costs	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Plan	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Actual	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Plan	Finance Division	Mark Ellis	High
Other	NHS Clinical income	Finance Division	Mark Ellis	High
Other	NHS Clinical income Plan	Finance Division	Mark Ellis	High
Other	Non Pay	Finance Division	Mark Ellis	High
Other	Other Clinical income	Finance Division	Mark Ellis	High
Other	Other Clinical income Plan	Finance Division	Mark Ellis	High
Other	Other income (excl donations)	Finance Division	Mark Ellis	High
Other	Other income (excl donations) Plan	Finance Division	Mark Ellis	High
Other	Pay	Finance Division	Mark Ellis	High
Other	Share of Gains on Joint Ventures	Finance Division	Mark Ellis	High
Other	Surplus/(Deficit)	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (5)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Activity by PoD: A&E	Finance Division	Mark Ellis	High
Other	Activity by PoD: Day case	Finance Division	Mark Ellis	High
Other	Activity by PoD: Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Non Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Outpatients	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Plan	Finance Division	Mark Ellis	High
Other	Month on month cash balance	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Actual	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Plan	Finance Division	Mark Ellis	High
Other	SLA Income: BSW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Dorset CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Hampshire, Southampton and IoW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Other	Finance Division	Mark Ellis	High
Other	SLA Income: Specialist Services	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (6)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Agency total Actual	Finance Division	Mark Ellis	High
Other	Agency Total Plan	Finance Division	Mark Ellis	High
Other	Bank total Actual	Finance Division	Mark Ellis	High
Other	Bank total Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Plan	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Actual	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Plan	Finance Division	Mark Ellis	High
Other	Month on Month total pay Actual	Finance Division	Mark Ellis	High
Other	Month on Month total pay Plan	Finance Division	Mark Ellis	High

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	9th March 2023		

Report tile:	Charitable Funds Strategic Update			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Mark Ellis, Chief Finance Officer			
Executive Sponsor: (presenting)	Mark Ellis, Chief Finance Officer			

Recommendation:

The committee is asked to note the contents of this paper

Executive Summary:

SFT's charitable funds, The Stars Appeal, are comparatively large for a Trust of its size. There is a track record of supporting the Trust and its public in a number of fields, including well-being and improvement of environments, as well as individual appeals such as the second MRI scanner.

An appeal for an extended cancer unit is being developed in conjunction with the Trust's overall Estates strategy, with the Stars Appeal has a strong track record of supporting cancer services at the Trust. The Trustees, and therefore the Board will be kept briefed as this workstream develops.

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

Purpose

1.1 The purpose of the report is to update the Trust Board on the strategic intent of the Trust's charitable Funds, The Stars Appeal'.

2 Background

2.1 Salisbury NHS Foundation Trust's charitable fund, known as the The Stars Appeal ('Stars'), is comparatively large for a District General Hospital of this size. This size is representative of the bond held between the hospital and its local community.

The activities of the charity are defined as:

The Stars Appeal is the NHS charity for Salisbury District Hospital. We invest the money we receive from donors, fundraisers and those who remember our charity in their Will in initiatives that directly benefits patients, their loved ones and the staff who care for them, across all of Salisbury NHS Foundation Trust (SFT) wards and departments.

Further to this the charitable funds policy states that funds should be utilised to:

The Stars Appeal aims to fund initiatives that provide direct, practical support to patients, their loved ones and staff at Salisbury Hospital. The work funded by the Charity should enhance the care provided by Salisbury NHS Foundation Trust, and not seek to replace or duplicate it.

2.2 The members of Salisbury NHS Foundation Trust's Board constitute the sole Trustee of the charitable funds.

2.3 Due to their size, the charitable funds are consolidated into the Trust's annual accounts. As at March 2023 held funds amounting to £16.3m, with a 58% to 42% split of unrestricted to restricted funds.

The balance of these funds includes fund raising for projects that are underway, such as the MRI appeal (£1.2m), the project for which has been concluded in 2022/23, but uncommitted funds remain significant.

As well as cash, the funds are also held within property (£1.9m), and an investment portfolio (c£7.9m). In the case of the property holdings, work is being undertaken to understand if this should remain part of the investment strategy moving forward, considerations include future maintenance requirements, return on investment, and strategic fit.

Trustee's 2021/22 Annual Report for Salisbury District Hospital Charitable Fund
Statement of Financial Activities for the year ending 31 March 2022

	Note	Endowment Funds	Restricted Funds	Unrestricted Funds	Total Funds 2022	Total Funds 2021
		£000	£000	£000	£000	£000
Income and endowments from:						
Donations and legacies	3	-	431	1,031	1,462	1,045
Charitable activities	4	-	3	83	86	18
Other trading activities	5	-	14	241	255	215
Investments	7	-	-	175	175	191
Total incoming resources		**-**	**448**	**1,530**	**1,978**	**1,469**
Expenditure on:						
Raising funds	8	-	-	(299)	(299)	(248)
Charitable activities						
- Medical research and clinical support	10	-	(230)	(32)	(262)	(380)
- Medical equipment and facilities	11	-	(375)	(298)	(673)	(442)
- Staff education and welfare	12	-	(66)	(72)	(138)	(195)
- Patient education and welfare	13	-	(104)	(207)	(311)	(296)
		-	(775)	(609)	(1,384)	(1,313)
Total expenditure		**-**	**(775)**	**(908)**	**(1,683)**	**(1,561)**
Gain/ (loss) on investment assets		-	-	438	438	1,421
		-	-	438	438	1,421
Net income/ (expenditure)		**-**	**(327)**	**1,060**	**733**	**1,329**
Gain on revaluation of tangible fixed assets		-	-	218	218	51
Transfers between funds		(9)	(1,209)	1,218	-	-
Net movement in funds		**(9)**	**(1,536)**	**2,496**	**951**	**1,380**
Reconciliation of funds						
Total funds brought forward		9	8,398	6,937	15,344	13,964
Total funds carried forward		**-**	**6,862**	**9,433**	**16,295**	**15,344**

3 Charitable Funds priorities

3.1 The Stars appeal has a track record in supporting a number of initiatives on behalf of the Trust and the public it serves, these include but are not limited to:

- Wi-fi services and other connectivity initiatives;
- Staff well-being;
- Innovative medical equipment; and
- Environment improvements.

These investment themes will continue into 2023/24.

3.2 In December the charitable funds committee were briefed on the strategic intent to focus on the development of a Trust Cancer Unit. This intent would take two forms:

i. Providing more facilities and services which would support the health and well-being of patients, providing a range of more wholistic care and support for those undergoing treatment for cancer and those who have completed their treatment.

ii. The expansion of facilitates from which care is provided, including facilities to treat patients without admitting them, and the consolidation of services in one place where currently patients have to move around the site.

3.3 Given the financial constraints of both SFT, and the wider NHS, consideration will also be given to opportunities for the Trust to move faster in its offerings of medical equipment that would otherwise be possible.

5 Recommendations

6.1 Trust Board should note the contents of this papers and consider future requests for support through charitable funds in the context of the priorities set out.

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	09 March 2023		

Report Title:	**Patient Feedback Report - Q3 2022/23**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	
Approval Process (where has this paper been reviewed and approved)	Patient Experience Steering Group – 22nd February 2023 Clinical Governance Committee 28 February 2023			
Prepared by:	Victoria Aldridge, Head of Patient Experience			
Executive Sponsor (presenting):	Judy Dyos,Chief Nursing Officer			
Appendices (list if applicable):	APPENDIX 1: FFT Inpatient Feedback Sample – Q3 APPENDIX 2: HWW Survey Feedback - Action Plan - Working Document – v2.0 APPENDIX 3: Real-Time Feedback Survey Template APPENDIX 4: Your Views Matter – Bereavement Survey Report - Q3			

Recommendation:
This report is for assurance and noting by the Trust Board.

Executive Summary:

This report provides a summary and insights drawn from the various methods by which our service users feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and National surveys covering or reported during Q3 of 2022-23.

To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

There has been a decrease in the total number of complaints and concerns received in Q3 (n~116) in comparison with Q1 (n~117) and Q2 (n~127).

There were 288 comments/enquiries logged by the PALS team in Q3, a small reduction on the 302 seen in Q2.

The most common high-level theme for complaints across the Trust has been **Patient Care (including nutrition and hydration)** equating to **(38%)** of the total complaints. This was followed by **Communication** at **(17%).** Both of these themes are consistently the two highest common themes for both Q1 and Q2. **Access to Treatment and Appointments (including delays)** account for **(12% respectively)** of the third highest complaint theme for Q3.

There has been a significant reduction in the total number of re-opened complaints/concerns in Q3 (n~6), when compared with Q2 (n~10) and Q1 (n~13).

Friends and Family Test: The Trust wide average response rate for Q1 and Q2 was 1.5 and 2.2% respectively. Q3 has seen a reduction in response rate to an average of 1.8%. This continues to be significantly lower than the Improving Together metric target of 10% which was set for 2022-23.

Friends and Family Test responses rates within inpatient areas was noted to have fell in Q3 to 7.4%, (8.6% average recorded in Q2). Of those who responded to the FFT questions during Q3 the Trust recorded an average Good or Very Good experience rating of 97%. This has reduced slightly on Q2 where 98% was recorded.

National Surveys: The National Maternity Survey 2022 is scheduled for presentation to the Patient Experience Steering Group in Q4 of 2022/23 and will be reported in the Patient Experience Q4 report. National Surveys for UEC and Inpatients for 2022 are currently underway and will be presented once completed.

Local Surveys: Re-launch of inpatient real-time feedback and summary of feedback from Bereavement Surveys – Q3.

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

Patient Experience

Patient Feedback Report – Q3 2022/23

Purpose of paper

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

This paper will also outline the other methods of patient feedback that the Trust collects, and as these processes develop will seek to triangulate these various data sets to provide balanced insight to how patients experience our hospital.

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. 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. This includes learning from feedback, transparency and honesty on when healthcare goes wrong.

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 concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh these complaints and concerns. Compliments can also help improve practice by allowing good practice to be disseminated and shared where possible.

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1. Complaints, Concerns and Compliments Overview

There were 5 items of feedback posted on the NHS Website* in Q4.

- Negative – 0.
- Positive – 4.

*All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and 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 Quality Directorate for forwarding onto the individual and their line manager. Compliments continue to be recorded (in their numbers) through cards, letters, gifts sent received directly to these areas. However, from February 2023 all compliments will be allocated a Datix entry for more robust reporting and utilised for individual staff feedback where applicable. This will be facilitated through PALS.

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the trust and this is used to calculate this feedback on a per 1,000 basis (see Figure 1.1).

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q4 2021-22	30,057	32,715	32,321	4,850	99,943
Q1 2022-23	30,147	29,026	34,242	4,482	97,897
Q2 2022-23	29,779	28,414	34,493	4,526	97,212
Q3 2022-23	31,906	29,040	35,374	4,802	101,122

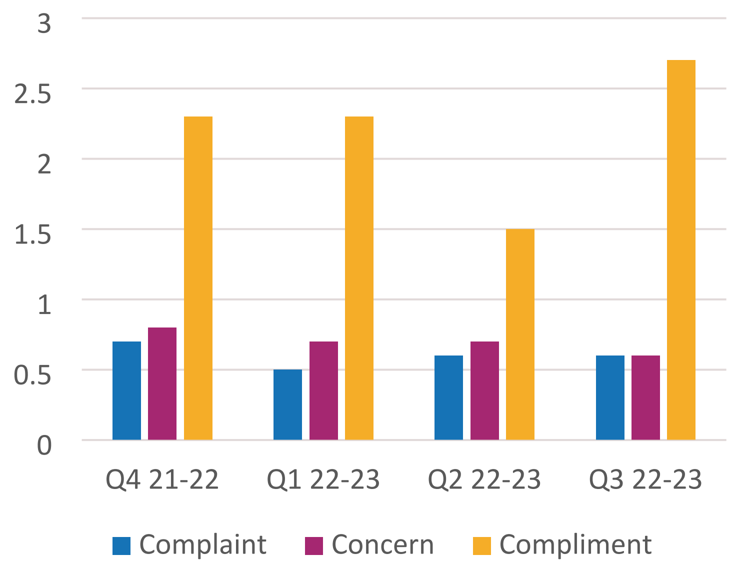


Figure 1.1 Total Number of Complaints, Concerns, and Compliments per 1,000 of total Trust activity

Figure 1.1 shows an stability in the number of total complaints and reduction in the number of concerns received in Q3 when compared with the previous quarter.

Compliments have significantly increased; and methods to improve the recording these more robustly are currently being implemented throughout Q4 of 2023.

In Q3 the PALS department logged 288 comments/enquiries. This is reduction on the 302 logged in Q2. This equates to an average of 2.8 contacts per 1,000 patient activity across the Trust.

Table 1.2 shows the high-level theme for complaints received in Q3 and the most prevalent theme being in relation to, **patient care, including nutrition and hydration**. This theme has continued to be the most prevalent across the Trust from both Q1 and Q2.

Table 1.2 Raw data - Themes from Q3 Complaints

	CSFS	Medicine	Surgery	Women & Newborn	% of total by theme
Access to treatment or drugs	1	1	7	0	12%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package	0	1	4	0	7%
Appointments including delays and cancellations	2	0	7	0	12%
Communications	0	8	5	0	17%
End of Life Care	0	1	0	0	1%
Facilities Services	0	1	0	0	1%
Patient Care including Nutrition / Hydration	1	6	21	1	38%
Prescribing errors	0	0	0	1	1%
Privacy, Dignity and Wellbeing	1	0	1	0	3%
Values and behaviours (Staff)	0	0	4	1	7%
Waiting Times	0	0	1	0	1%
Total by Division	**5**	**18**	**50**	**3**	
Divisions Total	**76**				

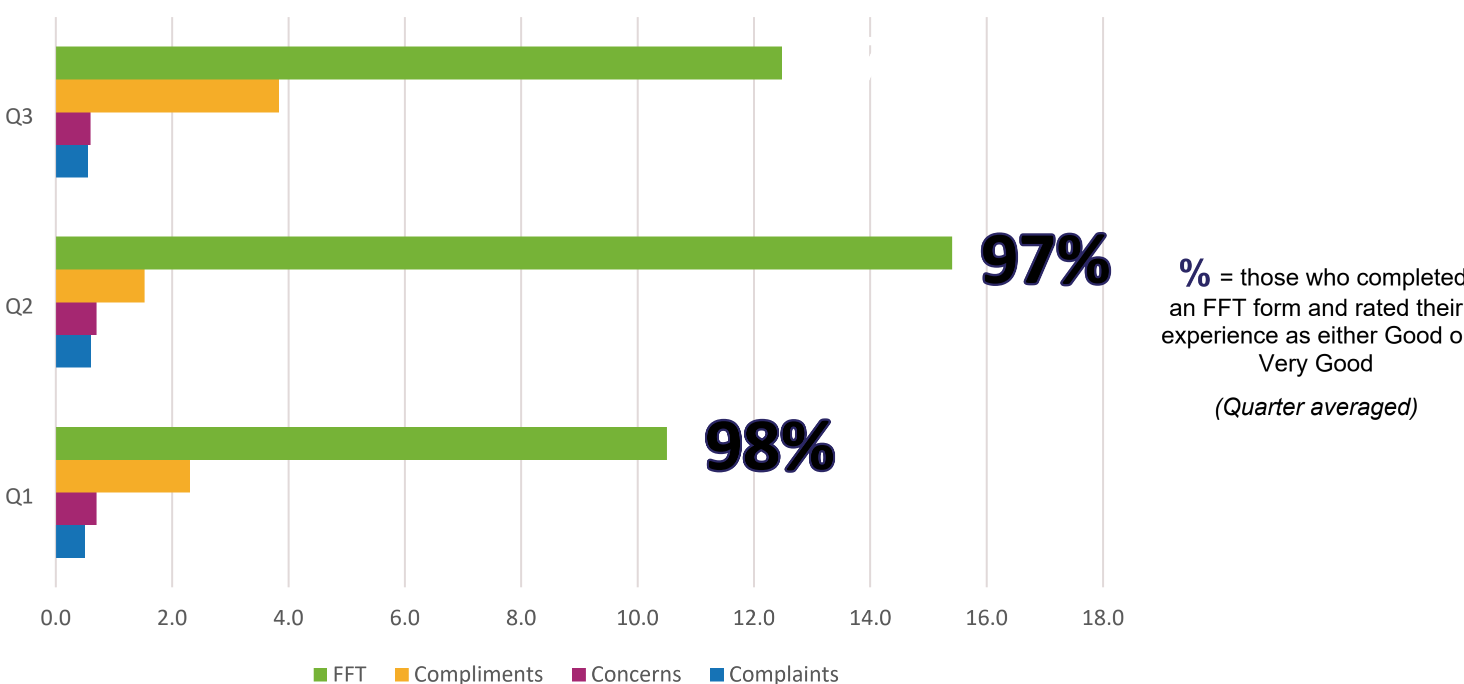
We continue to high level themes with patient care and communication going into Q3 as noted in Q1 & Q2.

Communication as a theme is being actively targeted through encouragement of staff to access the accredited EOLC Communications course. There are also efforts to consolidate this further through the trialing of new approaches within the communication skills and introduction to complaints training packages currently offered.

These revised communication skills and introduction to complaints training programs will be being tested in the Band 7 ward leads development days, F2 Doctor inductions and newly qualified consultants leadership days throughout Q4 of 2022/23.

Patient Care is noted to have been heavily linked with staffing numbers and stretched resources. This is somewhat anecdotally evidenced by the significant variation in quantity of FFT responses received vs complaints (see Figure 1.2) as we continue to see average ratings of 97- 98% rating their experience as good or very good. This feedback also somewhat evidences the conclusion that even during the most difficult staffing challenges, our staff are striving to provide the best possible patient care (See sample selection of Q3 Inpatient FFT comments appendix 1)

Figure 1.2 – FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) – Trust wide.



2 Complaints/concerns were recorded in total for non-clinical divisions in Q3.

Table 1.3 summarises these:

Table 1.3 Themes from Q3 complaints and concerns (non-clinical divisions)

Directorate admitted	Location (exact)	First received	Closed	Description	Outcome
Facilities	Facilities - management offices	21/12/2022	23/12/2022	Concern raised about the coloured zebra crossing within the hospital grounds. Feels this is confusing and potentially dangerous for children, people with learning difficulties and dementia patients. Would also like to know why we single out groups of people (veterans) in our welcomes to the hospital.	Thanked for raising concerns and reassured re: risk assessment. Invited to join patient/carer groups to ensure representation of those with LDs.
Facilities	Facilities - management offices	16/12/2022	13/01/2023	NHS van tailgating and dangerous driving	Apologies given and driver has received further training

Overdue Complaints

Complaints exceeding their designated timescale for response was noted as an area of concern at the beginning of Q2. This has been monitored closely through the Patient Experience Steering Group (PESG) and escalation to the Clinical Management Board (CMB) where appropriate.

This aspect of the complaints process continues to be an area of focus as we continue to implement various mitigations to reduce these delays. This forms part of our workstream aimed at moving the Trust towards alignment with the new PHSO Framework, also taking into consideration our Improving Together Targets.

In July 2022 the Trust had 53%* of its total open complaints recorded as past their timescale, this had significantly reduced to 40% by October, however an increase was noted again in November to 52%.

**Previous benchmark data wasn't available to determine how tolerable or concerning this level proportion was for the Trust, therefore this information will be recording going forward.*

The Trust overall is seeing an increase in the number of complaints being closed within the target timeframe. However, this continues to be significantly below our A3 Improving Targets of 80% for 2022-23.

Improvements seen to date have been actively celebrated through PESG. CSFS are also noted to have achieved a 100% closure rate in this most recent quarter. Medicine continue to make significant strides to improving both their response rates and reducing their overall number of opened complaints (see Section 2 Division Summaries – Complaints, Concerns and Compliments).

Figure 1.3 – Complaints closed within Target (by Division and Trust Total)

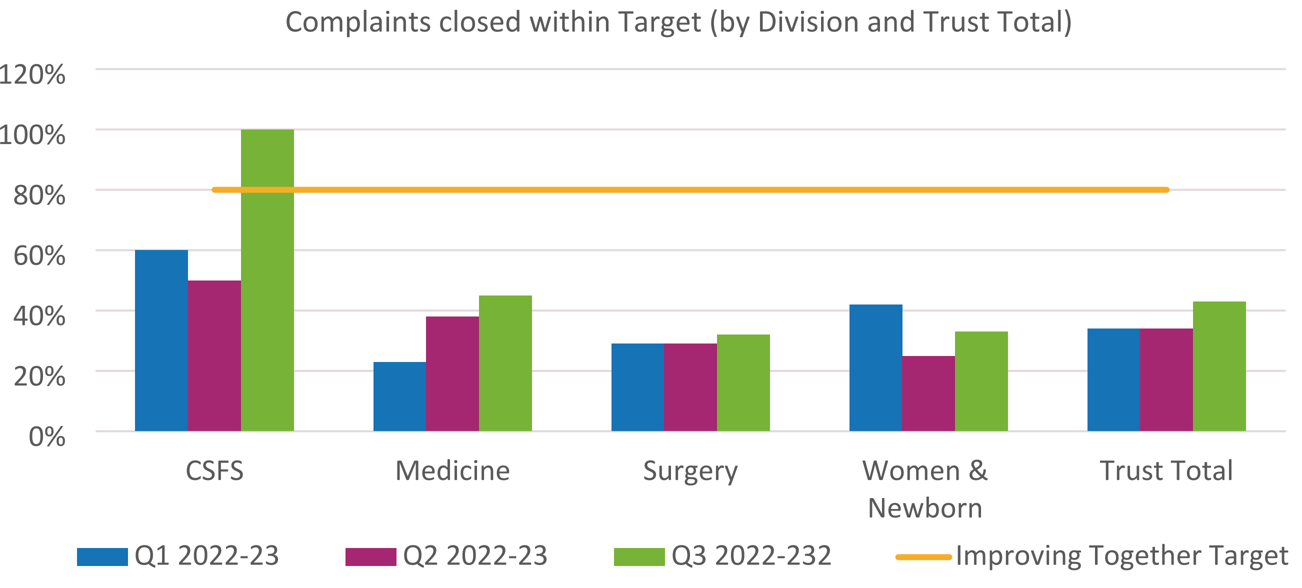
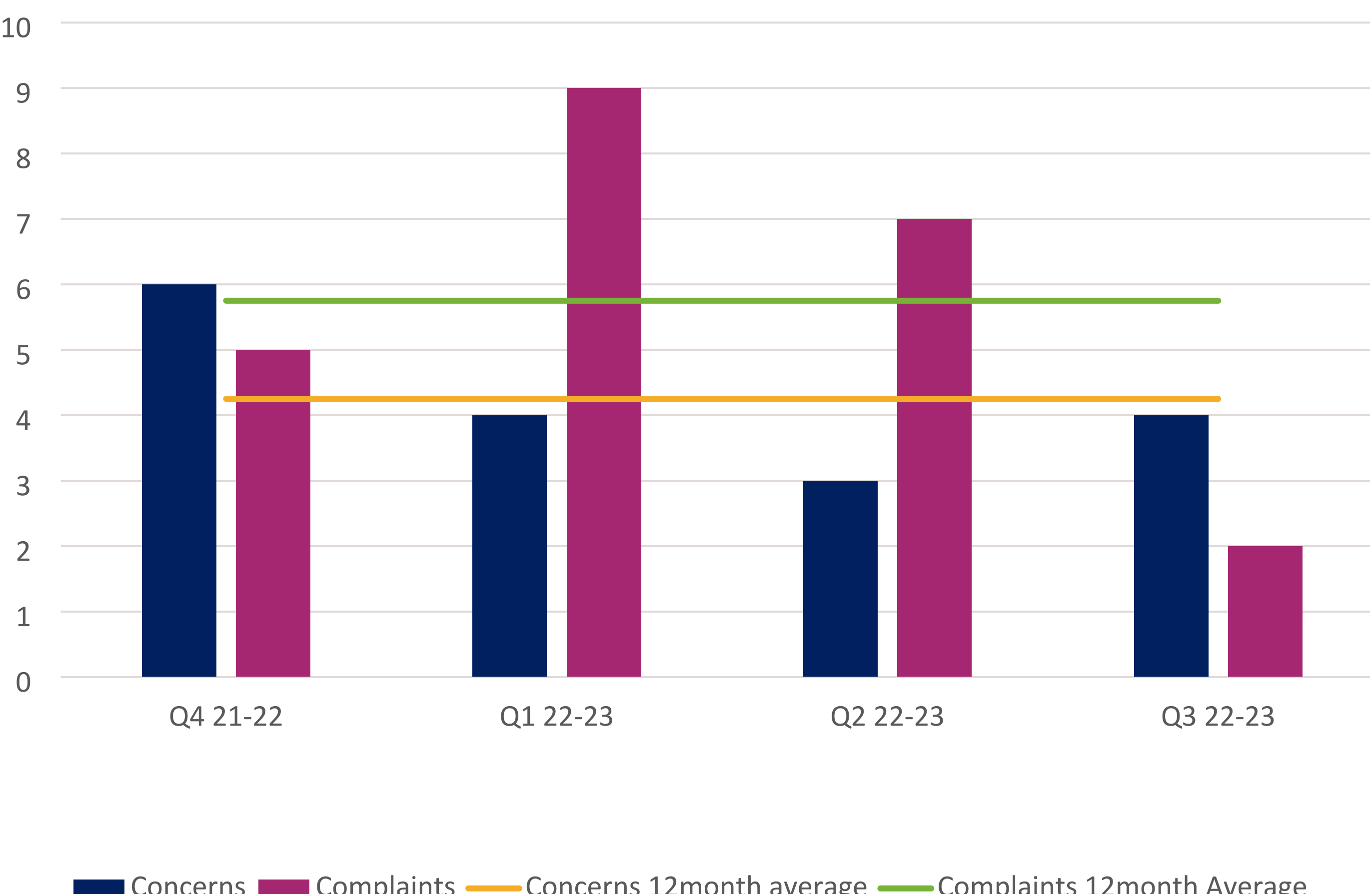


Figure 1.3 shows the number of reopened complaints and how this compares with the average number reopened on a rolling 12months basis (since Q4 of 21/22).

Q3 is currently demonstrating a significant reduction in both the number of reopened complaints and the total overall number of both concerns and complaints (n~6)

Figure 1.4 – Number of re-opened complaints or concerns



Re-opened complaints are felt to be a key factor in determining whether a complaint has been managed and responded to in the best way and a potential indicator for the quality of this process. From January 2023 these will be included with the weekly PALS complaints review meetings. The numbers, location and reason for reopening will be explored in detail to indicate any themes and trends.

Further details on all of the actions taken to mitigate the risks and areas for improvement outlined in this report have been structured following the findings of the co-produced Complaints Project with Healthwatch Wiltshire. This includes the final report conclusions, the Trusts response to these findings and the finalised action (see Section 3 – PHSO Complaints Project Outcomes and Action Plan).

2. Division Summaries – Complaints, Concerns and Compliments

Clinical Support and Family Services (CSFS)

- There were a total of 10 complaints and concerns for Q3
- 4 complaints were closed in Q3; with 100% of these being responded to within the agreed timescale. This is a notable improvement on Q1 and Q2 where this was 60% and 50% respectively.

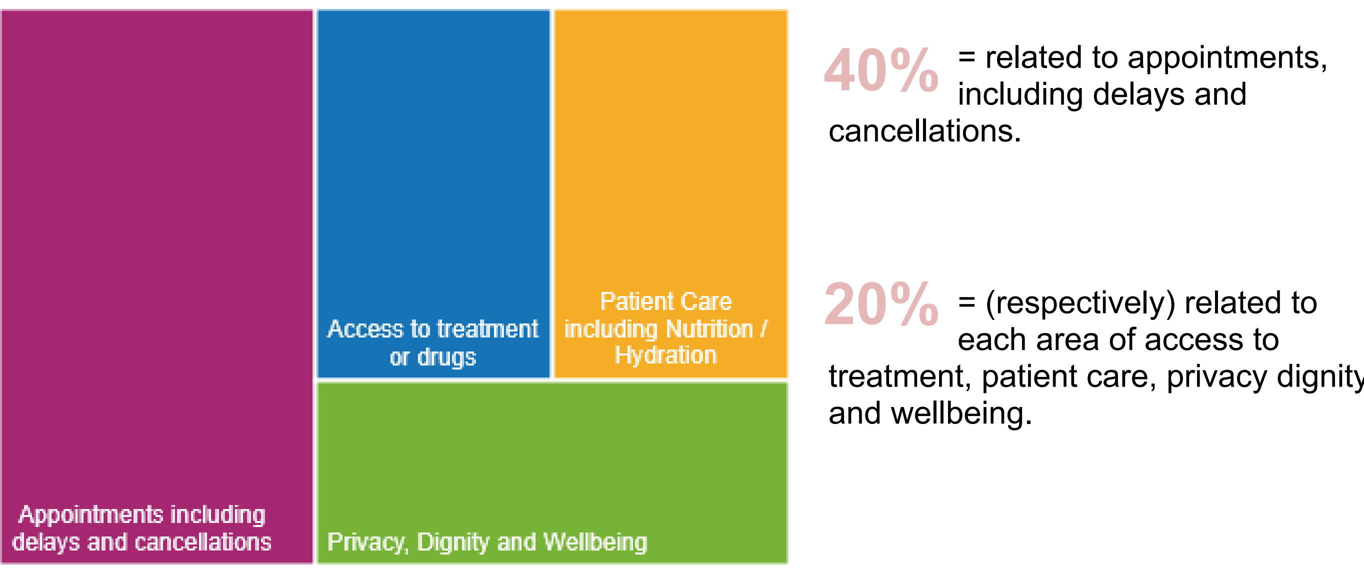
Table 2.1 Summary of number of received, reopened and response within timeframe – rolling annual comparison.

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q4 21-22	Q1 21-22	Q2 21-22	Q3 21-22
Complaints	▼ 3	▲ 5	▼ 2	▲ 5
Concerns	▲ 10	▼ 7	▼ 6	▼ 5
Compliments	▶ 3	▲ 4	▼ 3	▲ 6
Re-opened complaints/concerns	▼ 0	▲ 3	▼ 0	▲ 1
% closed complaints responded to within agreed timescale	▲ 60%	▶ 60%	▼ 50%	▲ 100%
Complaints closed in this quarter	5	5	2	4
Complaints by Division activity (per 1,000)	*0.4 (30,057)*	▼ 0.2 (30,147)	▼ 0.1 (29,779)	▲ 0.2 (31,906)
Concerns by Division activity (per 1,000)	*Not available (data is now separated out)*	▼ 0.2 (30,147)	▶ 0.2 (29,779)	▶ 0.2 (31,906)
Compliments by Division activity (per 1,000)	▶ 0.1 (30,057)	▶ 0.1 (30,147)	▶ 0.1 (29,779)	▲ 0.2 (31,906)

Figure 2.1 demonstrates the top two high-level themes for opened complaints during Q3.

Figure 2.1 – Summary of themes for CSFS Complaints and Concerns – Q3 2022/23



For comparison, the top theme common with Q1 & 2 22/23 was **patient care (including nutrition hydration)** - (57%).

Previously noted themes were in relation to **Clinical Treatment**, **End of Life Care** and **Values & Behaviours of Staff** (14% respectively).

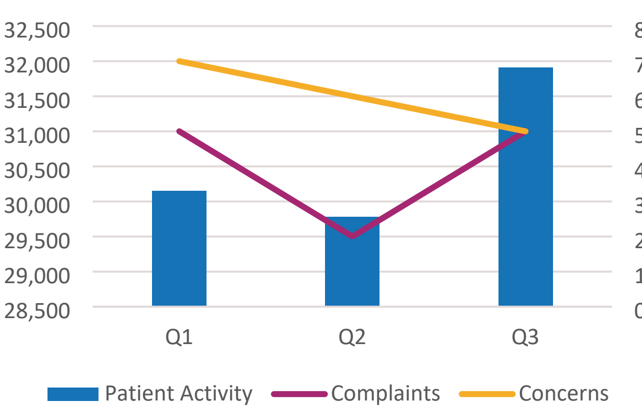
Compliments – Clinical Support and Family Services

There were a total of 6 compliments for CSFS across Q3, an increase to the number seen in both Q1 and Q2 of 22/23.

From the New Year compliments will be formally recorded on Datix and as we move to the new FFT provider implementation, we hope to be in a position to provide a more robust way of reporting compliments through this method as well.

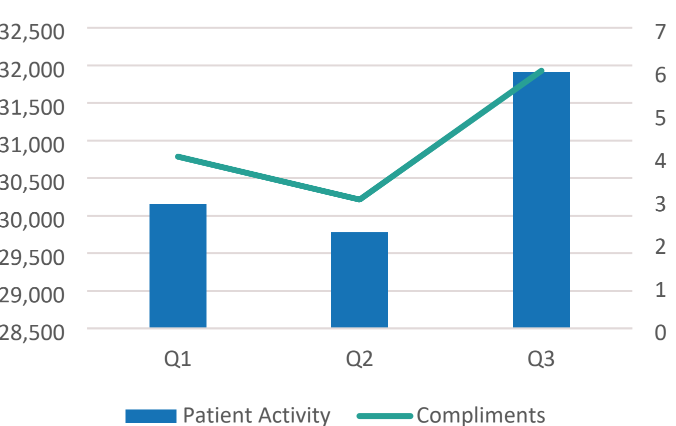
Wider theming for departments where things have gone well as well as enabling individual feedback to aid appraisals and recognition are hoped to be gained from these changes too.

Figure 2.2a and 2.2b shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services.



Figures 2.2a and 2.2b are showing a correlation of compliments and complaints with the patient activity numbers for those periods.

However, there is noted to be a positive steady decline in the number of concerns recorded - despite the increases in patient activity.



Women and Newborn

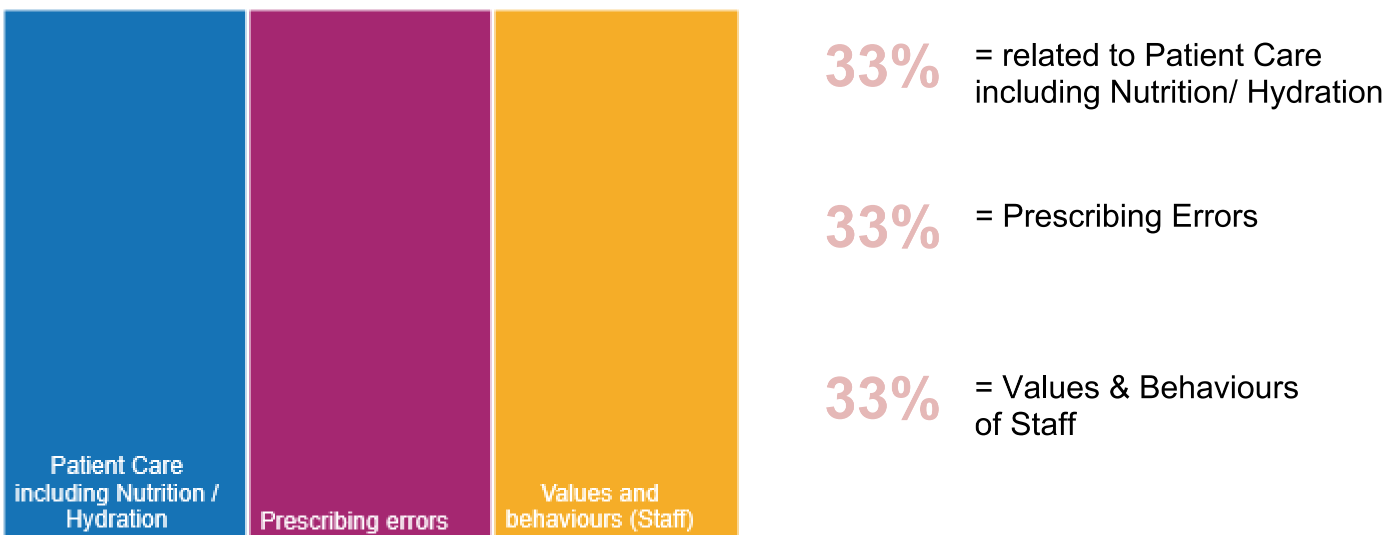
- There were a total of 12 complaints and concerns for Q3
- 9 complaints were closed in Q3; with 33% being responded to within the agreed timescale. This is a notable improvement on Q2 where this was 25%.

Table 2.2 Summary of number of received, reopened and response within timeframe – rolling annual comparison.

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23
Complaints	▲ 11	▼ 7	▲ 8	▼ 7
Concerns	▼ 7	▶ 7	▼ 5	▶ 5
Compliments	▲ 75	▼ 8	▲ 21	▼ 19
Re-opened complaints/concerns	▼ 0	▲ 1	▶ 1	▼ 0
% closed complaints responded to within agreed timescale	▼ 50%	▼ 42%	▼ 25%	▲ 33%
Complaints closed in this quarter	6	12	4	9
Complaints by Division activity (per 1,000)	*9.7 (4,850)*	▲ 1.6 (4,482)	▲ 1.8 (4,526)	▼ 1.5 (4,802)
Concerns by Division activity (per 1,000)	*Not available (data is now separated out)*	▲ 1.6 (4,482)	▼ 1.1 (4,526)	▼ 1.0 (4,802)
Compliments by Division activity (per 1,000)	▼ 8.0 (4,850)	▼ 1.8 (4,482)	▲ 4.6 (4,526)	▼ 4.0 (4,802)

Figure 2.3 – Summary of themes for W&N Complaints and Concerns – Q3 2022/23



For comparison, the top themes common for Q1 & Q2 22/23 were **Patient Care (including nutrition hydration)** - **(43%)** and **Values & Behaviours of Staff (29%)**.

Previously noted themes were in relation to **Communication (29%).**

Compliments – Women & Newborn

There was a total of 19 recorded compliments for W&N across Q3, a slight decrease on the number seen in Q2, but still a significant increase on the numbers seen in Q1 of 22/23.

From the New Year compliments will be formally recorded on Datix and as we move to the new FFT provider implementation, we hope to be in a position to provide a more robust way of reporting compliments through this method as well.

Wider theming for departments where things have gone well as well as enabling individual feedback to aid appraisals and recognition are hoped to be gained from these changes too.

Figure 2.4a and 2.4b shows correlation of number of complaints, concerns and compliments by patient activity for Women & Newborn.

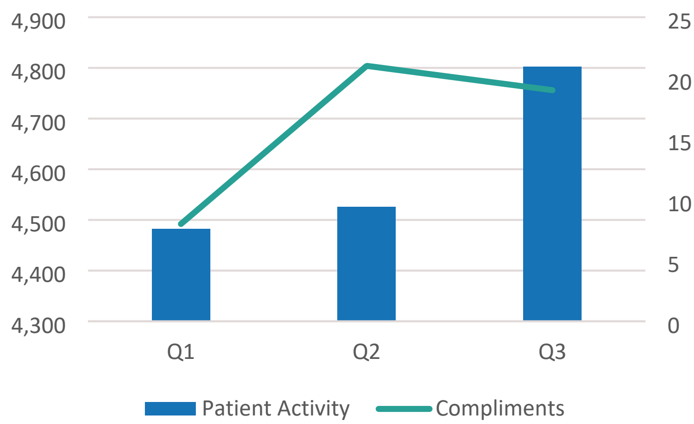
Fig 2.4a Activity compared with Complaints and Concerns

4,900 4,800 4,700 4,600 4,500 4,400 4,300
10 8 6 4 2 0
Q1 Q2 Q3
Patient Activity Complaints Concerns

Figures 2.4a and 2.4b are showing a slight correlation between the number of complaints and concerns received with patient activity

However, overall there appears to be s a positive decline in these numbers.

Compliments appear to track higher in Q2 when patient activity was lower (comparatively), which could indicate the subsequent knock on impact on patient experience vs how busy the department is.



Medicine

- There were a total of 42 complaints and concerns for Q3
- 29 complaints were closed in Q3; with 45% being responded to within the agreed timescale. This is a notable improve on Q1 and Q2 where this was 23% and 38% respectively.

Table 2.3 Summary of number of received, reopened and response within timeframe – rolling annual comparison.

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23
Complaints	▲ 16	▲ 20	▲ 24	▼ 18
Concerns	▼ 23	▲ 32	▼ 31	▼ 24
Compliments	▼ 148	▼ 139	▼ 85	▲ 251
Re-opened complaints/concerns	▲ 4	▼ 2	▲ 5	▼ 2
% closed complaints responded to within agreed timescale	▼ 25%	▼ 23%	▲ 38%	▲ 45%
Complaints closed in this quarter	12	13	24	29
Complaints by Division activity (per 1,000)	*1.2 (32,715)*	▼ 0.7 (29,026)	▲ 0.8 (28,414)	▼ 0.6 (29,040)
Concerns by Division activity (per 1,000)	*Not available (data is now separated out)*	▼ 1.1 (29,026)	▶ 1.1 (28,414)	▼ 0.8 (29,040)
Compliments by Division activity (per 1,000)	▼ 4.5 (32,715)	▲ 4.8 (29,026)	▼ 3.0 (28,414)	▲ 8.6 (29,040)

Figure 2.5 – Summary of themes for Medicine Complaints and Concerns – Q3 2022/23

Communications

Patient Care including Nutrition / Hydration

Access to treatment or drugs

Admissions, discharge and transfers excluding delayed discharge due to ansence of care package

End of Life Care

Facilities Services

44% = Communications

33% = related to Patient Care including Nutrition/Hydration

6% = related to access to treatment, admissions/discharge /transfers, EOLC and facilities services (respectively)

For comparison, the top themes common for Q1 & 2 22/23 were noted to be **patient care** and **communication.**

Compliments - Medicine

There was a total of 251 compliments for Medicine for Q3, this was noted be significantly higher than the combined total of both Q1 and Q2 for 22/23 (n~224).

From the New Year compliments will be formally recorded on Datix and as we move to the new FFT provider implementation, we hope to be in a position to provide a more robust way of reporting compliments through this method as well.

Wider theming for departments where things have gone well as well as enabling individual feedback to aid appraisals and recognition are hoped to be gained from these changes too.

Figure 2.6a and 2.6b shows correlation of number of complaints, concerns and compliments by patient activity for Medicine.

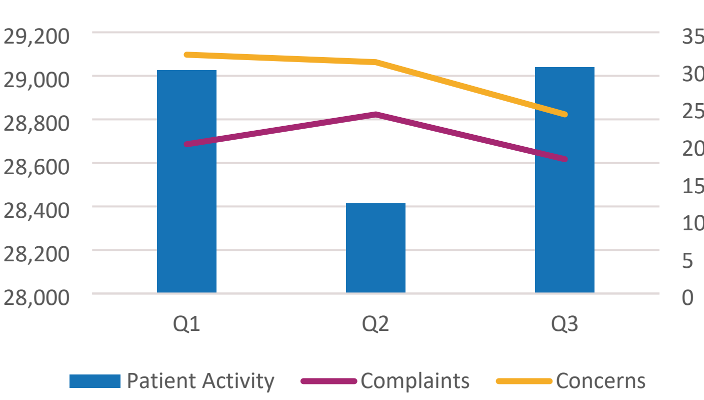
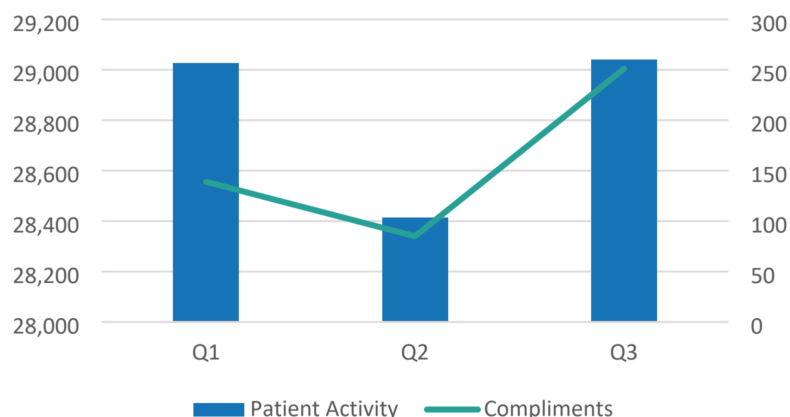


Figure 2.6a is showing an overall decline in the number of complaints and concerns recorded for Medicine – this is despite a similar patient activity number being noted in Q1.

This division has been actively engaged since the Summer in trialling new processes and department leads have demonstrated commitment to changing the culture of how complaints are managed - adopting the PHSO principles of early resolution and meaningful apology.

Figure 2.6b is showing a positive correlation between number of compliments and patient activity.



Surgery

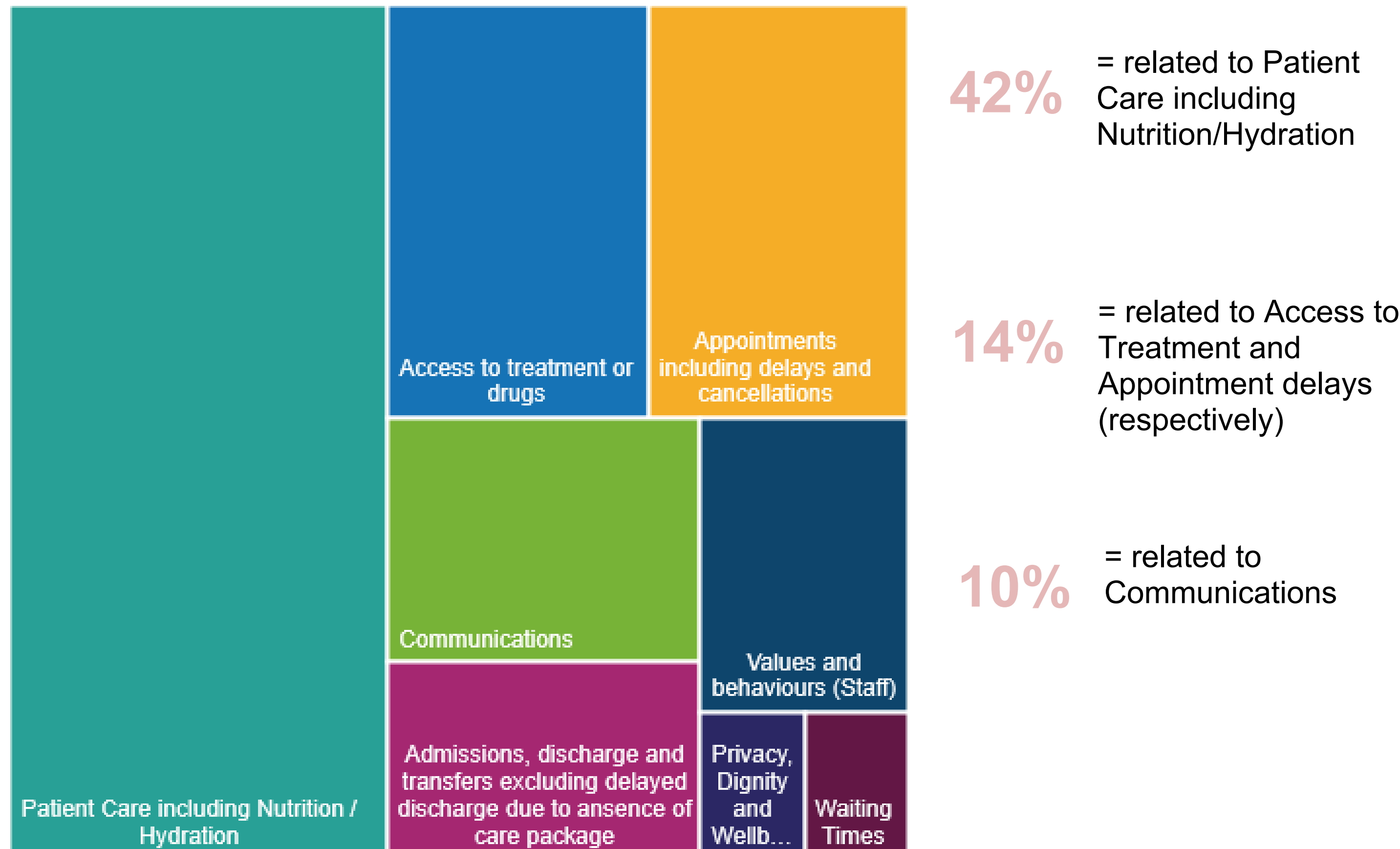
- There were a total of 52 complaints and concerns for Q3
- 19 complaints were closed in Q3; with 32% being responded to within the agreed timescale. This is an improvement on Q1 and Q2 where this was 29% respectively.

Table 2.4 Summary of number of received, reopened and response within timeframe – rolling annual comparison.

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23
Complaints	▲ 25	▼ 17	▲ 25	▲ 26
Concerns	▼ 22	▶ 22	▲ 26	▶ 26
Compliments	▼ 39	▲ 75	▼ 39	▲ 112
Re-opened complaints/concerns	▼ 4	▲ 7	▼ 4	▼ 3
% closed complaints responded to within agreed timescale	▼ 14%	▲ 29%	▶ 29%	▲ 32%
Complaints closed in this quarter	18	17	17	19
Complaints by Division activity (per 1,000)	*1.5 (32,321)*	0.5 (34,242)	▲ 0.7 (34,493)	▶ 0.7 (35,374)
Concerns by Division activity (per 1,000)	*Not available (data is now separated out)*	0.6 (34,242)	▲ 0.8 (34,493)	▼ 0.7 (35,374)
Compliments by Division activity (per 1,000)	▼ 1.2 (32,321)	▲ 2.2 (34,242)	▼ 1.1 (34,242)	▲ 3.2 (35,374)

Figure 2.7 – Summary of themes for Surgery Complaints and Concerns – Q3 2022/23



For comparison, the top themes common for Q1 & 2 22/23 were reported to be in relation to **Patient Care** and **Access to Treatment & Appointments (including delays and cancellations)**

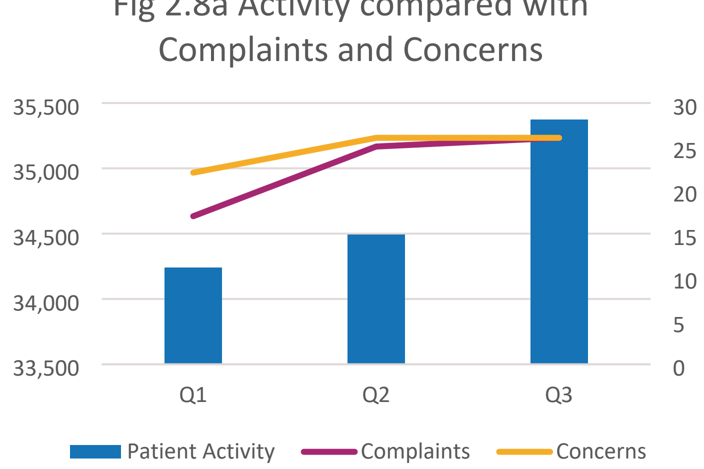
Compliments – Surgery

There was a total of 112 compliments for Surgery for Q3, this was noted be significantly higher, as the combined total of both Q1 and Q2 for 22/23 was (114).

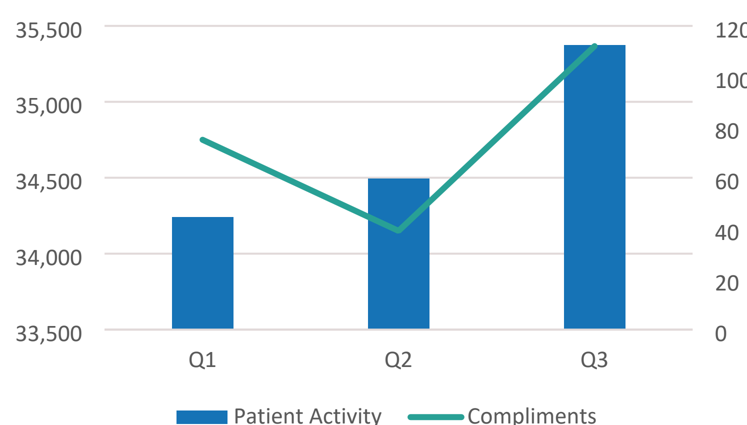
From the New Year compliments will be formally recorded on Datix and as we move to the new FFT provider implementation, we hope to be in a position to provide a more robust way of reporting compliments through this method as well.

Wider theming for departments where things have gone well as well as enabling individual feedback to aid appraisals and recognition are hoped to be gained from these changes too.

Figure 2.8a and 2.8b shows correlation of number of complaints, concerns and compliments by patient activity for Surgery.



Figures 2.8a and 2.8b are showing a positive correlation between patient activity numbers and complaints, concerns and compliments.



3. PHSO Complaints Project Outcomes and Action Plan

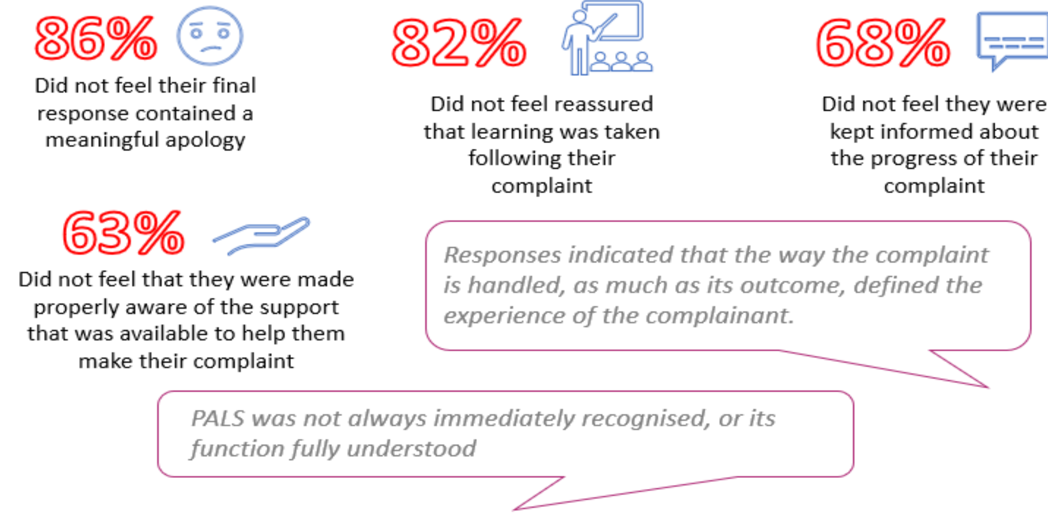
Through Q1-Q3 we engaged in a co-produced complaints process review project with Healthwatch Wiltshire (HWW). HWW are an independent statutory body, which has the power to make sure NHS leaders and other decision makers are made aware of and listen to local feedback in order to improve standards of care.

The survey was co-developed and based around the principles of the PHSO Complaints Framework (see Figure 3.1)

Figure 3.1 - Summary of the key principles of the New PHSCO Complaints Framework

90 participants were invited to give their feedback and the only criteria for selection was a closed complaint between 1st of January 2022 and 30th June 2022. Options offered for completion of the survey include by post, over the phone or online. A mixture of quantitative and qualitative analysis was used and demographic information was also collected. The survey achieved a 25% response rate.

The following key findings were highlighted:



In response, the following immediate key actions were identified:

- Simplification of the initial process for raising a complaint and supporting complainants to clearly articulate their concerns and linking in with local advocacy services.

- Working more closely and supporting investigating managers to improve accountability and identify opportunities for early and appropriate resolution.
- Move towards a more tailored and individual management of a complaint. This includes regular communications, and clearer information from the outset on who is managing the complaint and support services that are available.
- Continue to develop the profile of PALS to ensure its functions are clear for patients, visitors and our staff. This will be an evolving piece of work initially mobilised through revised posters, leaflets, use of social media and internally through our ward based 'PALS Outreach Services'.
- Improved and more regular training programmes for staff on the management, investigation and learning from complaints. This will be underpinned by ensuring a clear understanding of the principles of the new PHSO Framework.
- Lastly, working with our Divisions to ensure we develop more effective methods of publicising and celebrating improvements made to services as a direct result of complaints and concerns raised

A full action plan has been developed to operationalise the above objectives – all of which are largely in progress and on track for completion. (See appendix 2)

The full HWW publication and response to the findings from SFT can be found (here).

4. Friends and Family (FFT)

Response Rates

A total of **1262** patients provided feedback through the paper Friends and Family Test (FFT) in Q3 of 22/23. For comparison, this is more than Q1 22/23 (1028) but less than Q2 22/23 (1498).

We are still unable to delve into these data sets without using a time consuming and subjective interpretation or the comments to produce any reliable theming.
Implementation of the new provider system is currently underway, although this has hit some delays due to the conflict of priorities from the required teams. This is currently being worked through CPPG and related workforce groups. A revised timescale for phase 1 roll-out (with ED) is still to be determined.

97% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q3 2022-23)

1.8%* Response rate (*of eligible population and averaged for Q3 2022-23)

The target response rate continues to be significantly below our Improving Together target of >10% of eligible patients for 2022/23. This is largely owed to the sole reliance on the paper FFT cards in the inpatient areas and subsequently little visibility in the outpatient areas. An audit on the existing FFT boards is almost complete, which will identify improvements with location and presentation of these boards to encourage more uptake in the interim of the new provider solution. The new solution will encompass alternative ways to engage feedback i.e., through SMS messages, and online using QR codes.

Table 4.1 summarises the response rates in accordance with patient activity.

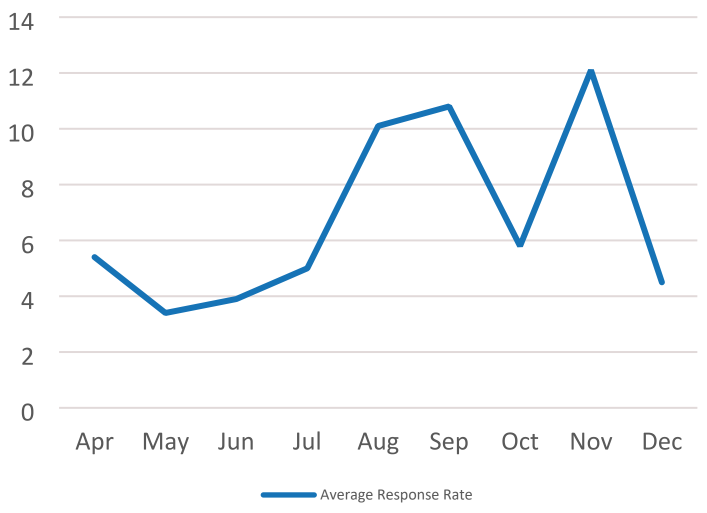
Table 4.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ► No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23
Across all Directorates	▼ 11.5 (99, 943)	▼ 10.5 (97,897)	▲ 15.4 (97,212)	▼ 12.5 (101,122)

Figure 4.1 Average (inpatient wards only) response rate % based on eligible population

Figure 4.1 shows the average response rate (based on eligible population) for **inpatient wards only**.



Work continues to promote the current method of collecting FFT (FFT cards) on the inpatient wards through our PALS Outreach Service and through Divisional DMT and Governance meetings.

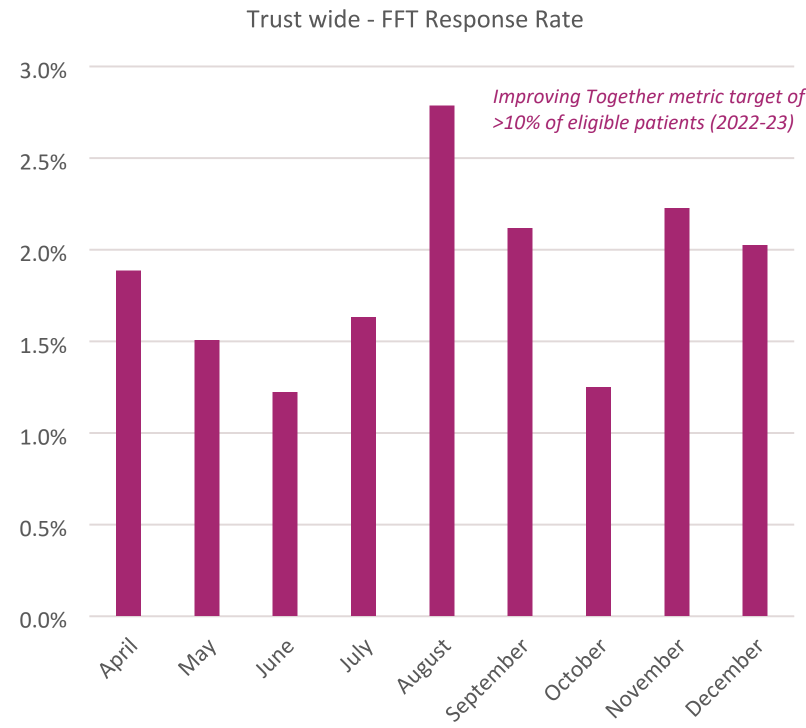
Going into Q2 we saw clear efforts from the wards to facilitate responses following this promotion.

There is a spike noted in November of Q3, but this is in part owed to a data anomaly recorded for Pembroke Ward where a 127% response rate was recorded (likely to be duplication of data input or the same patient completing more than one feedback card)

We continue to regularly promote positive feedback received via FFT through weekly social media plugs under “*#ThankyouThursday*” and “*#FeedbackFriday*” hashtags. Most recent examples below from December 2022:

Benchmarking against Improving Together Targets

Figure 4.2 – Response rate for period Q3 2022/23 (based on eligible population) – Trust wide



As Figure 4.2 demonstrates - we continue to be far from our **Improving Together** targets as we go into 2023. We have successfully secured a digital provider to improve these response rates, however implementation of this has been delayed. A renewed timescale for implementation is currently being worked through with CPPG and the related Work Package Groups as this requires some resource from both IT and Informatics to progress.

Once the implementation timescale has been approved, there will be a phased rollout, beginning with the Emergency Department, followed by outpatient areas. These areas have been prioritised due to their current low response rates and/or the challenges posed by the limited means of providing this feedback.

5. Patient and Public Feedback – Local Surveys

Real-Time Feedback

Plans to relaunch the Real Time Feedback on the inpatient wards (excluding maternity) have been developed throughout Q3. The survey has been revamped to bring this into line with the national inpatient survey areas of focus.

The new template has been tested with Longford ward and Farley Stroke Ward, with further adjustments made. The finalised survey is included in appendix 3.

The survey has been added to Tendable under the Patient Experience tab and will be accessed using Ipads. The feedback will be facilitated by volunteers, Governors and staff with an interest in this area. It will also form part of our PALS shadowing opportunities that are being promoted.

This feedback will become a standing item covered under the Patient Experience report going forward and feedback will be shared with division leads and themed for presentation at Divisional Governance meetings where appropriate.

Your Views Matter – Bereavement Survey – Q3 Report Summary

Background: In July 2022 the administration of the “Your Views Matter” EOLC surveys was moved over to the PALS team due to constraints on resources within the End of Life services and was seen as an opportunity to improve the transition of feedback into compliments or complaints as necessary.

This change in administration has also prompted review of the process and data collection and seek to improve the data correlation alongside our complaints and concerns.

This report is new for presentation at Patient Experience Steering Group and elements are also included with the quarterly Learning from Deaths Report.

Summary of analysis:

Overall, there is an improvement in overall experience and subsequent satisfaction ratings are noted from the Q2 report. 73% of those surveyed rated their overall experience as Good or Very Good.

Response rates have noted to decline slightly, down to 20% from 25% in Q2.

6 survey participants requested a call-back from PALS, 2 of these went on to record a formal complaint or concern.

There was no significant theming this quarter, however facilities were noted to be a recurring theme for those had rated an overall poor experience. This has been highlighted previously and work is currently underway with the support of the Starts Appeal to improve these facilities where noted.

See Appendix 4 for full report.

6. Patient and Public Feedback – National Surveys

National Maternity Survey 2022

- Scheduled for presentation at Patient Experience Steering Group in Q4 2022/23, this will be included in the Q4 Patient Experience Report.

Scheduled Surveys:

Urgent & Emergency Care 2022 – will be reported in 2023

National Inpatient Survey 2022 – will be reported in 2023

Children and Young People Survey 2023 – will be reported in 2024

APPENDIX 1: FFT Inpatient Feedback Sample – Q3

AMU

AMU were so caring, very helpful and the care received was excellent. Every possible test/treatment given.

ED

The nurses and team were all individually amazing, caring and supportive. The department was clean, staff kind and food was very good. Thank you to all the amazing nurses and team, you are brilliant.

Farley

Making you feel nothing was a nuisance. Care and kindness. All questions answered. Professional with a smile.

Breamore

All the staff were friendly and helpful. Harry from Breamore was funny and very helpful.

Durrington

The staff worked hard to support our father during his time on this ward. He was shown great kindness and compassion.

Laverstock

All the nurses were amazing even though they were short staffed. They go out of their way to help you. .

Whiteparish

Excellent care. Very good and friendly nurses.

Spire

All the staff that looked after me were very kind, very caring and made me feel safe and relaxed. In fact as my health improved I enjoyed my stay on Spire ward. Thank you all x

Pitton

Attention and care from staff and letting me have different to what was on the menu

Pembroke

Staff are kind, attentive and professional. Room was good with a large window. It made a significant difference.

Tisbury

Excellent service despite the difficulties and pressures the NHS is facing. I think the staff go beyond in the face of immense difficulties. Well done everyone at Salisbury.

Amesbury

The kindness to my grandma was truly lovely. The nurses were so accommodating and Beth was beyond great to my grandma. She made her so comfortable. My grandma had never been to hospital before and you all made her feel so safe and looked after. Thank you.

Chilmark

Superb staff, always cheerful and helpful. I was given every encouragement to try and do what is right for each step of the way. I was never hurried. You were incredibly busy and in such times you could not have done anything better.

Britford

The care and attention by all the staff was excellent. We all have opinions about the NHS but to experience it first hand was to see that dedication and excellence at work.

Downton

The care and attention from everyone was 1st class. I came in really poorly and you made me better for which I am eternally grateful. Everyone that has helped me has been amazing. You are all superstars.

Odstock

Every single member of staff was kind, considerate, compassionate. They wiped my tears, held my hand and made everything better when my anxiety was sky high.

Sarum

Whenever my son is here he is very well looked after. Everyone is very kind. My son's answer - they have good toys!

Wessex Rehab

Staff are amazing and their approach to recovery is very unique. I always felt like I had achieved something after each session..

Postnatal

With any part of NHS it is the staff that set the standard of any ward. The entire staff we met made our visit special with professionalism, kindness and openness. You should be extremely proud of individual and team spirit. Thank you all.

Labour

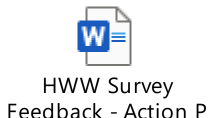
The staff are friendly and look after you. They are professional at what they're doing and respect your opinion.

DSU

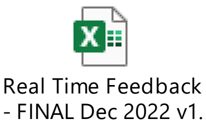
Everyone was friendly and put me at ease. Can not fault the service. Such a wonderful team, thank you.

APPENDIX 2: HWW Survey Feedback - Action Plan - Working Document – v2.0

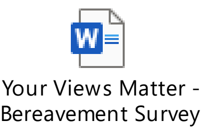
Action Plan from HWW survey report



APPENDIX 3 - Real-Time Feedback Survey Template



APPENDIX 4: Your Views Matter – Bereavement Survey Report - Q3



Action Plan from HWW survey report

Recommendation	Actions taken	Responsibility	By when	Status	Evidence to demonstrate actions have been completed
Disseminate information about the complaints process across all Trust departments and ensure all staff can explain the role of PALS.	PALS Outreach Service	PALS team	Ongoing since August 2022 – make BAU	In Progress	
	Regular attendance at DMT meetings	PALS Lead / Head of Patient Experience	Ongoing since August 2022	In Progress	
	PALS leaflet currently being developed Posters to be designed and audit undertaken as where these need to be located	PALS Lead / Head of Patient Experience	March 2023	In Progress	
	Opportunities for shadowing PALS enquiries	PALS Lead	Ongoing since November 2022 – make BAU	In Progress	
	Staff development – F2 doctor training, B7 development days, Admin Training	Head of Patient Experience	January 2023	Complete	Patient Experience - Staff Development Patient Experience - FF2 Core Teaching Pr PALS Services - Admin Presentation
	Collaboration with Mentor4Leaders.		March 2023	In Progress	
	Consideration with standard Trust Induction timetable		*TBC*	Not started	
Provide regular updates to complainants and inform them of revised timescales as appropriate.	Weekly meetings between PALS Lead and complaints co-ordinators for escalation and ensure regular communications	PALS Lead and complaints co-ordinators	January 2023	Complete	Cycle of meetings added – format continues to develop with focuses on overdue and complex complaints, escalation and communication/update to complainants
	Review of holding letter timescales. Change to acknowledgement letters to be clearer on timescales, reference numbers and who is overseeing their complaint.	PALS Lead / Head of Patient Experience	January 2023	Complete	Updated acknowledgement letters. Acknowledgement letter 25 working da

Identify potential communication barriers with complainant at first contact.	Record of discussion re-designed to include: Summary of the key points to address Accessibility needs i.e. larger font letters or translation services etc.	PALS Lead / Head of Patient Experience	January – March 2023 January – March 2023	Complete In Progress	Updated Record of Discussion template to incorporate 48hour review process – and launched with Divisions. Division 48-hour Initial Complaints R‹ Changes to Complaints Processi
	Embedding the 48hr review template to highlight challenges from department/divisions	PALS Lead / Head of Patient Experience	January – March 2023	Complete	As above.
Improve signposting to additional support e.g., advocacy services.	Acknowledgement letters, leaflets amendments Building links with local advocacy services	PALS Lead / Head of Patient Experience	January – March 2023	In Progress	Talk from Local Advocacy Services – PALS Team Meeting – February 2023.
Publicise and celebrate improvements made to services as a direct result of complaints raised e.g., you said, we did.	Review of FFT Boards (location, information etc.) Implementation of new digital provider to allow for insightful analysis of feedback and meaningful triangulation with complaints.	PALS Lead / Head of Patient Experience / Engagement Lead	January – March 2023 April 2023 - ongoing	In Progress	
	Reporting on outputs and learning from complaints – exploring the use of the actions recording and reporting function on Datix	PALS Lead / Head of Patient Experience	March 2023	In Progress	
	Introduction of a new standard to response letters which bullet point/summarise actions being taken Embedding cultures for following up closed complaints with “you said, we did”.	PALS Lead / Head of Patient Experience	January 2023 March 2023	Complete In Progress	Updated process with Divisions and use of examples. FW_ Changes to complaint response: Example letter.pdf

Scoring method

Very poor	Poor	Adequate	Good	Very good
1	2	3	4	5

Area of Questioning										
Admission to hospital	Q1	How would you rate your overall wait time for your admission to hospital	1	2	3	4	5	Unsure	Not applicable
The hospital and ward	Q2	Please select the ward you are currently on from the dropdown list:	*drop down list**						
	Q3	How would you rate the cleanliness of the ward you are in?	1	2	3	4	5	Unsure	Not applicable
	Q4	How would you describe the quality and selection of dietary options available to you?	1	2	3	4	5	Unsure	Not applicable
	Q5	How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	1	2	3	4	5	Unsure	Not applicable
	Q6	How would you describe the noise level on the ward at night?	1	2	3	4	5	Unsure	Not applicable
Clinicians	Q7	How well have medical staff explained things to you?	1	2	3	4	5	Unsure	Not applicable
	Q8	How would you describe the trust and confidence you have in those involved in your care?	1	2	3	4	5	Unsure	Not applicable
	Q9	How would you describe the numbers of medical staff on duty during your stay?	1	2	3	4	5	Unsure	Not applicable
Your care and treatment	Q10	How would you describe your involvement with decisions around your care and treatment?	1	2	3	4	5	Unsure	Not applicable
	Q11	How would you describe your pain management?	1	2	3	4	5	Unsure	Not applicable
	Q12	How would you rate the level of privacy when being examined or treated?	1	2	3	4	5	Unsure	Not applicable
Operations and procedures	Q13	How well did the staff explain how you might feel following your operation or procedure?	1	2	3	4	5	Unsure	Not applicable
	Q14	How would you describe the quality of written information provided about your operation or procedure?	1	2	3	4	5	Unsure	Not applicable
Leaving hospital	Q15	How would you describe your understanding or involvment with your discharge plan?	1	2	3	4	5	Unsure	Not applicable
Respect and dignity	Q16	Have you felt treated with dignity and respect during your stay?	Yes	No	Unsure				
Overall Experience	Q17	Overall, how would you rate your experience so far with the hospital?	1	2	3	4	5	Unsure	Not applicable
	Q18	Do you have any other comments you wish to make?	Yes	No	Comments box:				
Further Actions	Q19	Would you like to speak to a member of the PALS team further about your experience?	Yes	No	If yes, please add Name and ward:				
Identifying Veterans and Carers	Q20	Do you have a carer? If so, are you/they aware of our Carers Passport (use comments box if needed)	Yes	No	Unsure	Not applicable			
	Q21	(if yes) If you would you like us to send you further details of the Carer's Passport, please list your name and either phone number or email address below	Comments box:						
	Q22	Are you or have you ever been a member of the armed forces?	Yes	No					
	Q23	(if yes) Has a member of staff ever asked you this?	Yes	No	Unsure				

Feedback

Amended	Q6/7/8	I wonder if Theme 3 - Doctors: Confidence, trust, understanding of information, inclusion - is sufficiently covered in the questions
Covered under d/c question	Q15	It would be to do with whether the patient felt they had just been "told" by clinicians or whether an active dialogue had been entered into, so things were explained and their opinions sought - and taken properly into account. It's the difference between being invested in a process or just being told what is going to happen to you. Does that make sense?
Amended	Q7	1. Q7 Run with "numbers of" rather than "level of" and call them "doctors" rather than "medical staff" if it means more to the audience.
Amended Q13	Q6, 12, 14	4)Q6, Q12 and Q14 Would it be worth adding something about the quality of information the patient is provided with before the procedure/when they are discharged – e.g. a leaflet explaining common after effects of the treatment. I remember feeling that I could have been better prepared for the after effects of a procedure both as a patient and parent
Amended	Q19	? Carers passport rewording
Amended		The hospital and ward" section (Qs2-5) so it's more chronological rather than start with noise at night
Amended		Carers passport to be taken
Amended		Veteran info to be taken

Report to:	Patient Experience Steering Group	**Agenda item:**	2.5
Date of Meeting:	22 February 2023		

Report Title:	**Q3 2022/23 Your Views Matter – Bereavement Survey Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Approval Process (where has this paper been reviewed and approved)	Mortality Surveillance Group (14.02.2022) - (extract included in Learning from Deaths Report)			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor (presenting):	Angie Ansell – Deputy CNO			
Appendices (list if applicable):	None.			

Recommendation:
This report is asked to be noted by the steering group and feedback on the contents and focuses of the report. For note - elements of this report are extracted for inclusion within the quarterly Learning from Deaths Report, presented to the Mortality Surveillance Group.

Executive Summary:
Overall, there is an improvement in overall experience and subsequent satisfaction ratings are noted from the Q2 report. 73% of those surveyed rated their overall experience as Good or Very Good. Response rates have noted to decline slightly, down to 20% from 25% in Q2. 6 survey participants requested a call-back from PALS, 2 of these went on to record a formal complaint or concern. There was no significant theming this quarter, however facilities were noted to be a recurring theme for those had rated an overall poor experience. This has been highlighted previously and work is currently underway with the support of the Starts Appeal to improve these facilities where noted.

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) -	☐

Q3 2022/23 Your Views Matter (Bereavement Survey) Analysis

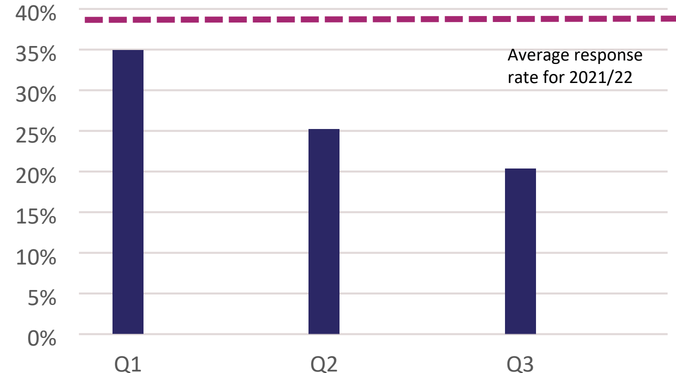
Background

The Your Views Matter Bereavement survey was established in 2020 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives are able to name individuals they would like to acknowledge and thanked for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

Metric Data

During Q3 of 2022-23 the Trust saw 254 deaths, of which 43% (n~108*) were subsequently sent bereavement surveys after follow-up with the Medical Examiner's Office.
The response rate to the surveys seems to be on downward trajectory, and significant lower when compared with the average response rate for 2021/22.

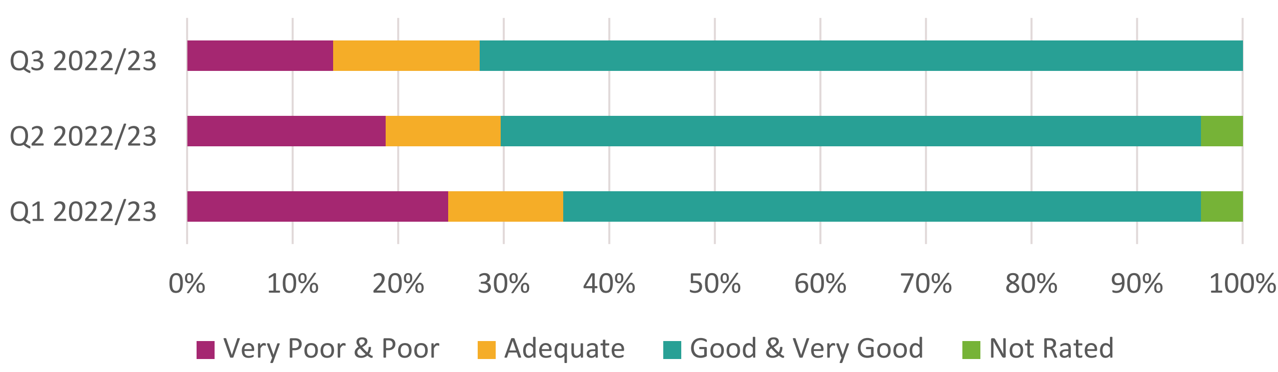
Figure 1.1 Survey response rate



Response rate was 20% (n~ 22), and is considerably lower, than the average response rate for 2021-2022 (39%) and the average response rate seen across Q1 and Q2 (30%).

We have seen improvements in the proportions of those surveyed reporting a very poor or poor experience – decreasing from 19% (n~5) to 14% (n~3) between Q2 & Q3.

Table 1.1 Overall rating of experience for Q1 - Q3 2022-23



There is also a noted increase in the proportion of Good/Very Good between these two periods - (67% n~18, to 73% n~16).

Insights and Analysis

73% of those surveyed rated their experience as **good or very good** (n~16).

Of those who rated their experience as good or very good – the following further breakdowns are noted:

- **16/16** felt that on reflection the hospital was the right place for your loved one to be
- **12/16** felt that the room in which they spent their last days or hours was appropriate
- said that they did not have any outstanding questions
- **13/16** said that if they had any questions or concerns that they able to talk to someone about their loved one's care. The remaining **3** noted this question as not applicable.
- **4/16** requested further contact by PALS, **1** of these did go to raise a complaint.

YVM 325 (Laverstock)

All staff were very attentive when dad needed help or care throughout his time in the hospital. Cannot fault any of the staff professional attitudes to their work.

YVM 326
(AMU)

The sister was very sensitive to knowing I did not live locally, and I was called at an appropriate time. Unfortunately, traffic on the route did not get me there in time for my father's passing. The sister was thoughtful knowing I was driving and did not call me – instead waited to tell me in person on arrival.

14% of those surveyed rated their experience as **poor or very poor** (n~3).

Of those who rated their experience as poor – the following further breakdowns are noted:

- **2/3** either did not have an advanced care plan in place or the family were unaware of it
- Only **1** had an advanced care plan in place, but did not know whether this was taken into account when their loved one was admitted
- **3/3** felt that the hospital was not the right place for their loved one to be
- **2/3** did not feel that the room/ward in which they spent their last days or hours was appropriate. **1** was unsure.
- **1/3** received support from the hospital chaplaincy team in the days before or after their loved ones death. This was rated as Good. **1** was unaware of these services.

- **3/3** still had outstanding questions
- **2/3** requested further contact by PALS, **1** has since been formally raised as a concern.

YVM 333 (Pitton)
Some staff were nice and knew dad needed feeding as he couldn't do it alone. Others just left food in front of him, so if he was asleep when we visited he just starved.

YVM 316
(Pitton/Laverstock)

Listen to families! We knew she was dying as did the Doctor but no one seemed to listen to us about getting her home. There was no treatment being given to mum in hospital that could not have been given to her at home with her family around her when she passed.

Figures 1.3 to 1.6 show the overall ratings in the key areas of patient experience:

- Relief of symptoms
- Communication
- Compassion and Dignity
- Support for loved ones

There is a clear spike in positive responses to all of these areas in October and this appears to decline throughout November and into December.

Communication is noted to have improved significantly when compared with Q2.

Figure 1.3 Relief of symptoms

	Oct	Nov	Dec
Poor	1		1
Adequate	1	2	
Good	4	2	
Very good	6	2	2
Don't know	1		

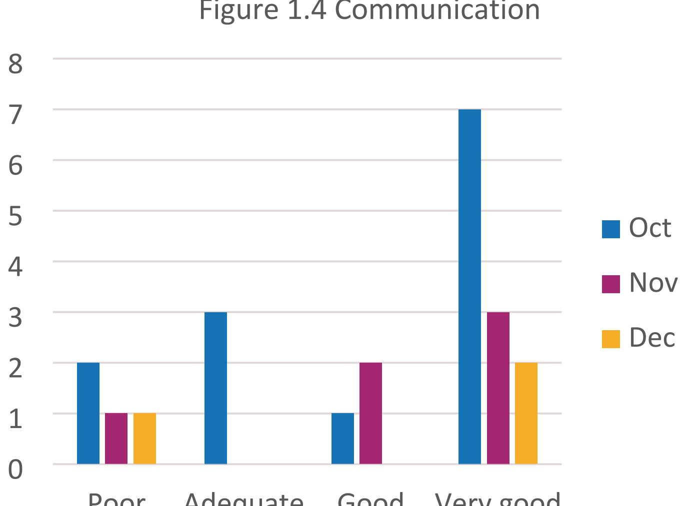
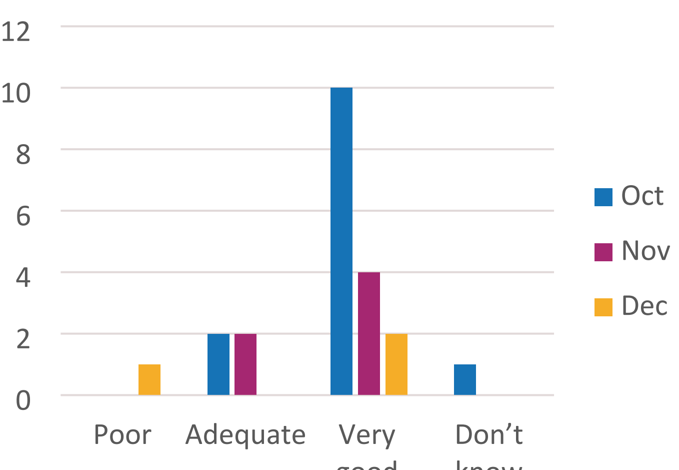
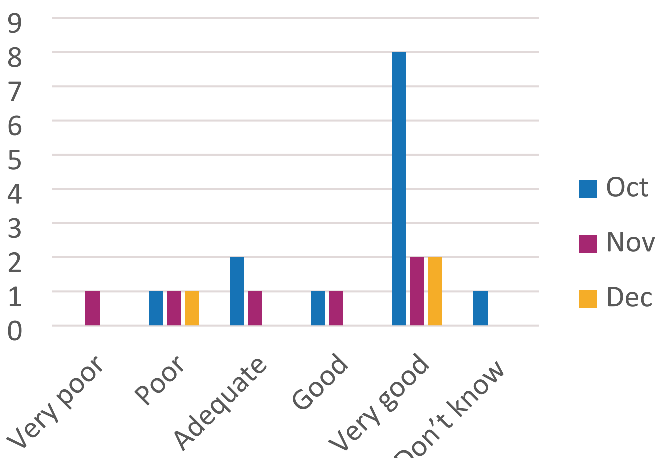


Figure 1.4 Communication





Correlation with Complaints:

In Q2 we saw a high-level theme related to End of Life Care. Themes within this were noted to be in relation to lack of communication when patients were deteriorating or had passed away.

This highlighted a need for further communication training to be given across the wards to ensure staff are able to comfortably break bad news whether this be over the phone or in person.

Throughout Q3 – the accredited EOLC Communications course was attended by 16 staff.

There is a further date planned for Q4 of 2022/23, this currently has 15 members of staff booked onto this with 1 on the waiting list.

We have not seen the same correlation with complaints in Q3 noted in Q2 and overall satisfaction rates have increased based on the feedback from this cohort of surveys.

Other noted themes

Facilities continue to be highlighted through these surveys as an area of attention and based on the comments reviewed it is clear that there are links between the environment at the time of end of life and the impact this has on the overall experience of end of life care.

Stars Appeal have provided the EOLC CNS team with a supply of free tv cards to offer EOLC patients and their loved ones. The EOLC team have also purchased two overnight bedside chairs which can be used by EOLC families to sleep at the bedside. These are well used with very positive feedback from families and staff. There are some issues with logistics of storage, making staff aware of them and locating them (they get moved around the Trust).

There are continued conversations in relation to the ward environment with the Stars Appeal, fuller scoping of the requirements and work to assess the scale of the project is still needed before any formal bidding for funds can take place.

The work being scoped encompass consideration of artwork, recliner chairs (that meet both patient rehab and overnight carer needs), dimmable lighting, china cups etc.
Additional considerations are also being scoped in relation to refurbishment disruption and how this effects patient flow and capacity.

Report written by Victoria Aldridge - Head of Patient Experience

CLASSIFICATION: NHS CONFIDENTIAL

Report to:	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	9 March 2023		

Report tile:	Adult National Inpatient Survey 2021 – Action Plan Progress Update			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Inpatient Survey findings have been presented in the following forums to date: • Presentation at Patient Experience Steering Group – 27.07.2022 • Noted in PESG escalation report to Clinical Management Board – 17.08.2022 • Admin Governance Patient Experience Update – 04.11.2022 • Medicine DMT – Patient Experience Update 11.10.2022 *(unable to present, presentation sent to Division Leads)* • Surgical Governance – Patient Experience Update 12.10.2022 • Featured in the Patient Experience Q1 & Q2 Report – presented to CGC on 29.11.2022 • Featured in the Patient Experience Q1 & Q2 Report – presented to PESG on 30.11.2022 • Clinical Governance Committee 28.2.2023			
Prepared by:	Judy Dyos – Chief Nursing Officer			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the following presentation of the action plan progress update in response to the Adult Inpatient Survey 2021 findings.

Executive Summary:

Adult National Inpatient Survey 2021

The National Inpatient Survey was conducted during November 2021 and included patients aged 16years+ who had spent at least one night in hospital during that period. Full CQC report was published on the 29th September 2022 (click here to view).

The Trust's response rate was 48%, this being noted as a higher-than-average rate when compared with other Trusts (40%), however it was noted that this response rate had reduced from 57% back in 2020. There was a total of 585 responses.

The Trust's performance scored the same as others for 45 of the 47 scoreable questions. There were no questions where we scored better and 2 where our Trust performed worse than other Trusts. These questions were in relation to patients experience of noise at night and having enough to drink during their stay.

- More than 50% of the overall comments made were positive

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- Theming of the comments indicated four key areas for improvement:
    - Discharge process and follow-up
    - Communication
    - Staffing levels
    - Food and drink, noise and disruption, facilities

Highlight: The 5 areas with the lowest scores noted in 2020 that had stayed the same or seen a further decrease in 2021 were in relation to: Ward noise, privacy, cleanliness of ward, having enough to drink and being asked for views on quality of care.

<INSERT>

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

PATIENT EXPERIENCE SURVEY CODED COMMENTS REPORT

Salisbury NHS Foundation Trust

National Inpatient Survey 2021

Sample: Patients who were discharged in November 2021

Supplementary analysis of patient written comments

(to be read in conjunction with the headline report and full list of patient written comments)

NB Full reporting at: www.patientperspective.co.uk

© Patient Perspective Ltd.

STARTING WITH SOME POSITIVES

- I had excellent treatment during my stay in hospital and the same for follow up appointments.
- The staff were lovely.
- The care was constant and on time.
- Prompt diagnosis with timely escalation to senior medical staff. I was also very pleased that the appropriate referral to my GP was made efficiently and quickly.
- Excellent care during my stay at Salisbury hospital.
- The care I received from the ward nurses after my surgery was outstanding.
- The operating team gave me all the information I needed and did a great job.
- Nursing varied from very good to superb. My planned procedure was performed on the planned date and the result was better than I had dared hope.
- The nurses and doctors were completely proactive with me in my care.
- I found the nurses from many nationalities very kind and how they worked together so well.
- All hospital staff doctors nurses and administration were wonderful. I am incredibly grateful.
- Great care taken to explain my operation and after effects.
- All the staff in the ward I was in were all so very hard working and attentive to my needs.

EXECUTIVE SUMMARY

The following report provides analysis of each written comment received as part of the National Inpatient Survey of 2021. Each comment has been read and coded by a trained coder, using a consistent coding schema, covering four key topic areas: The Pathway of Care, Care and Treatment, Staff , and the Hospital Environment and Facilities.

The analysis is presented in a series of charts, and sample comments are provided for illustrative purposes. The full sample of written comments is provided separately for reference and further detail. All survey data is presented at www.patientperspective.co.uk

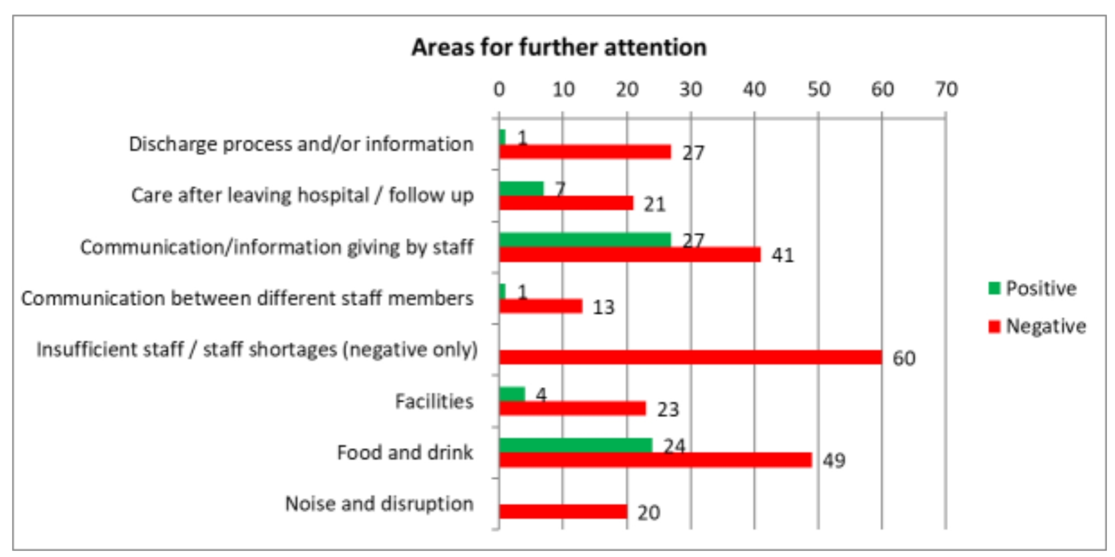
What did patients comment on most?

- Staff – 479 comments
- Care – 398 comments
- Pathway – 198 comments
- Facilities – 175 comments

56% of the comments overall were positive.

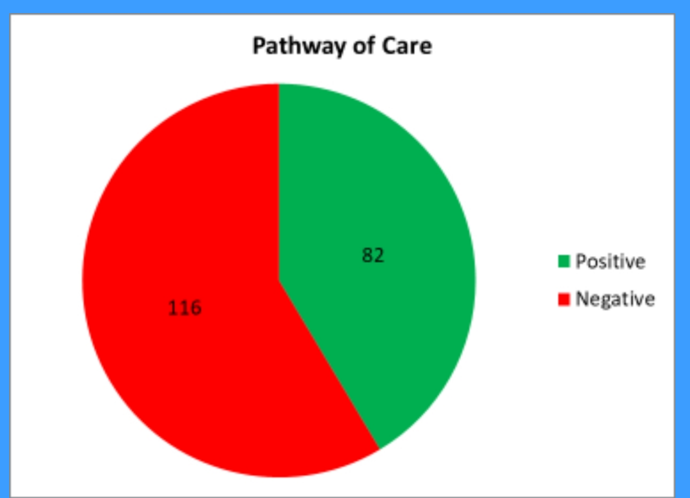
- Staff – 71% of comments were positive
- Care – 57% of comments were positive
- Pathway – 58% of comments were negative
- Facilities – 70% of comments were negative

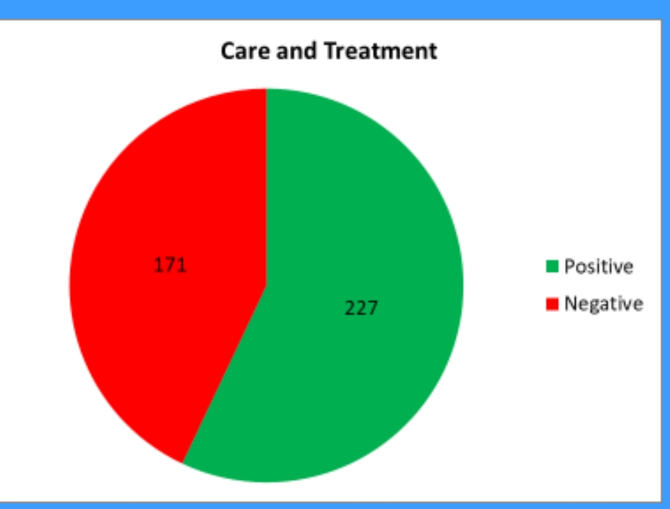
Particular areas for your attention highlighted in the analysis of the comments were:

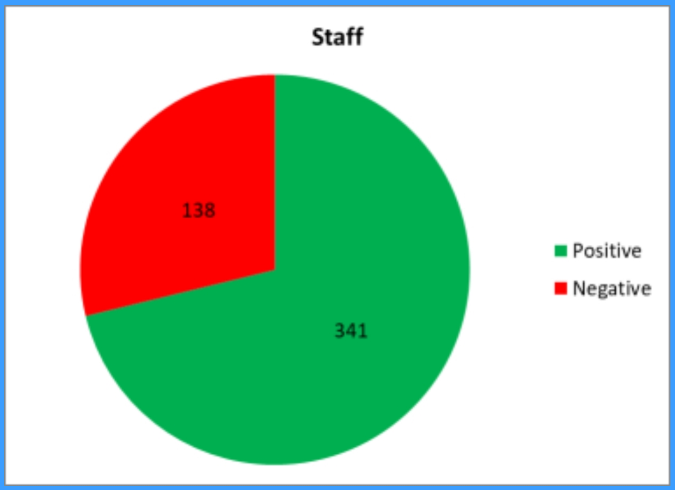


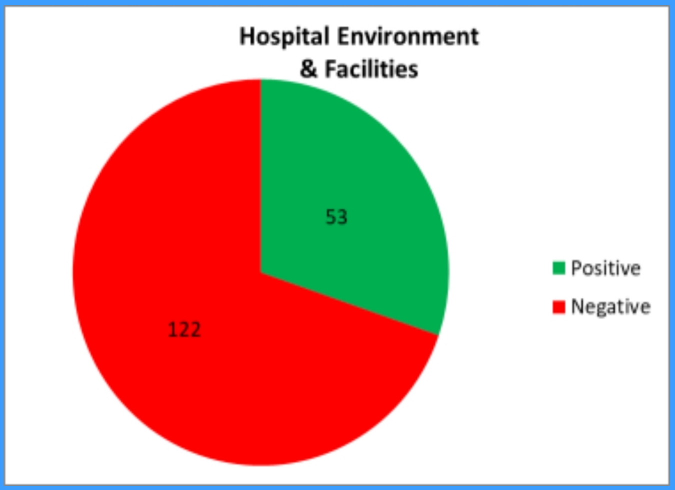
patient PERSPECTIVE

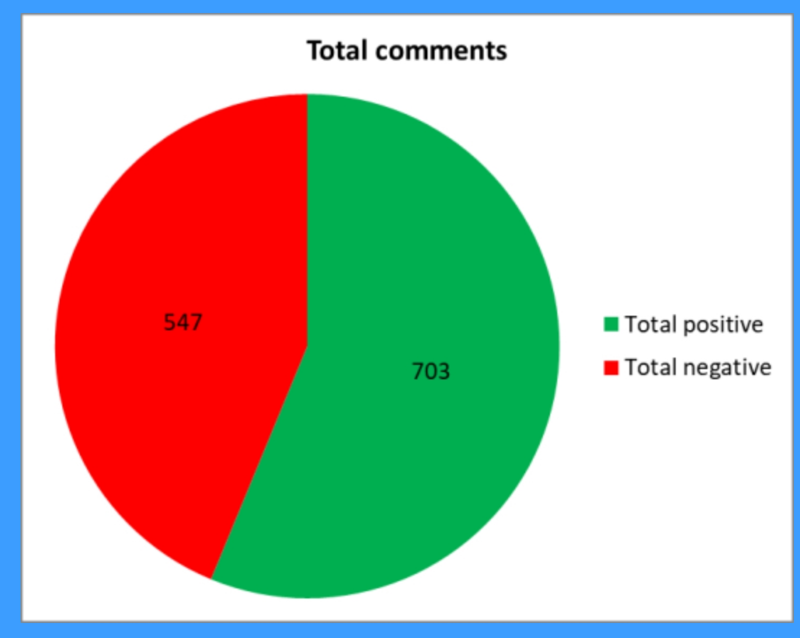
RESULTS HEADLINES: CODED COMMENTS, NATIONAL INPATIENTS' SURVEY 2021











COMMENTS ABOUT THE PATHWAY OF CARE

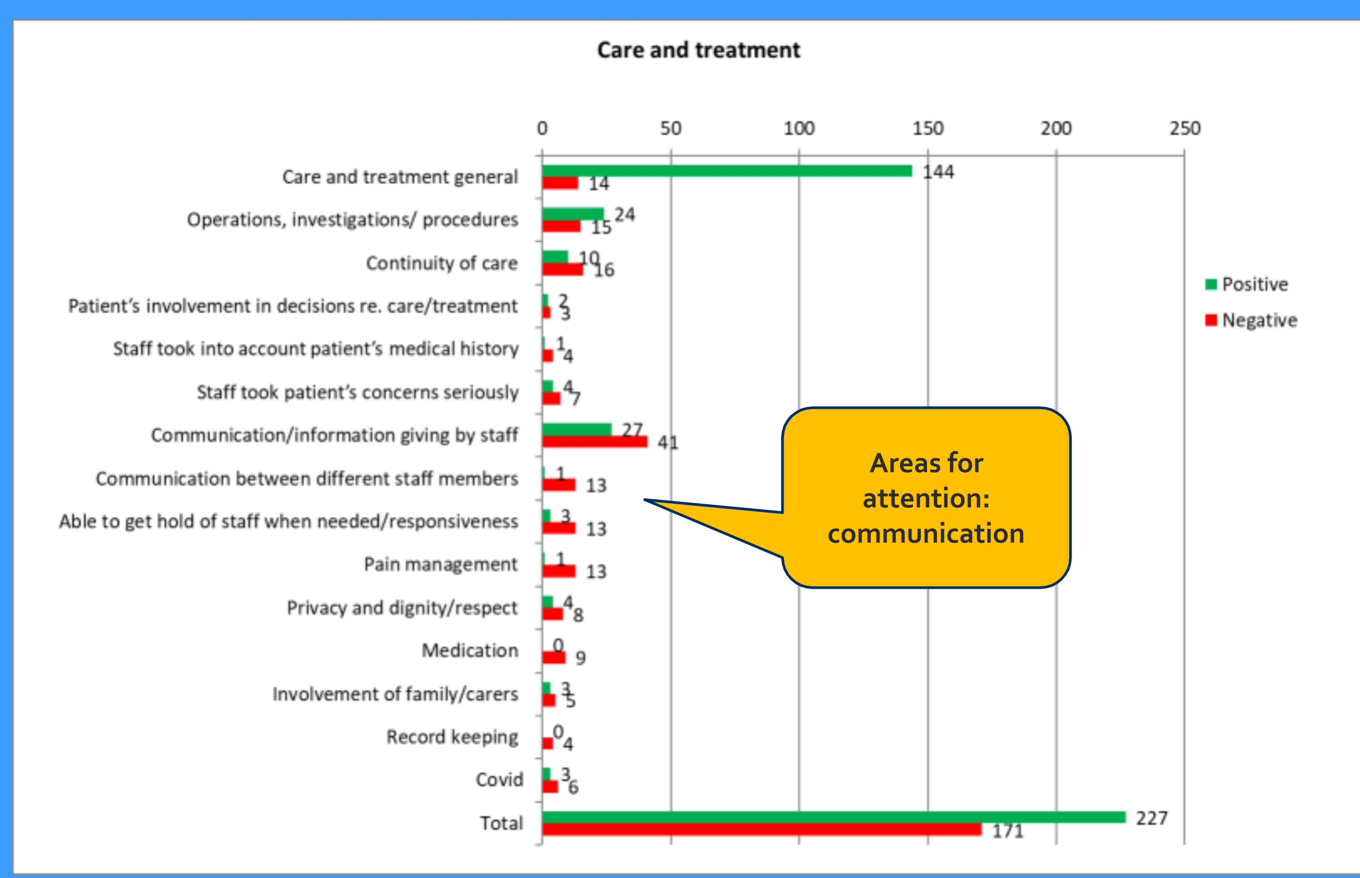
Pathway of Care

	Positive	Negative
Waiting/access	6	10
Cancelled treatment	0	2
A&E/Emergency department	7	11
Admission to hospital	3	6
Hospital / ward stay	55	12
Discharge process and/or information	1	27
Care after leaving hospital / follow up	7	21
Organisation and administration	3	10
Moving wards	0	16
Transport	0	1
Total	82	116

Areas for attention: discharge process and follow up

- [could be better] The outpatient appointments booking procedure.
- Follow up physio sessions by the team would have been so useful after leaving hospital instead of leaving it to physios in the community who do not deal with my complex needs.
- A&E waiting time. It was 11 hours before I was admitted to the ward. Very, very uncomfortable.
- Follow up appointments not yet notified.
- Follow up appointments requested by consultant not always booked in.
- After 3 days told by doctors could go home so got ready but not allowed by OTs until 3 days later - had to wait to show kitchen capability.
- Being told you could go home, and then having to wait 5hours for medication. This has happened on my last 5 or 6 stays in hospital.
- The discharge was a complete shambles. I was told to leave the ward with no medication and go to the pharmacy to collect it myself. Pharmacy told me I had to go to the discharge lounge to collect my meds. I had been on oxygen for 7 days and not able to walk around before being sent all over the hospital.

COMMENTS ABOUT CARE & TREATMENT



- Not enough done to get mobile more which resulted in a DVT.
- Left for almost 3 days with no water or food as moved 4 times.
- I wish the nurses could tell me when I am going to have a scan or any other procedure that I would be sent to do.
- [could be better] Communication between nurses and social care.
- [could be better] Passage of information, as I felt I needed to know more about my condition and what would happen next/in the future.
- Have a Dr to do rounds on a weekend and discuss what's going on.
- Administration of pain medicine on time was appalling.
- I feel that with better planning the infection and discomfort I suffered could have been avoided.

COMMENTS ABOUT STAFF

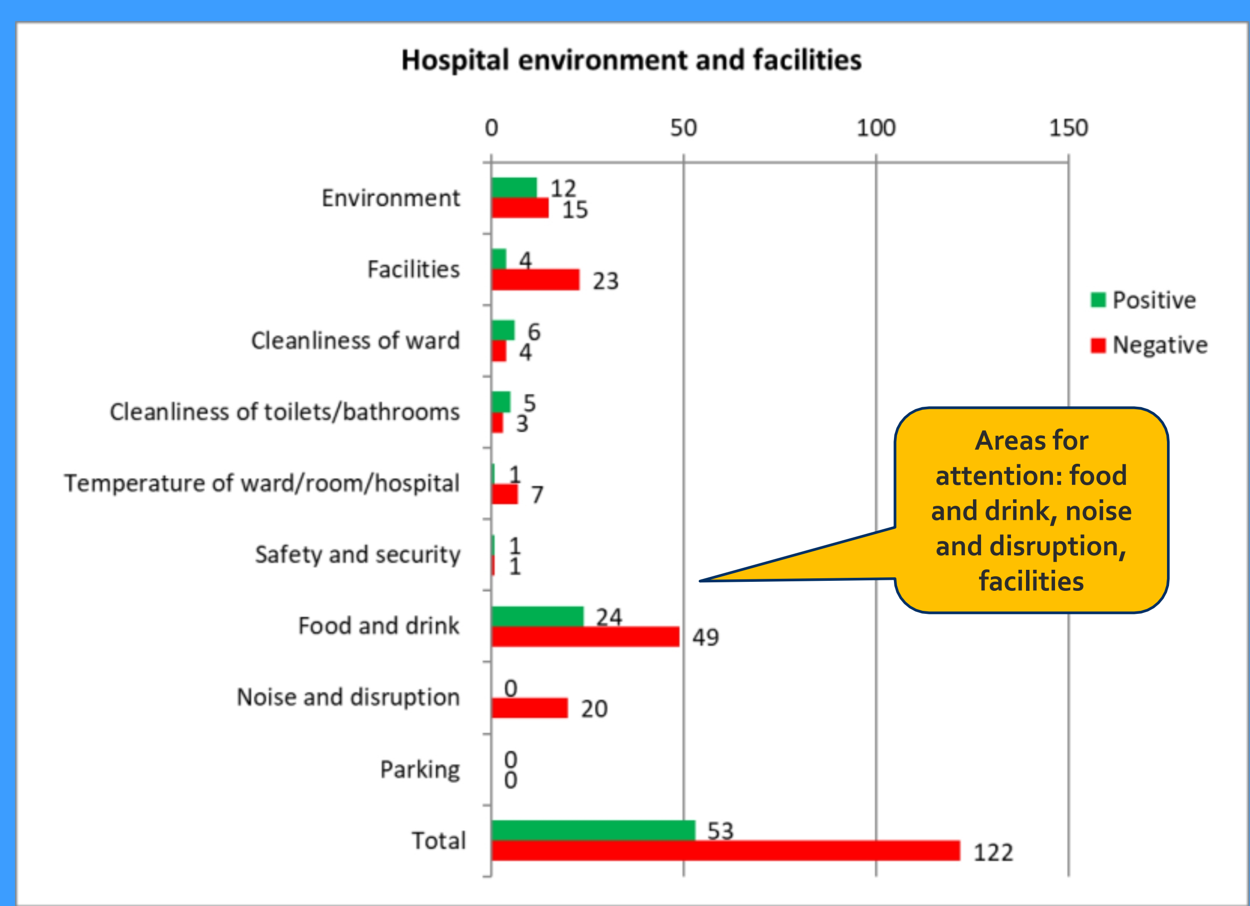
Staff

	Positive	Negative
Staff general	154	9
Doctors/consultants	63	12
Nurses	92	14
Therapists	8	4
Healthcare assistants / auxiliary staff	9	4
Support staff	4	0
Other staff groups	9	2
Staff skills and training	2	13
Insufficient staff / staff shortages (negative only)		60
Staff negative attitude/rudeness (negative only)		19
Staff giving conflicting/inconsistent advice (negative only)		1
Total	341	138

Areas for attention: staffing levels

- The nurses could be a bit more visible and a bit more tolerant on how they speak to the patient.
- Not enough staff in evenings - witnessed someone having a fall because they decided to get out of bed when they had been told not to do this on their own. She should have been watched all the time she was awake.
- I don't think I saw the same nurse twice. There was always a new nurse everyday. This made it difficult to build the patient nurse relationship.
- Staff levels definitely need to be improved, any short comings almost always came down to staffing levels.
- A different doctor every day, each with a different view and plan all contradicting one another. Nurses and I tried to keep track but it was virtually impossible. Not enough nurses, not able to help you when you needed it, late with pain killers. Left on a trolley for 21 hours.

COMMENTS ABOUT THE HOSPITAL ENVIRONMENT & FACILITIES



- Offer patients fluids as a regular item of care. Everyone should have a jug of water.
- Activity at night by both nurses and patients without thought of other patients trying to sleep.
- The food was terrible. I know money is tight but it really was dire.
- The only down side that I experienced was the quality of the food and in particular the cooked food always arrived cold.
- I was unable to bring my wheelchair and was therefore unable to more around whilst in hospital. Not having my wheelchair became a distinct problem at discharge.
- The ward was cold all the time. I was given extra blankets and bed socks.
- Longer availability of food, I was late arriving on to my ward after treatment and hadn't eaten since lunchtime. I had facial fractures, jaw damage and broken fingers after a cycling accident, when I asked for some food I was left with a small pack of biscuits that I couldn't open or chew. This was all that was available until breakfast, next morning.
- Not enough fluid - one cup of tea a day! Towels old, thin and falling to bits. Patients crying in pain when they have bed baths because the flannels and towels were so rough. I was not fed for 48 hours because no one was sure what was going on - no fluids given either.

POINTS TO DISCUSS AND NEXT STEPS

Points to discuss:

- ❑ What is your overall impression of these results?
- ❑ What are you most pleased about in these results?
- ❑ What are you most unhappy about in these results?
- ❑ How do these results compare with previous results or other patient written comments data?
- ❑ What works? What have you learned from your successes that you can use to help you make improvements in other areas of patients' experience?
- ❑ What hasn't worked so far? What have you learned from what hasn't worked that you can either avoid doing in future or can do differently next time?
- ❑ What do you see as the priority areas for further investigation in order to help you improve patients' experience of care?
- ❑ Are any of these areas immediately actionable, quick wins, requiring limited resources?

Next steps and actions:

- ❑ Detailed review of these results alongside the full survey results and other available data
- ❑ Dissemination of results – consider with which stakeholder groups (internal and external), in which level of detail and in what format to share the results widely – NB face to face presentations and discussions with staff are more likely to lead to improvements than dissemination by paper or email alone
- ❑ Identify your priority areas for improvement – ensuring these are linked with current priorities and are fully integrated into existing service improvement initiatives will mean they are more likely to be acted upon
- ❑ Involve staff and patients/carers in deciding upon the actions to take to make the improvements real and lasting
- ❑ Set up a process for ongoing monitoring of the actions and improvements and regular communication about progress to stakeholders
- ❑ Consider whether any further detailed analysis would be helpful in supporting your quality improvement initiatives and whether there is anything else we can help you with

To discuss how we might help you further please contact our Senior Project Manager, Chris Henderson:

chris.henderson@patientperspective.org

APPENDIX: DATA TABLE

Please refer also to:
www.patientperspective.co.uk

	Positive	Negative	Totals
Pathway of Care	82	116	198
Care and Treatment	227	171	398
Staff	341	138	479
Hospital Environment/ Facilities	53	122	175
	703	547	

Pathway of Care	Positive	Negative
Waiting/access	6	10
Cancelled treatment	0	2
A&E/Emergency department	7	11
Admission to hospital	3	6
Hospital / ward stay	55	12
Discharge process and/or information	1	27
Care after leaving hospital / follow up	7	21
Organisation and administration	3	10
Moving wards	0	16
Transport	0	1
Total	**82**	**116**

Care and Treatment	Positive	Negative
Care and treatment general	144	14
Operations, investigations/ procedures	24	15
Continuity of care	10	16
Patient's involvement in decisions re. care/treatment	2	3
Staff took into account patient's medical history	1	4
Staff took patient's concerns seriously	4	7
Communication/information giving by staff	27	41
Communication between different staff members	1	13
Able to get hold of staff when needed/responsiveness	3	13
Pain management	1	13
Privacy and dignity/respect	4	8
Medication	0	9
Involvement of family/carers	3	5
Record keeping	0	4
Covid	3	6
Total	**227**	**171**

Staff	Positive	Negative
Staff general	154	9
Doctors/consultants	63	12
Nurses	92	14
Therapists	8	4
Healthcare assistants / auxiliary staff	9	4
Support staff	4	0
Other staff groups	9	2
Staff skills and training	2	13
Insufficient staff / staff shortages (negative only)		60
Staff negative attitude/rudeness (negative only)		19
Staff giving conflicting/inconsistent advice (negative only)		1
Total	**341**	**138**

Hospital Environment/Facilities	Positive	Negative
Environment	12	15
Facilities	4	23
Cleanliness of ward	6	4
Cleanliness of toilets/bathrooms	5	3
Temperature of ward/room/hospital	1	7
Safety and security	1	1
Food and drink	24	49
Noise and disruption	0	20
Parking	0	0
Total	**53**	**122**

National Inpatient Survey Results (2021)

Action Plan Update

Clinical Governance Committee – 28th February 2023

Presented by: Judy Dyos - Chief Nursing Officer

Salisbury NHS Foundation Trust
National Inpatient Survey 2021

CQC Benchmark Results

Sample: *Patients aged 16years+ who had spent at least one night in hospital during November 2021*

Scoring: *Each question in the survey that can be scored are converted into scores on a scale of 0 to 10. Scores of 10 are assigned to the most positive and scores of 0 are assigned to the least positive.*

CQC Benchmark Report:

https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2021/

Summary of comparisons

134 NHS Acute Trusts involved

62, 235 Total responses received (return rate of 39.5%)

585 Total responses received for SFT

48.07% Response rate

No. of questions where SFT scored better than other Trusts = **0**

No. of questions where SFT scored about the same as other Trusts = **45**

No. of questions where SFT scored worse or somewhat worse than other Trusts = **2***

**Q5.4 Were you ever prevented from sleeping at night by hospital lighting?*

**Q15 During your time in hospital, did you get enough to drink?*

Demographic breakdown

Age

12.8% of those surveyed were aged
between 16 and 50
87.2% were aged 51 or over

Sex

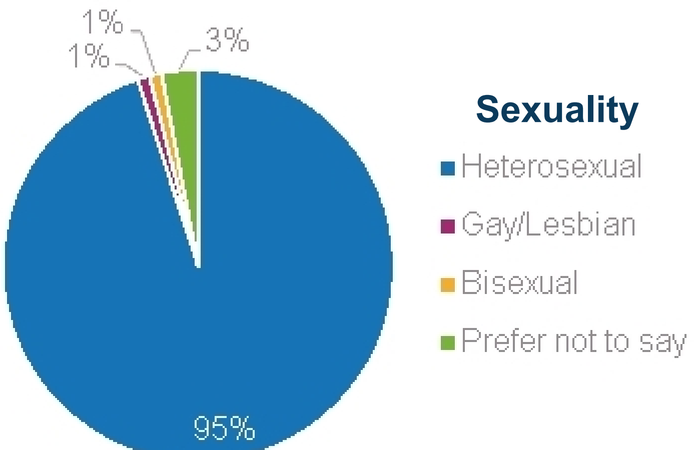
50.0% of those surveyed identified as female

49.3% of those surveyed identified as male

0.2% of those surveyed identified as intersex

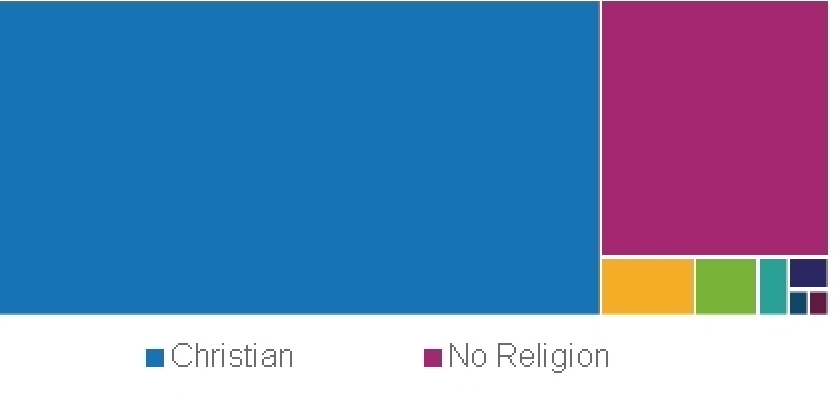
0.5% preferred not to say

Sexuality



- Heterosexual
- Gay/Lesbian
- Bisexual
- Prefer not to say

Religion



- Christian
- No Religion
- Prefer not to say
- Other religion
- Buddhist
- Jewish
- Muslim
- Sikh

**Total Buddhist, Jewish, Muslim and Sikh equate to less than 2%*

Ethnicity

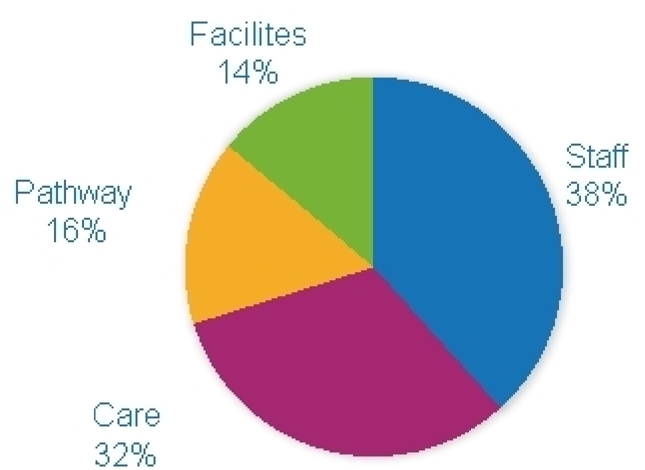
95.4% of those surveyed were White

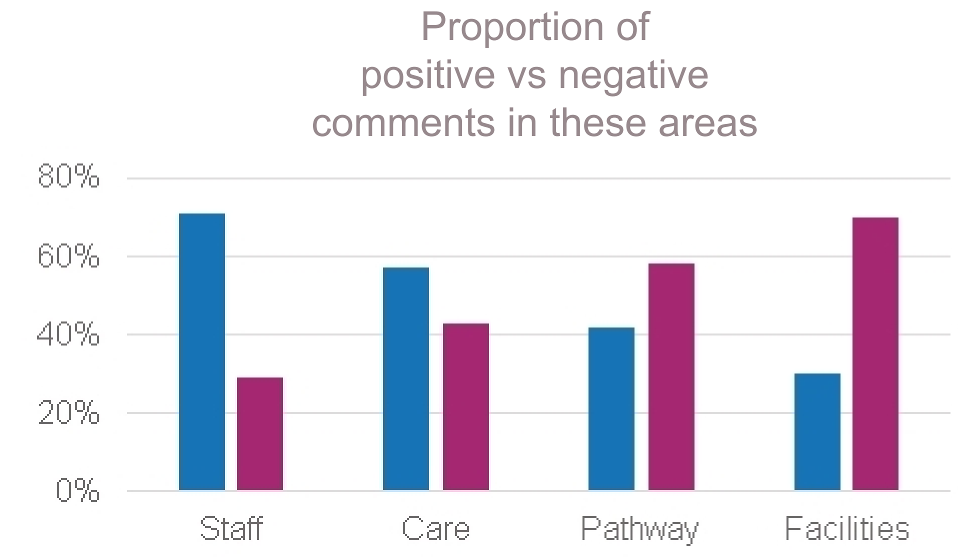
Less than 2% were either, Asian, Black, Arabic, other or of multiple ethnic groups

2.7% were unknown

Summary of Report Themes

What did patients comment on the most?





56%

Of the overall comments were positive

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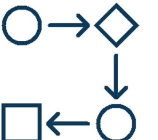
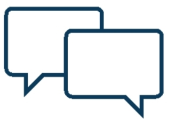
Summary – areas for improvement



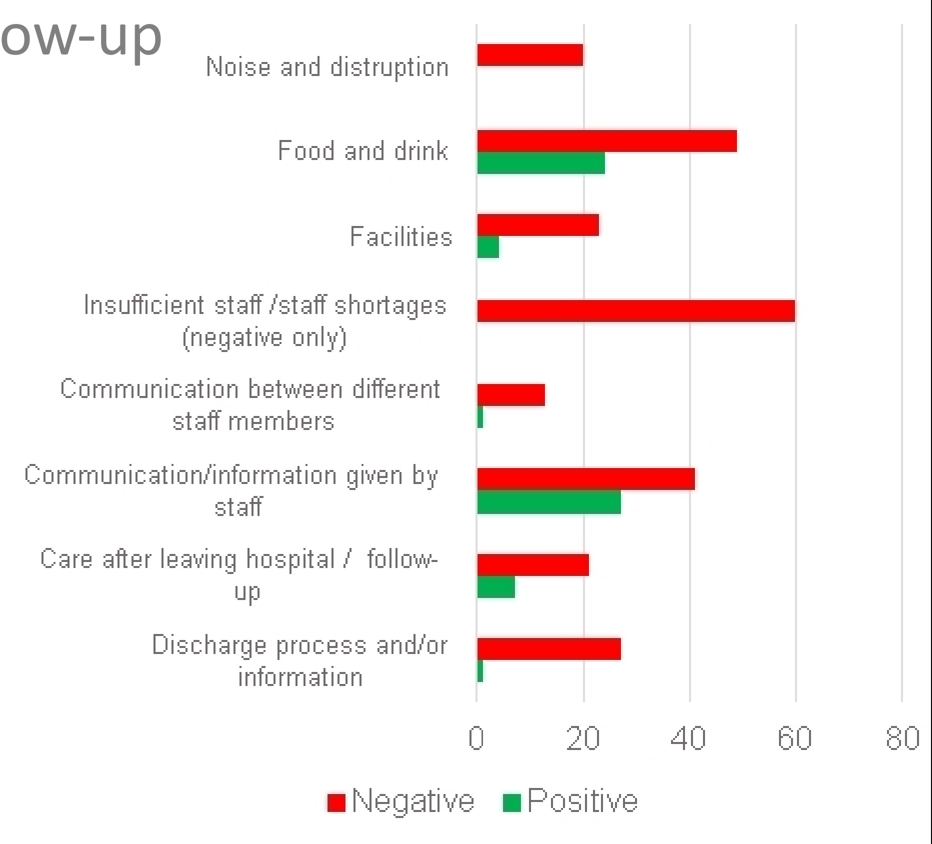
Discharge process and follow-up



Communication

Staffing levels

Food and drink, noise and disruption, facilities



Patient Centred & Safe | Professional | Responsive | Friendly | Progessive

Action Plan and Progress Update Breakthrough Objective

Area for improvement	Actions taken to date	Further actions required	Timescale	Responsible person
Discharge process and follow-up	Safer Red to Green	Embedding the processes	July 2023	DCOO DHONS
	White board updates daily to ensure timely processes	E white board upgrade and training	April 2023	DCOO DHONS
	Patient flow group commencement to focus on LOS and bed occupancy	Engagement with all professionals groups	April 2023	DCOO Head of patient flow
Communication	Refocus on the use of SBAR handover processes	Audit of SBAR handover documentation	June 2023	DHONS
	Commencement of EDOCU to aid information passage	All areas completed in roll out	April 2023	CNIO
	Feedback to individual doctors named in concerns and incidents with discussion with educational and clinical supervisors	Development of communication education module for both senior and junior medical staff	August 2023	CMO

Action Plan and Progress Update Breakthrough Objective – available staff

NHS
Salisbury
NHS Foundation Trust

Area for improvement	Actions taken to date	Further actions required	Timescale	Responsible person
Staffing levels	Increased HCA recruitment. 100 HCAs increase to date	Ongoing focus and regular open session in progress	Complete	Sharon Holt
	Overseas recruitment of RNs	40 further RNS in progress	March 2023	Sharon Holt
	Retention focused activities – Related to people plan	Improving Together Objectives	December 2023	Mark Robinson
	Strategic medical workforce review completed to ensure adequate staffing levels	Business case to be developed to describe investment required in medical and supporting professionals workforce to describe benefits to flow and patient care	April 2023	Stuart Henderson
	Up banding of staff to make SFT more attractive	Band 2 to 3 to be fully actioned	March 2023	Mark Robinson Fiona Hyett

Action Plan and Progress Update

Area for improvement	Actions taken to date	Further actions required	Timescale	Responsible person
Food and drink, noise and disruption, facilities	Band 2 ward assistant role developed to focus on nutritional and hydration	Recruitment process in progress Advert out	March 2023	Head of Resourcing DCNO
	Increased band 2 recruitment. Additional 100 HCAS recruited	Maintain recruitment trajectory	April 2023	Head of Resourcing DCNO
	Ward buddies and volunteers to support wards	Volunteers meal time rota to be developed	April 2023	DCNO Jo Jarvis
	Business case approved to deliver phased compliance with national cleaning standards	Recruitment ongoing	Three year phased approach	Head of Facilities

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CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	9th March 2023		

Report tile:	Maternity Quality and Safety Report for Quarter 3 2022/23.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	Report approved through DMT (virtually) • Noted at Divisional Governance – 17th February 23 • On agenda at Maternity governance 21st February 23 • On agenda for Maternity Safety Champions February 23 • CGC 28th February 2023			
Prepared by:	Joanne Hayward - Director of Maternity and neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Committee are asked to take the report as information and assurance reading the work untaken in the maternity service

Executive Summary:

This report will highlight achievements and demonstrate current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Salisbury Foundation Trust Board of present and emerging safety concerns.

It will evidence current compliance with national reporting to include Care Quality Commission (CQC), Maternity Incentive Scheme (MIS) and Ockenden 2020 recommendations. It will also demonstrate patient experience and feedback and learning.

Clinical outcomes will be reviewed against local and national benchmarks to demonstrate safety in maternity and key improvements and service development will be identified.

This report reflects data from quarter 3 22/23.

Positive points to note:

- Beatrice birthing unit audit
- Patient experience
- Professional Midwifery advocate
- Safety Champions staff engagement

Points needing to focus on

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

- Screening quality assurance action plan
- Ockenden compliance
- Progress on the Maternity safety programme

Points for committee / Board to approve and provide sign off :

- ATAIN action plan in appendix 2

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

QUALITY AND SAFETY REPORT QUARTER 3 2022/23.

1. EXECUTIVE SUMMARY

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the LMNS Board and the Board of Directors of present or emerging safety. The information within the report reflects actions in line with Ockenden and the CNST Maternity Incentive Scheme, and progress made in response to any identified concerns alongside key information regarding quality and safety.

2. GOOD NEWS STORIES

The Beatrice Birth Unit was officially opened on 31st October 2022 to provide labour care to women in a home-from-home environment. Funded by the LMNS, NHS England and the hospital's charity, 'Stars Appeal'. This funding enabled us to reach the ambition of the National strategy by offering a choice of birth places at Salisbury Foundation Trust – home birth; midwife led care birth (alongside birthing unit) and obstetric birth (labour ward). There was an official opening where families and service users joined us to celebrate. This was hosted jointly with the STARS charity.

The first women to deliver in the Beatrice Birth Unit.

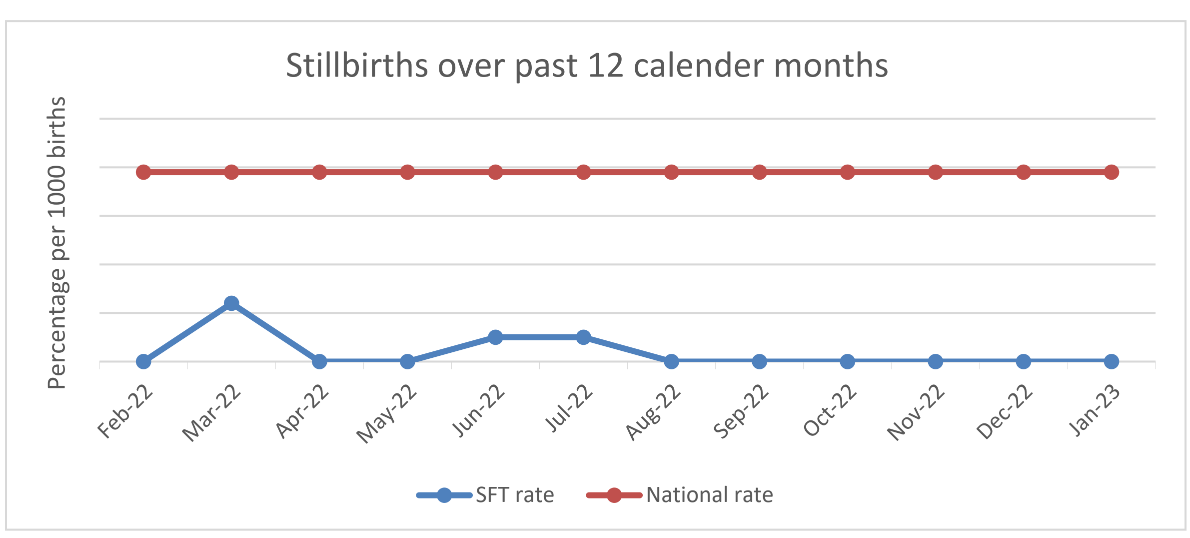
3. PERINATAL MORTALITY RATE

The following graphs demonstrate how Salisbury Foundation Trust is performing against the national ambition to reduce rates of stillbirths, neonatal and maternal deaths and brain injuries in babies that occur during or soon after birth by 20 per cent by 2020 and 50 per cent by 2025.

3.1 Stillbirth over 12 months

There were no stillbirths for Quarter 3 2022/23.

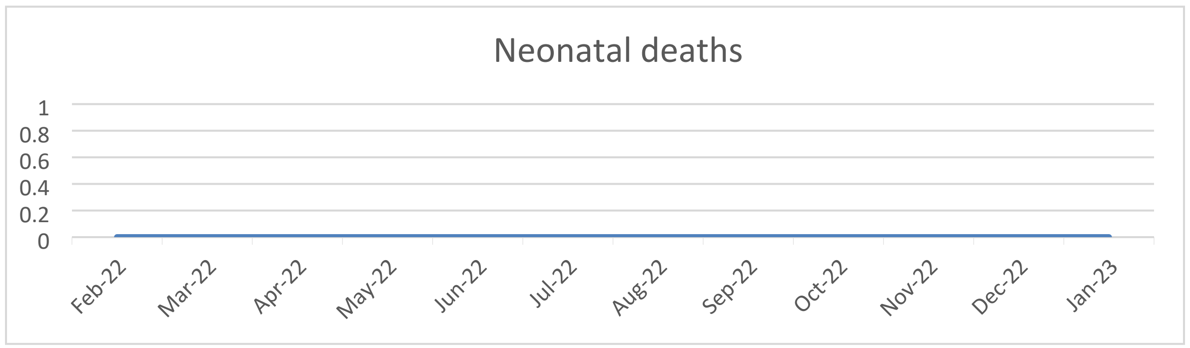
Chart 1. SFT stillbirth rate per 1000 births over past 12 months



3.2 Neonatal deaths over 12 months

There were no neonatal deaths for Quarter 3 2-22/23.

Chart 2 .SFT neonatal Death rate per 1000 births over last 12 months



4 PERINATAL MORTALITY SUMMARY FOR QUARTER 3 2022/23 / Safety Action 1 (MIS)

During Q3 22/23 there were 0 pregnancy losses in Salisbury Maternity Unit, 0 fitted the criteria for MBRRACE notification, MBRRACE surveillance and PMRT review.

Chart 3: Number of loses by definition.

22/23 (excluding terminations for abnormalities)	Q3
Stillbirths (>37^{+0} weeks)	0
Stillbirths (>24^{+0} weeks - 36^{+6}weeks)	0
Late miscarriage (22^{+0} weeks - 23^{+6}weeks)	0
Neonatal deaths	0
Total	**0**

4.1 Perinatal Mortality Review Toolkit (PMRT) real time monitoring tool

PMRT was designed and will be further developed with user and parent involvement to support high quality standardised perinatal mortality reviews on the principle of 'review once, review well'. Introduced in 2018 PMRT is a collaboration led by MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised tool building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'

During Q3 22/23 there were no outstanding cases to be reviewed by the PMRT group from previous quarters.

This report will achieve compliance with the required standard d and will be submitted on a quarterly basis.

This report will be presented at the Mortality Surveillance Group meeting in February 2023.

4.2 Learning from the Perinatal Review Toolkit

There was no learning as no cases identified for Quarter 3 2022/23

5 HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

• Maternal Deaths

• Intrapartum stillbirth

• Early neonatal death

• Severe brain injury diagnosed in the first seven days of life

In Quarter 3 2022/23 we referred one case:

A primigravida lady was induced at 38+4 weeks for ruptured membranes over 24 hours. She laboured and this was augmented with a syntocinon infusion. The laboured progressed to full dilation and she was delivered by ventouse due to suspected fetal distress in the second stage. The baby was born in poor condition (Apgar 1 at a minute) and was transferred to a tertiary centre for therapeutic colling . Duty of Candour was completed in accordance with local policy.

5.1 Investigation progress update to follow

Ref	HSIB reference	Confirmed level of investigation	Date Confirmed investigation	External Notifications & Other Investigations
151230	018963	Agreed at Patient Safety Summit for referral to HSIB	6/12/22	Interviews with staff happening this week (wc 6/2/23)

5.2 CORONERS REGUALTION 28 MADE DIRECTLY TO TRSUT

Not Applicable

5.3 MATERNITY SERIOUS INCIDENTS to follow

During Quarter 3 there was one Serious Incident. All cases referred to HSIB are investigated as Serious Incidents in this Trust

Datix no	Category	Outcome	Immediate Learning
October	None		
November	None		
December			
151230	Term baby required therapeutic cooling at tertiary unit	Unanticipated resuscitation and had an abnormal neurological examination – fitted TOBY criteria. Spent 5 days in tertiary unit and 2 days in Salisbury before discharge	1 minute delayed cord clamping not appropriate in this case as baby pale and floppy. May have been a delay in resuscitation – plan for paediatrician to attend **all** assisted births

6 MIDWIFERY CONTUNITY OF CARE

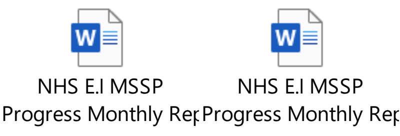
We have no midwifery continuity of care teams at present. Due to increased midwifery vacancies out plans to implement this model is paused. This is in recommendation from NHSE. There are no plans to implement MCoC teams at present however it is recognised then when staffing significantly improves consideration will be given to reviewing a team for our BAME population.

7 MATERNITY SUPPORT IMPROVEMENT PROGRAMME (NHSE)

Formal support from the NHSE programme continues. Work remains ongoing with the Maternity Improvement Advisor. Attached are monthly reports.

The Maternity Improvement plan is being refined within the division to ensure that fits with the improving together framework and aligns with the Trust and divisional strategies.

There is a planned 'away 'day, with key members of the team , to review and refine the plan on 28/02/23.



7.1 Maternity Improvement Plan (MIP)

Work remains ongoing to develop and launch the over arching Maternity Improvement Plan for SFT Maternity service. A maternity improvement group will be launched in quarter 4 to monitor progress against the identified actions and feed into the divisional governance process. The executive team will also have oversight of the MIP via the executive performance review monthly meeting.

8 OCKENDEN

We recognise that we remain non compliant with the initial 7 immediate and essential actions of the Ockenden report. We have an action plan in place to achieve compliance by the end of April 2023. We are working with the LMNS and aim to report back to the LMNS Board in February 2022 citing our compliance against the identified clinical priorities.

We need to complete several audits to evidence that previous work of implementing key actions is now embedded in practice.

Total Compliant	Twelve Clinical Prioirities											
	IEA 1: Enhanced Safety		IEA 2: Listening to Women and Families		IEA 3: Staff Training and Working Together			IEA 4: Managing Complex Pregnancy		IEA 5:Risk Assessment	IEA 6: Fetal Monitoring	IEA 7: Informed Consent
	1A	1B	2A	2B	3A	3B	3C	4A	4B	5	6	7
9 (75%)	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Partial

The embedded regional return shows SFT compliance in more detail.

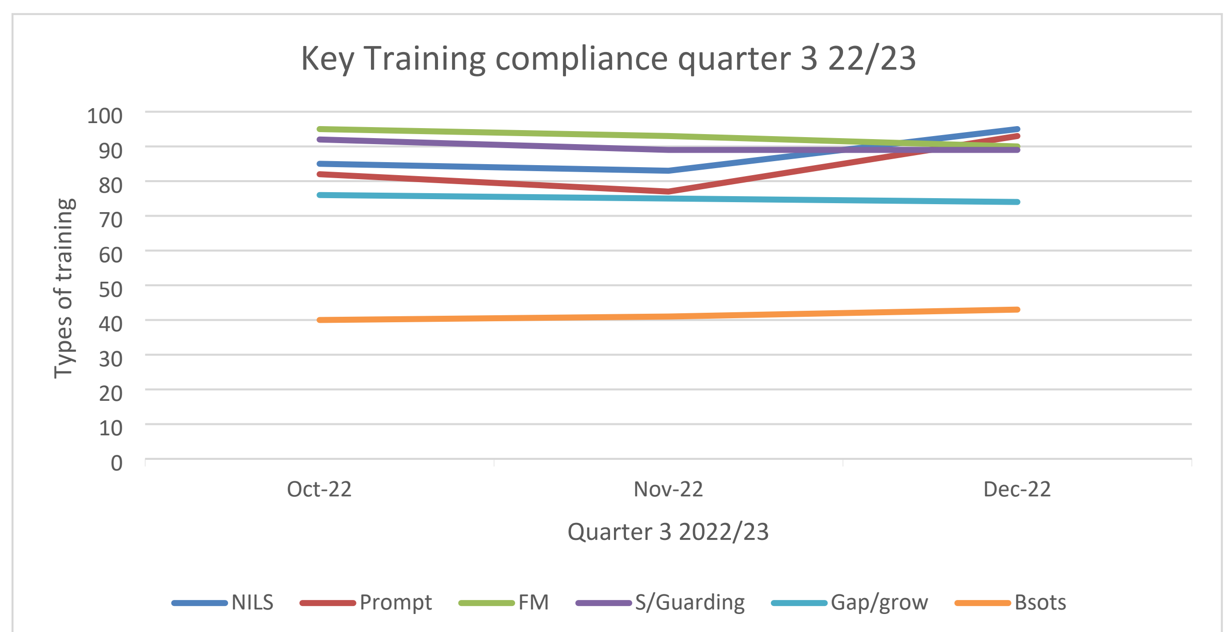
9 TRAINING /Safety Action 8 (MIS)

As part of the Maternity Incentive Scheme and the Core Competency framework, work has been on going to achieve compliance for all our staff groups to be compliant in key training. To support this training remains a driver for our Improving Together work. Here 6 key areas were identified. Using the methodology compliance has been achieved in 5 out of the 6 areas chosen by the division to include in the driver.

As part of our work with the Maternity Support Programme it was identified that SFT maternity did not have a current training needs Analysis. This has now been written and awaiting to go through the approval process in quarter 4. This details what training each staff group needs in accordance with the Core Competency framework and the Trust mandatory training.

9.1 Training data

Chart 4 Key Maternity training /aligning with Improving Together driver.



Within the MIS 3 key areas are identified to achieve compliance of over 90% in 3 areas:

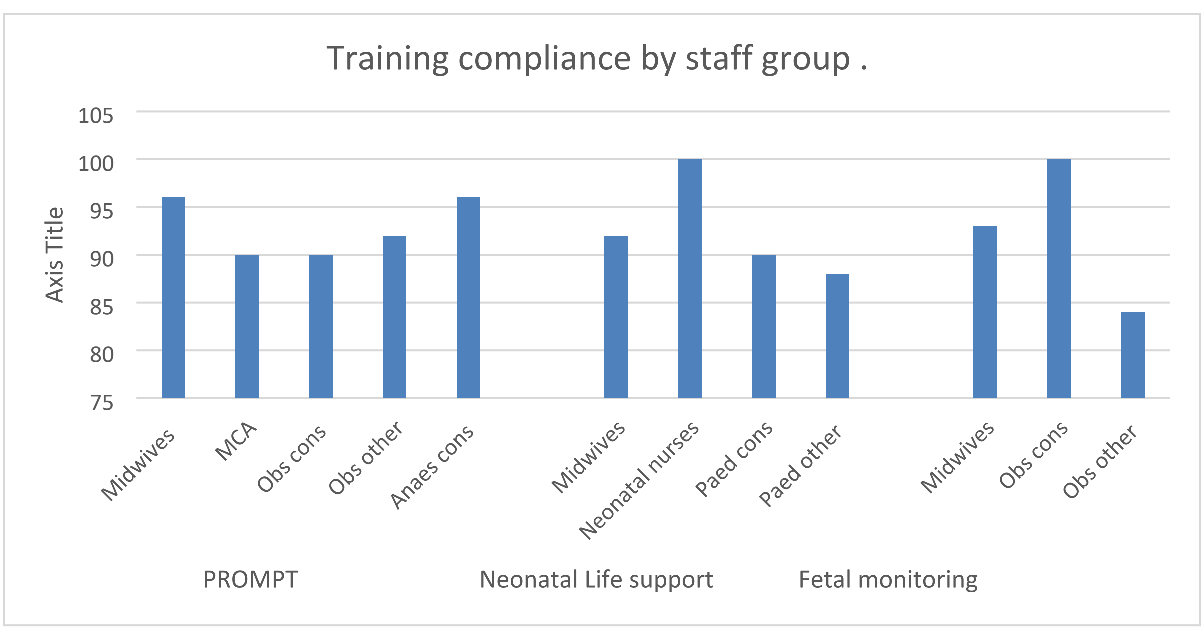
PROMPT – Multidisciplinary Obstetric Emergencies

New-born Life Support

Fetal Monitoring

In Maternity Incentive Scheme year 4 these data needed to be further stratified to be compliant with safety standard 8 group to include.

Chart 6 Key training by staff group (5.12.22)

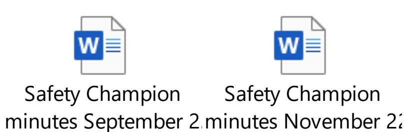


This chart shows full compliance with PROMPT. There is non compliance with Fetal monitoring with the non consultant doctors at 84%,which translates to 11 out of 13 people, There is non compliance with the New-born Life support where 8 out of 9 of the paediatricians (non consultants). This data is correct as of December 5th 2022 in compliance with the MIS standard where we have self declared as non -compliant.

10 SAFETY CHAMPIONS PRODUCTION BOARD MEETINGS/ Safety Action 9 (MIS)

In Quarter 3 bi monthly meetings for the Safety Champions continued in accordance with Safety action 9 of the Maternity Incentive Scheme.

Minutes can be accessed :



10.1 Board Safety champions Walkabouts were undertaken

- October 2022- Judy Dyos- Chief Nurse visited the post natal and labour ward
- November 2022 – Director of Finance Mark Ellis and Non Executive Director Michael Von Bertelli
- December – Judy Dyos Chief Nurse

Feedback and themes identified

- Dissatisfaction from maternity support workers for being a band 2 – Trust process addressing banding within the support workers
- Concerns regarding not enough midwives on labour ward- escalated at time and midwives pulled from training to support acuity
- Lack of second obstetric theatre- on risk register and escalated via trust execs meeting

11 SAVING BABIES LIVES version 2- Safety Action 6 (MIS)

The Trust continues to work towards full compliance with all elements within Saving Babies Lives Care Bundle Version 2 (SBLCBv2). This is a requirement detailed in Safety Action 6 of the Clinical Negligence Scheme for Trusts.

There are 5 elements to the Saving babies lives care bundle,(v 2).

Element 1: Reducing Smoking in Pregnancy

Element 2: Risk assessment and surveillance for fetal growth restriction

Element 3: Raising awareness for reduced fetal movements •

Element 4: Effective fetal monitoring during labour •

Element 5: Reducing pre-term birth The Trust is compliant with 3 elements.

In depth detail regarding the key standards within each element and compliance in detailed blow and form our submission for the maternity Incentive Scheme safety action 6. There are no audits for quarter 3 due to sickness.

Element one	RAG scoring	Narrative
A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded		Regular audits show compliance of over 70% on consecutive audit but action plans have not been robust.
B. Percentage of women where CO measurement at 36 weeks is recorded		Percentage over 90% on consecutive cases audit.
In addition, the Trust board should specifically confirm		1) Passed 2) Pathway in place

that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: · Percentage of women with a CO measurement ≥4ppm at booking. · Percentage of women with a CO measurement ≥4ppm at 36 weeks. · Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.		3) regular audits quarterly **but not including referrals and so we are unable to evidence this.** 4) quarterly audits include all three measures
Element two:	**RAG scoring**	**Narrative**

A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking and at 20 weeks. In addition the Trust board should specifically confirm that within their organisation: 1) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards. 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation. 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 4) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 5) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 6) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or		Risk assessment not done at 20 weeks as this is not a time for routine review along the patient pathway. Benchmarking with other Trusts reveals that alternative pathways agreed with other CCGs within clinical network. Action plan to be produced to address this. 1.offered from 28 weeks 2.UAD not offered, alternative pathway for assessment discussed with CCG. 3.quaterly audits completed 4. There has been auditing of PMRT cases where FGR was a relevant issue but the governance process ensuring that the review is discussed and a relevant action plan generated is not robust 5.Guideline on micro guide complies with NICE guidance. 6.regular audit of cases of babies born at term who are FGR takes place but once again governance processes are not robust. The next steps are to ensure discussion at appropriate governance meetings of themes and action plans.

scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems.		
Element three	**RAG scoring**	**Narrative**
A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy		100% compliance on regular audits
B. Percentage of women who attend with RFM who have a computerised CTG.		100% compliance on regular audits
Element four	**RAG scoring**	**Narrative**
A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. annual competency assessment		See SA 8
B. Percentage of staff who have successfully completed mandatory annual competency assessment		See SA 8
Element 5	**RAG scoring**	**Narrative**
A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.		Most recent audit shows 55% of women receive full course of steroids, action plan needed to achieve >80% which will then confirm compliance.
B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
C. Percentage of women who give birth in an appropriate		

care setting for gestation (in accordance with local ODN guidance).		

12 CARE QUALITY COMISSION

CQC Maternity Domain	Overall	Safe	Effective	Caring	Well-led	Responsive
Rating	Requires Improvement	Requires Improvement	Not inspected	Not inspected	Inadequate	Not inspected
Inspected 31 March 2021						

Following the above inspection regulatory notices were served to ensure standards were implemented they primarily focused on leadership and governance.

Two of the 'must do's', clinical deterioration and midwifery staffing are two of our drivers for Improving Together. There are some low level audits being implemented this quarter to ensure processes are embed in practice in relation to 3 of the 'should do' recommendations- mental health SOP; notes storage; WHO safety checklist.

13 CNST / MATENRITY INCENTIVE SCHEME YEAR 4

As off 5th December 2022 SFT will be self declaring that they are compliant with 5 out of the 10 safety action as defined in the Maternity Incentive Scheme year 4. This is following a deep dive by two Maternity Improvement Advisors.

	Criteria for Maternity CNST	RAG SCORING
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	

5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?	
7	Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through you maternity voices partnership (MVP) to co-produce local maternity services?.	
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS year 4?	
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety	
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	

The submission will be taken to Board in January 2023 and the submission will be sent to NHS Resolution by 2nd February 2023 once reviewed and signed by the board and the Senior Responsible Officer for the Local Maternity and Neonatal System.

14 MIDWIFERY STAFFING / Safety action 5 (MIS)

Six monthly staffing review paper will be submitted to clinical governance committee as per Maternity Incentive Scheme Safety Action 5 in Quarter 4 2022/23. Midwifery Vacancies are monitored monthly through the monthly IPR. Staff vacancies across the division remain one of our drivers for improving together where midwifery staffing remain the biggest challenge-countermeasures are monitored weekly through our driver meetings .

Safety metrics are reviewed monthly through the safety assurance dashboard at the Individual Performance Review shown below providing evidence that whilst midwifery staffing remains a challenge.

Chart 7 Midwifery staffing safety measures

Measure	Aim	Oct 22	Nov 22	Dec 22
Midwife to Birth Ratio	1:28	1:33	1:29	1:31
Supernumerary labour ward coordinator status	100%	100%	100%	100%
1.1. care in labour	100%	100%	100%	100%

Active available workforce is a driver for our divisional Improving Together works team where midwifery vacancy remains the biggest challenge. Whilst midwifery vacancy remains unchanged initiatives have been employed to maintain a safe service

- robust escalation plan
- Registered General Nurse employed in clinical areas
- Over recruitment of maternity care assistants
- Engaged in collaboration to recruit International Midwives- we have 3 within the service
- Agency midwives
- Incentivised shift payments
- Recruitment campaign to include consideration of incentivised payment once in post
- Relocation package promoted
- Flexible working party to review current offers
- RGN to RM 'conversion' course- two places allocated
- Return to Midwifery placement
- Workforce planning with the BSW Academy

15 SAFEGUARDING

15.1 TRAINING

- Compliance for Level 3 safeguarding for midwives is 96%. The obstetric Team compliance is 26%. An email was sent to all obstetric staff who are non-compliant advising them to book onto the L3 training and the safeguarding lead midwife is offering in-house modules across the three years of full training.

15.2 SUPERVISION

- Safeguarding supervision for community midwives (CMW) is100%.
- Safeguarding supervision sessions for unit midwives are 3 x per year and remain on Teams, although mandatory study days and ad hoc sessions are done face to face. There is still Q4 for midwives to achieve compliance.
- 34 sessions have been facilitated = 50%. Attendance has been low his quarter due to a shortage of staff, sickness and high acuity. This has meant that it has been hard for midwives to attend when working, and they are reluctant to attend on their day off as they are exhausted and understandably are reluctant to work additional hours. This will hopefully improve in the next quarter as midwives have been emailed re how many

sessions they have/have not attended. Weekly S/G sessions arranged have been emailed out to all midwives as well as the multi departmental supervision dates.

15.3 SAFEGUARDING PLANS

- Currently there are 11 child protection plans in place, 3 child in need plane. CP plans = 11.
- Single assessments currently in progress is 14. With 3 of these for women under 18years of age.
- 17 MASH requests for information were sent These are sent by the CMW's if a woman has disclosed a history of police or social care involvement and the CMW needs to check that this is correct information. This is a good example of communication with our colleagues in MASH.
- 11 DPM. 7 babies went home with their mother. 1 mum and baby went to a foster placement 1 baby went to a parent and baby foster placement and 2 babies were removed from their mother.
- The HOPE Box project was launched in November 22. HOPE stands for *Hold On Pain Eases* and aims to help to alleviate the trauma that parents experience when they are separated from their baby soon after birth due to a court decision. The boxes were co-developed with a group of women with lived experience of separation at birth. 'The HOPE Mums' aim to allow families to capture important memories before they are separated and aim to promote a continued connection between them and their baby post-separation while the courts consider longer-term plans for the child.1 mother received the HOPE boxes,
- The reason the mother did not receive the HOPE boxes was because the parents were expected to go to a parent and baby foster placement. When they attended court, the judge made the decision for removal. The parents did not come back to the hospital.

16 ADVOCATING FOR EDUCATION AND QUALITY IMPROVEMENT (A-EQUIP) AND PROFESSIONAL MIDWIFERY ADVOCACY

Professional Midwifery Advocates (PMAs) work within the A-EQUIP model to work with women in three ways:

• Supporting midwives to advocate for women

• Providing direct support for women within a restorative approach and

• Undertaking quality improvement in collaboration with women

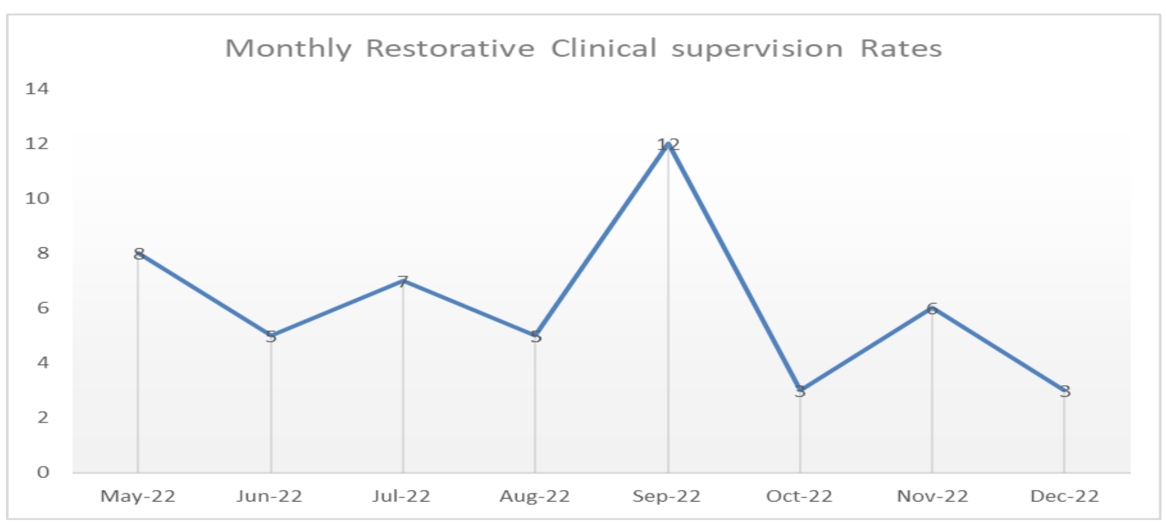
At SFT we received funding from NHSE and have a bespoke joint role of Lead PMA and retention Midwife utilising the A-EQUIP model to provide midwifery report via restorative supervisors and, in turn, this supports retention of midwives

The NHSEI Unit Based Midwifery Retention support programme was developed to support retention within Midwifery in response to increasing leaver rates nationally. The programme aims to support improving the experience and retention of midwives within the NHS and to reduce turnover between providers, recognising that it is time consuming, expensive, and challenging for trusts to recruit when staff leave. Supporting midwifery retention through job satisfaction and job fulfilment can support midwives to stay and thrive. The programme supports the commitment to increase the number of midwives nationally. A key part of this is retaining midwives and existing learners.

16.1 PMA Update

- As a new retention initiative, RCS is now offered to all Midwives at times of their working life when challenge is high, and they may benefit from additional support. All Midwives returning to work after long term (>4 weeks) sick leave and maternity leave and all new starters to the trust are contacted and offered RCS on a 1:1 basis with a PMA.
- Secure data is kept on the number of RCS sessions taking place, and themes are collected (whilst ensuring confidentiality is maintained). If any themes emerge from RCS, they are fed up to the Director of Maternity.
- Work is ongoing to encourage Midwives to engage with the PMA service. Data collected does evidence that this is starting to work, with improvement seen in the number of Midwives who approach the PMA service (rather than the PMA approaching them).
- Currently, with no other active PMA's the service is vulnerable and RCS rates will be dependent on when the lead PMA has AL or is redeployed from the role to support clinical areas.

Chart 8 rates of restorative supervision within maternity for midwives



- RCS sessions were carried out in Q3. 2 of these were Midwives returning to work after long term sickness, 1 was on return to work after Maternity leave, 1 was on preceptee programme and the other 8 were Midwives who had a work related issue they needed support with.
- A further 2 midwives have commenced their PMA training in Dec/Jan. Currently, there are 4 qualified PMA's (in addition to the Lead PMA) in the trust however none of them currently have protected time to undertake their PMA role and so are not practicing.
- PNA/PMA collaborative working –
  The Lead PMA has written a 'PMA/PNA plan to deliver the a-equip model at Salisbury NHS Trust'. This is currently sitting with deputy Director of Nursing for ratification. This joint plan will form the basis of collaborative working between the PMA's and the wider trust so that each service can benefit from the experiences of the other.
  There is a plan to deliver joint monthly meetings and training sessions with the PNA's and going forward regular supervision from the psychology department has been agreed for both PNA's and PMAs to ensure their wellbeing.

16.2 Retention Update

The retention improvement plan has been written following advice and guidance from regional networks. There are work streams within it which will also contribute to other programmes (such as Improving together) and the Retention lead is working collaboratively with Dom and Deputy Dom to ensure work is focused, shared where appropriate and that work streams do not double up.

16.3 Other Retention/Wellbeing Interventions

- A Women and New-born wellbeing event was held on 7th December 2022 around the Menopause. There was an educational talk, as well as a question-and-answer session and the opportunity for group support. This was well attended by 17 members of staff.
- Work is continuing a Behaviour Charter for Maternity and neonatal, with this work aiming to be completed by End February 2023.
- Lead PMA/Retention lead has completed wellbeing conversation training with the intention of rolling this training out to other line managers within maternity. Data on number of wellbeing conversations held being shared with OD & P.
- Coaching has been offered and taken up by 6 aspiring/new leaders within maternity. Engaging with a coaching programme not only benefits the individual and their development but can also help them feel valued by their team and can promote the coaching philosophy which is now recognised as vital within leadership.
- Regular supervision has been established for non-clinical roles within Maternity who are most at risk of vicarious trauma and burnout.
- Lead PMA has completed TRiM (Trauma Risk Management) training and undertaken first TRiM assessment.

- Preceptorship intense support package has been designed and implemented to include quarterly 1:1's with PMA and Mental Health at work awareness teaching being included on Preceptee's study days,
- Enhanced support offered to International Midwives via RCS (Restorative Clinical Supervision)

17 AVOIDING TERM ADMISSIONS INTO NEONATAL UNIT (ATAIN) AND TRANSITIONAL CARE / Safety action 3.

Avoiding term admission into neonatal units forms part of the national maternity transformation agenda with the recommendation to keep mums and babies together as much as possible. Transitional care ideally is where the neonate is kept with the mum , ideally on a post natal ward , and receive extra care at the bedside delivered by the neonatal team

Data in the charts below from the requirement for safety action 3 as part of the maternity incentive scheme.

Chart 9 Term admission into the neonatal unit – diagnoses.

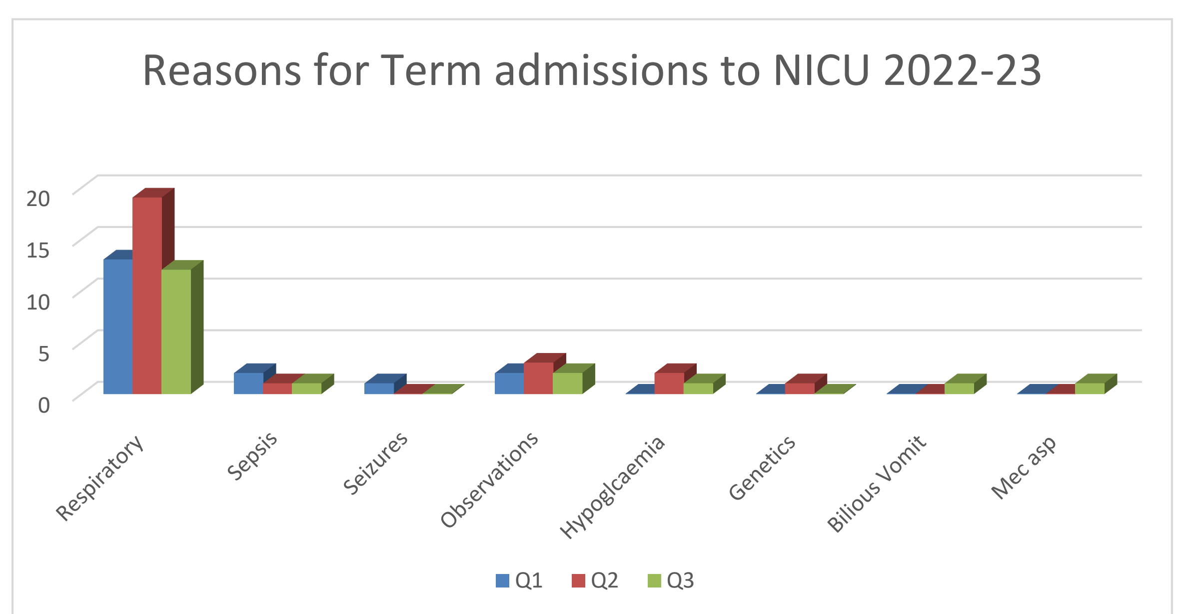


Chart 10 Term babies – reasons for NG feeding

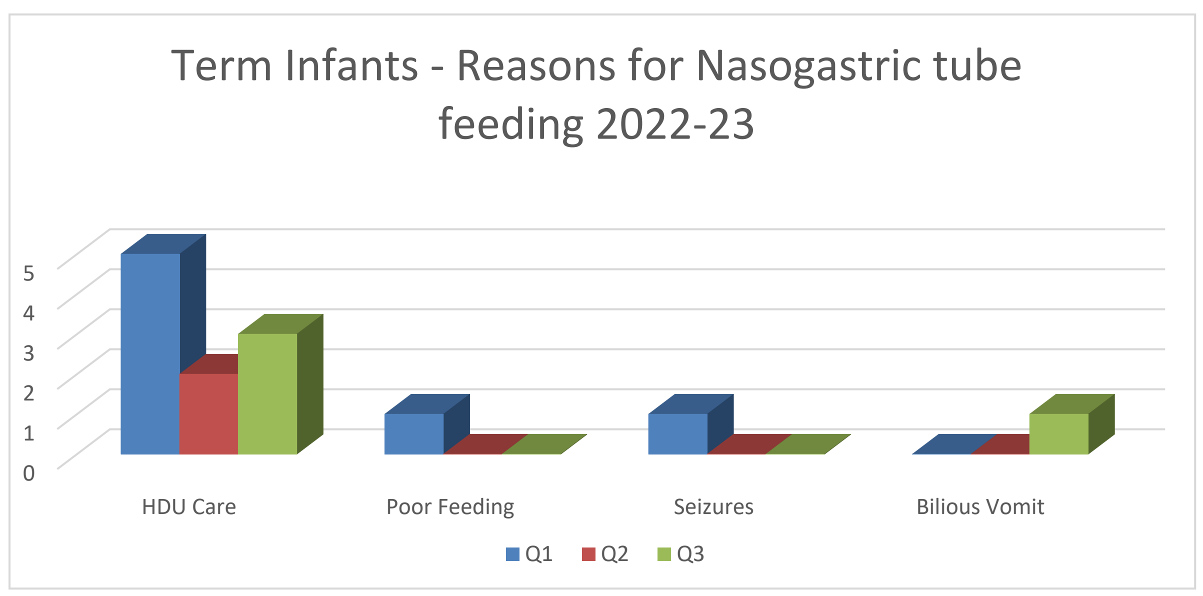


Chart 11 Numbers of TC babies on ward , with mum

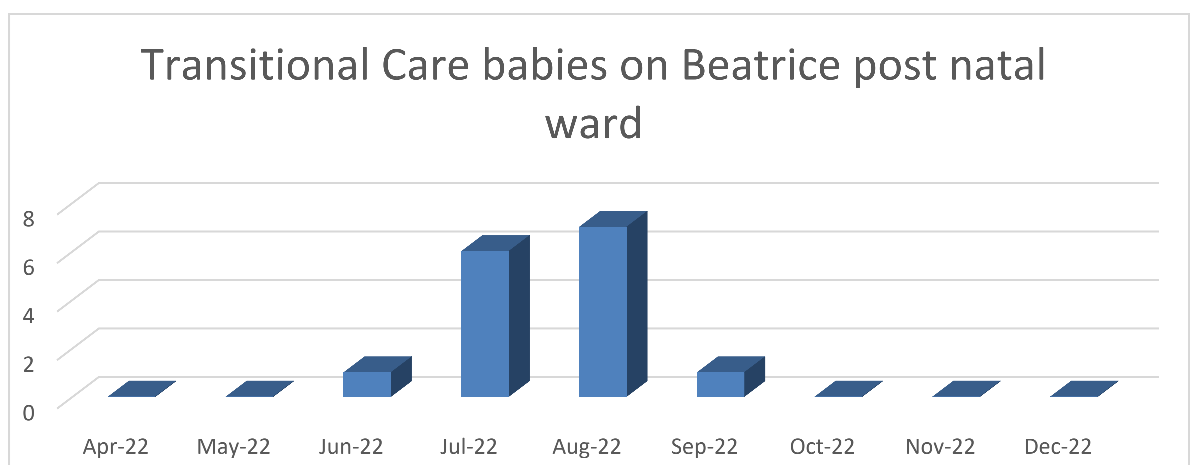


Chart 12 Days spent in TC pathway

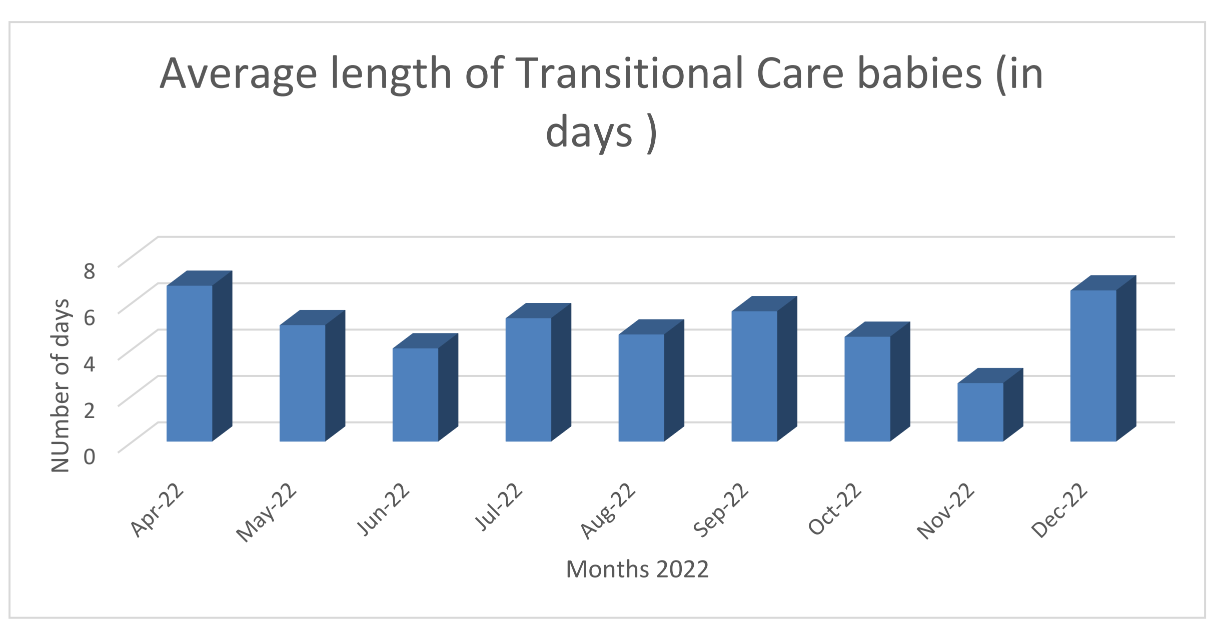
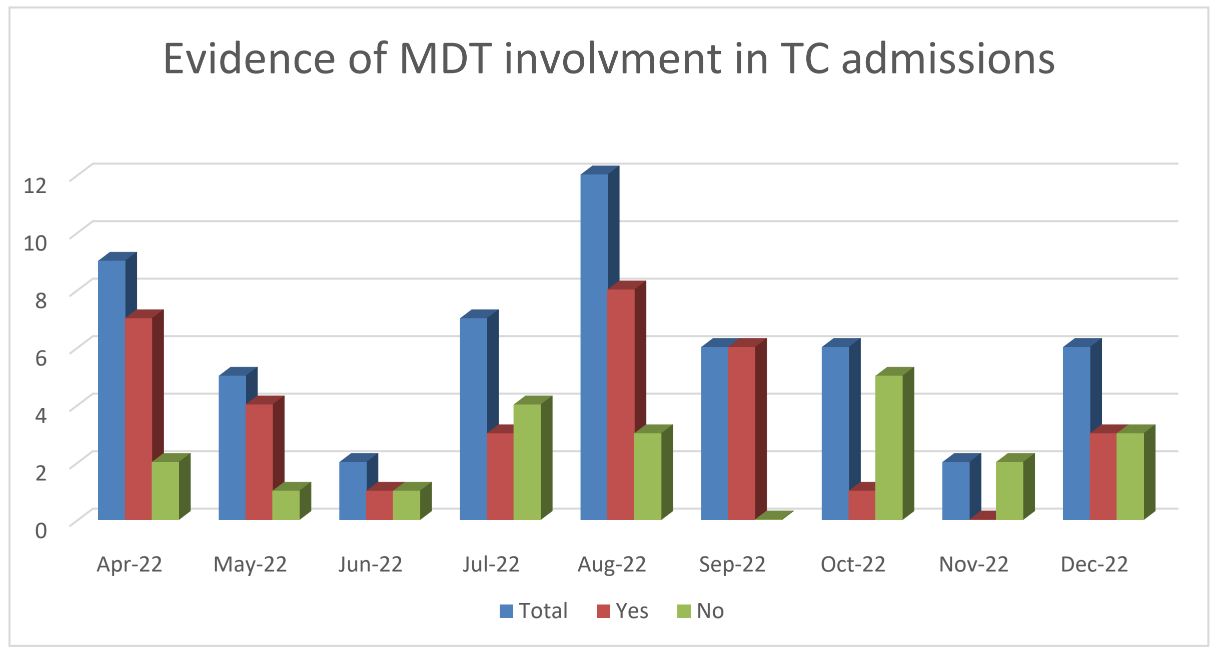


Chart 13 Evidence of MDT involvement



All term babies that are required to spend time in the neonatal unit have a formal MDT review to identify whether they could have been a TC baby and remained on the ward and to learn any lessons to prevent admission in the future . An ATAIN action plan in seen in appendix 2.

The ODN ambition is to have less than 6% of term babies admitted to the neonatal unit which we achieve .

Chart 14 Percentage of ATAIN admissions over last 3 quarters.

South West Region							National							
Measure	**Min**	**Median**	**Max**	**Improve direction**	**RED**	**GREEN**	**Mar-21**	**Oct-22**	**Nov-22**	**Dec-22**	**Q1 Total**	**Q2 Total**	**Q3 Total**	**Year To Date**
Babies (incl Non Reg)	170	186	206	Up				181	170		**549**	**588**	**351**	**1488**
Term babies admitted to NNU unexpectedly %	1.7%	3.8%	5.3%	Down	5.8%	5.5%	<5.8% NMPA	4.4%	3.1%		**2.7%**	**4.4%**	**3.7%**	**3.6%**

18 SCREENING SERVICES

Following on from our quality assurance visit in September 22 an action plan has been issued to SFT in November 22 , to be implemented over the next year .

A weekly working party has been commenced to review and close the recommended actions from the QA team .

A band 7 screening coordinator has been recruited to. Until then there has been on site support for one day a week from the screening midwives at Southampton University Hospital.

A business case is being worked up to reflect the structure that is needed to deliver the 6 screening programmes that we are commissioned to deliver.

The QA report from the visit and subsequent action plan can be accessed here.

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19 RISK REGISTER

Number	Title	Rating
7172	Depleted screening team and increasing SIAFs causing a safety concern to women and non compliance with the national screening KPIs	15
5173	shortage of midwives which may pose a risk to deliver safe care throughout the maternity care pathway	10
7221	There is a risk of cases with harm not being escalated due to the large number of Datix	10
7409	Building works blocks 79 & 81 disrupting gynaecology and obstetrics	9
7188	Maternity and neonatal guidelines	9
7185	There is a risk to patient safety because the anaesthetic room equipment for 2nd case not fit for purpose	9

There have been two maternity risks submitted for Quarter 3 2022/23 – these are waiting for approval

- Maternity quality and safety team depleted due to sickness / 12
- Ability to screen for diabetes in pregnancy / 15

20 DIGITIAL TRANSFORMATION

The maternity service has recruited to the digital midwifery post to enable us to deliver on the digital agenda. She is engaged with the digital across the Trust and the Local Maternity and Neonatal System.

Work is ongoing, with the other digital midwives in the acute Trusts, to align processes o deliver a joint digital roadmap best suited to our staff and service users.

SFT are currently going through a procurement process to move to a new standalone maternity system which will capture a woman's care end-to-end, beginning from self-referral through to discharge to the health visitor, also giving woman 24/7 access to their notes. This will also see the department becoming paper light/free in the coming months. The digital midwife will recruit superusers, and a working party to help me capture and understand the service and ensure we keep the amazing philosophy of care that woman and their families receive. The digital mdiwfe will work closely with the rest of the trust, keeping up to date with all digital projects to ensure that maternity is not working in silo as we very often can find ourselves, to improve networking and more linked up care for our families

21 BEATRICE BIRTHING UNIT

This alongside midwifery unit was opened in Quarter 3 2022/23 on October 31st 2022.

During the initial 3 months of opening there have been 21 women who have met the criteria and chosen to birth their baby in the Birth Centre.

The criteria for birth in the alongside unit can be accessed here

https://viewer.microguide.global/guide/1000000303#content,96e071af-86c7-4c0a-9e65-76d9e11f81c5

Of those 21 women,16 women birthed their baby in the Birth Centre. Of those 16, 9 women had their baby in the pool.

5 women transferred their care during their labour to the obstetric led labour ward

Further details on pain relief and transfer can be seen in the infographics on page 24 – ongoing audit will continue to ensure a safe service and to identify any learning – infographics will be shown on our social media pages for staff and service users to view.

Women and family feedback

During the immediate postnatal period, whilst still on the Birth Centre every women is consented to have a phone call 4-6 weeks postpartum to enable feedback about their experience on the Beatrice Birth Centre. To date there have been no negative comments, other than at the beginning some midwives weren't familiar with the area and took a while finding some items of equipment all users were very understanding and appreciate that it was a new clinical environment.

Other comments included

- Welcoming
- Amazing midwives
- Calm and kind midwife
- More homely than in hospital
- Calm environment
- Partner comfy
- Lighting good and relaxing
- Can't fault it
- Staff really helpful
- Glad to have the chance to start labour in the Birth Centre
- Amazing
- Given all the care and attention as midwife wasn't distracted by other buzzers or noise
- Very positive experience

BEATRICE BIRTH CENTRE

DATA FROM THE PERIOD OF 31ST OCT 2022 - 31ST JAN 2023

WITHIN THIS PERIOD **21** WOMEN USED THE BIRTH CENTRE

FROM THESE 21 WOMEN…

16 DELIVERED IN THE BIRTH CENTRE

9 DELIVERED IN THE BIRTHING POOL

5 TRANSFERRED DURING LABOUR

"Lovely calm environment, used the pool, partner comfy, lighting good and relaxing"

Reason for transfer

2
1.5
1
0.5
0
Prolonged 2nd Stage
Prolonged 1st Stage
Further pain relief

Pain relief received

NIL
2
Entonox
13
Water
9

"Was transferred to BLW but this was done smoothly, easily, and comfortably"

Post birth transfer

Labour Ward
0
Home
5
Postnatal
11

Perineum

Intact
2nd degree tear
0 2.5 5 7.5 10

Blood loss

>500
7.1%
401-500
7.1%
101-200
21.4%
301-400
21.4%
201-300
42.9%

3rd Stage of Labour

20
15
10
5
0
Physiological
Active
MROP

"Lovely nurses and midwives. Lovely experience, more homely than hospital rooms. "

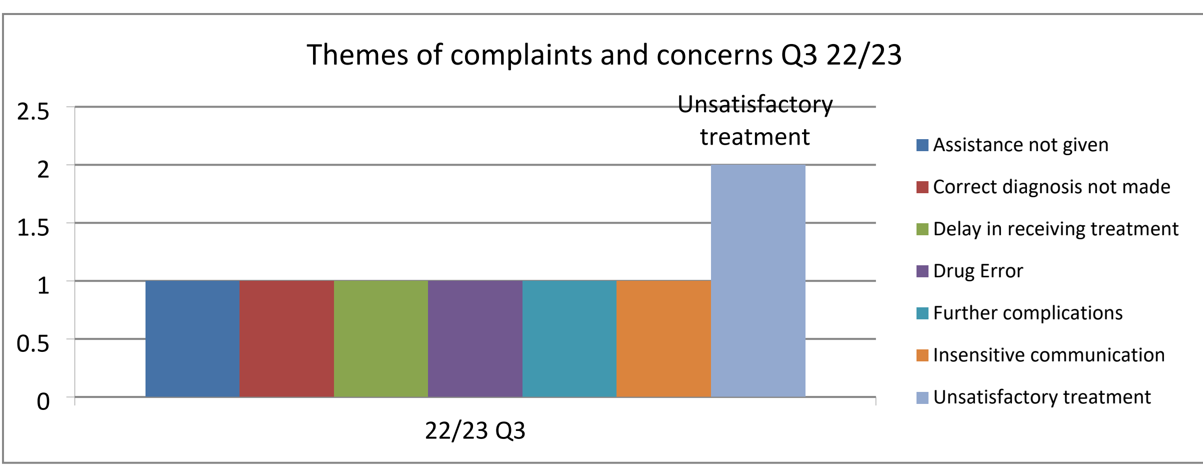
AVERAGE TIME IN BIRTHING CENTRE FROM ADMISSION TO BIRTH

153

MINUTES

22 FAMILY EXPERIENCE

22.1 Themes of complaints and concerns.



22.2 Details of complaints and concerns reported in Q3.

Location	First	Closed	Description	Outcome	Sub-subject (primary)
Postnatal	03/10/2022	03/11/2022	Poor postnatal care and feels her blood pressure and medication was not taken	Service manager has spoken to patient and resolved issues	Drug Error
Antenatal Clinic	11/10/2022	18/11/2022	Need appropriate staff dealing with sensitive information & provide accurate and up to date information on your website and throughout appointments.	Apologies given and patient will be followed up with a patient story.	Insensitive communication
Labour ward	15/12/2022	23/01/2023	Extremely traumatic experience as was not listened to and was refused an epidural.	Meeting to resolve concerns.	Delay in receiving treatment
Postnatal	12/10/2022	16/11/2022	Lack of care and support following birth of baby.	Apologies were offered and assurances were given that this has been escalated to the Inpatient Matron. Declined a patient story although permission was given for me to use her feedback (anonymously) for	Assistance not given
Antenatal Clinic	05/10/2022	04/11/2022	Feels that the service offered to women who have suffered an early fetal loss is unsatisfactory, fragmented and	Debrief booked in and arrangements made for required tests to be undertaken prior to the	Unsatisfactory treatment
Labour ward	16/11/2022	22/12/2022	Mixed communication on whether baby has down syndrome and checks not done when baby was born.	Patient mother happy with outcome of appointment earlier this month and there are no concerns regarding	Correct diagnosis not made
Labour ward	29/11/2022		1) I do not wish another set of parents to have to experience what we did. 2) I would like to contribute to the future training of staff involvement with miscarriage to improve their emotional intelligence vocabulary and the experience patients get so they can focus on loving, meeting and saying goodbye to their baby.	Ongoing	Unsatisfactory treatment
Labour ward	20/12/2022	19/01/2023	Patient was traumatised after birth and her needs were not respected.	Meeting to discuss complaint and happy with explanation and ongoing	Further complications

22.3 Actions from Complaints:

MATERNITY QUALITY ANS SAFETY REPORT
Quarter 3 2022/23
Author: J Cowan , Director of Maternity and Neonatal Services.

Action taken	Deadline	Current progress made	Date Completed	RAG Rating
As a result of our investigation into the complaint learning from your case will be shared with alit the doctors in the department at our next teaching day	Mar-23	Consultant Obstetrician		Amber
Bleeding in early pregnancy pathway shared with the community teams.	Jan-23	Out patient manager	Jan-23	Green
Pt was seen by Consultant Paed- reassurance and apology offered. Pt has planned follow up appt.	Dec-22	Paediatric consultant	22/12/2022	Green
To discuss the feedback from the resolution meeting with the staff member.	Dec-22	Family Experience Midwife	Dec-22	Green
To liaise with the Day Assessment Unit (DAU) lead , to ensure measures are in place to make certain that women who decline a ECV have a follow up appointment.	Jan-23	Family Experience midwife	Jan-23	Green
Reminder to all staff of the important of ensuring that a feeding assessment is carried out for all women prior to their discharge form the postnatal ward.	Nov-22	Family Experience midwife	Nov-22	Green
Appointment of a dedicated diabetic specialist midwife, who will be a point of contact to women and their families.	No fixed dat	In patient Matron		Amber
Newly appointed Postnatal/ Antenatal lead, who will be largely undertaking clinical duties and be instrumental in embedding the Trust's values and behaviours within the team.	Jan-23		Jan-23	Green
Education programme to include the importance of compassionate communication. Consideration will be given to extending this training to the ward clerks.	Mar-23	Family Experience Midwife		Amber
Introduction of a new theatre trolley which is appropriately sized to enable the smooth transfer of women from recovery to the NNU, in order for the mothers to be repatriated with their babies.	Dec 22/Jan 2	NNU Manager	Dec22/Jan 23	Green
Newly appointed Antenatal Clinic Lead will support the Diabetic Specialist Midwife.	Mar-23	Outpatient Matron		Amber
The Ultrasound Department intends to discuss the concern at their next team meeting, in order to establish any learning from the case.	Jan-23	Lead Sonographer	03/01/2023	Green
The consultant anaesthetist will discuss the case at an anaesthetic department meeting with the anaesthetist involved, for personal refection	Feb-23	Consultant lead for Anaesthetics		Amber
Education to be offered to midwifery staff on the importance of observing that the epidural catheter is secure.	Dec 23	Consultant lead for Anaesthetics	28/12/2022	Green
Patient experience survey to be undertaken on DAU	Nov-22	DAU lead and Family experience Midwife	Oct-22	Green
Facilities in place to support partners on the postnatal ward, over night.	Dec-22	In patient Matron		Over due
The subject of 'compassionate communication' will be circulated to staff, as an opportunity for reflection and learning, for future discussion.	Dec-23	Family Experience Midwife	ongoing	Green
As a result of our investigation into your complaint we have spoken to the doctor involved and learning from your whole case will be shared with all the doctors in the department at our next teaching day.	Mar-23	Consultant Lead		Amber
reminder to be sent to the Community teams RE management of bleeding in early pregnancy	09/01/2023	Out patient Matron		Amber

22.4 Compliance with target times:

Metric	Oct-22	Nov-22	Dec-22
Quality: % of Complaints Closed within Agreed Timescale	No closures	66.6%	0%
Quality: % of Concerns Closed within Agreed Timescale	No closures	40%	No closures

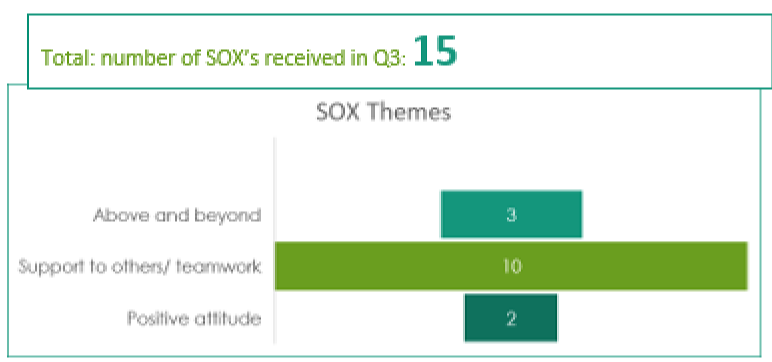
22.5 Local Patient experience surveys:

Please see appendices for neonatal; bereavement and day assessment surveys.

22.6 Compliment and SOX

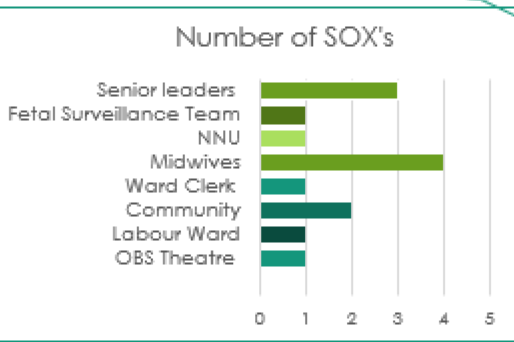
Total: number of SOX's received in Q3: **15**

Month	No. SOX
October	5
November	7
December	3



"Excellent management of a massive haemorrhage. Mature and calm team working with effective and timely interventions. The team worked together like a model simulation run. Well done all and thank you for your care of this patient."

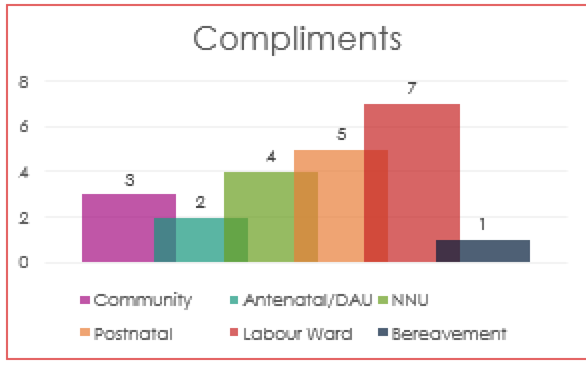
"X Stepped up to support the whole service and coordinate labour ward when there were no coordinators available. X hadn't done this role for a while, however, support her colleagues and ensured that our women continued to receive high quality and safe care alongside providing leadership for the midwives and doctors."



"X gave up her Christmas evening and night to cover the Labour Ward Lead who was sick. She did this despite already working Christmas eve with short notice"

Total: number of compliments received in Quarter 3: **21**

Month	No. compliment
October	9
November	5
December	8



"To the whole fab maternity team. Thank you for making my traineeship so enjoyable! I have thoroughly enjoyed learning from all of you! Thank you for the friendship and support on my less good days! You are all amazing I will miss the team in Salisbury"

"To the lovely people in Maternity- all of you- cleaning to nursing to caretaking and everything in between. Thank you for all that you do for out little ones and their parents. We are forever grateful for your kindness"

"To the lovely ladies within maternity. Thank you for taking such good care of us. For listening when I needed to share my crazy birth story. For the advice, the constant checks and reassurance, and the privacy when needed! Such a lovely caring feeling here at Salisbury and has totally started my journey with xx so well Thank you!"

23 QUALITY AND SAFETY NEWSLETTER

Newsletter January 2023.docx

24 RECOMMENDATION

The Committee of the Clinical Governance Committee is asked to receive and discuss the content of the report

MATERNITY QUALITY ANS SAFETY REPORT
Quarter 3 2022/23
Author: J Cowan , Director of Maternity and Neonatal Services.

APPENDIX 1: CLINICAL DASHBOARD

South West Region							National									FY 2020-21	FY 2021-22
Measure	**Min**	**Median**	**Max**	**Improve direction**	**RED**	**GREEN**	**Mar-21**	**Oct-22**	**Nov-22**	**Dec-22**	**Q1 Total**	**Q2 Total**	**Q3 Total**	**Q4 Total**	**Year To Date**		
Babies (incl Non Reg)	170	186	206	Up				181	170		**549**	**588**	**351**	**0**	**1488**	**2161**	**2212**
Women Delivered	168	182	204	Up				179	168		**539**	**577**	**347**	**0**	**1463**	**2136**	**2197**
Homebirth rate	1.6%	3.1%	4.8%	Up				2.8%	2.4%		**3.8%**	**2.4%**	**2.6%**		**3.0%**	**4.8%**	**3.6%**
Inductions %	36.4 %	39.9%	43.4 %	Down				36.9%	37.5%		**41.0%**	**40.7%**	**37.2%**		**40.0 %**	**35.1 %**	**37.4 %**
Instrumental deliveries %	8.4%	12.4%	14.1 %	Down	12.5 %	12.0%	12.5% NMPA	9.4%	11.2%		**11.3%**	**13.4%**	**10.3%**		**11.9 %**	**12.0 %**	**12.4 %**
Apgar less than 7 @ 5 min %				Down	3.5%	1.2%	Green <1.2%, red >3.5% NMPA	2.2%	1.2%		**1.7%**	**0.5%**	**1.7%**		**1.2%**	**1.0%**	**0.5%**
PPH >= 1, 500 mls	2.7%	3.7%	4.9%	Down	5.6%	2.7%	Green <2.7%, red >5.6% NMPA	3.9%	3.6%		**3.7%**	**3.8%**	**3.7%**		**3.8%**	**3.5%**	**3.4%**
Total 3 + 4 degree tears	0.7%	2.3%	4.4%	Down	6.5%	3.5%	green <3.5%, red >6.5% NMPA	4.4%	3.5%		**2.8%**	**1.0%**	**4.0%**		**2.4%**		**2.4%**

NOTE – it is recognised that the RAFG rating for Apgar’s have not been changed in recognition of the change in standard. However a new dashboard has been developed (power BI) and will be used moving forward in the division.

APPENDIX 2: ATAIN ACTION PLAN

Agenda Item	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
Changes to recording families 'reunited' and introduction of stickers for this	Stickers finalised and now on NICU, LW & PNW	GD/TH	31/01/23	Stickers available	Y	3
Recording Infants in ATAIN that attend NICU for observation but do not get admitted	GD informed Neonatal team to store infant notes in ATAIN box and GD will add to spreadsheet each month.	GD/NICU staff	31/01/23	This is now being recorded and reviewed in ATAIN meetings	Y	3
Theatre Trolley provided to be able to get post section mums into NICU room. Ward beds don't fit	Trolly now on LW education team to continue with training of staff	GD/BR	07/03/23	Teaching of full staff body to embed in practice	N	2
Pre & Post ductal saturations taken with all NIPE	DR SO continues training of MW's & Nurses for launch date in Feb.	DR SO	Mar-23	Pathways complete for each area and up for display launch date 06/02/23	N	2
Maternity Golden hour to be relaunched	BR to relaunch maternity golden hour this month	BR	07/03/2023	LW teaching	N	2
Obstetric admin time required for ATAIN	BR has spoken with JS and she has agreed to add this work into her role	BR/JS	Mar-23	We now have agreement on this time	N	2

Positive feedback to MW team around consistent good management of hypoglycaemia infants	AR to feed this back from risk team but has been fed back vis perinatal meeting	AR/MP	Jan-23	ATAIN learning to filter into perinatal meeting	Y	**3**
Kiser scoring not always printed out and in notes	BR reported that MW's cannot always print due to ongoing trust level printing issues. BR reported that they often write this in on the PN notes if they cant print.	BR/CL	Mar-23	BR to meet with CL to escalate and improve printing situation for MW team	N	**2**
	MW's to complete Datix when term admission to NICU	AR/CA	31/01/2023	AR reported that this is happening but will re email to ensure all are aware	Y	**3**
	Better obstetric consultant buy in to the ATAIN meeting	Obs consultants	07/03/2023	GD & BR to discuss with AK, lots of change with LW lead so inconsistency with meetings etc.	N	**2**
	March Meeting on the day of Nursing strike so to rearrange March date	GD/JB	Mar-23	GD to arrange best date with JB	N	**2**

APPENDIX 3:SFT PERINATA LSURVEILLANCE DASHBOARD

	SFT Assurance Dashboard	Guidance	Standard	RAG Target 2021-22 Q4	RAG rating: Red	RAG rating: Green	Improvement Direction	Rolling 6 months: Oct-22	Rolling 6 months: Nov-22	Rolling 6 months: Dec-22	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			NA	>= 2	= 0	Down	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP) per 1,000 Live (reg) Births	ONS	3.8 per 1000 live births	NA	>= 3.9	<= 3.7	Down	0.0	0.0	0.0	0
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	NA	>= 2.8	<= 2.6	Down	0.0	0.0	0.0	0
	Medical termination over 24 +0 registered			NA	NA	NA	Down	0	0	0	0
Maternal M&M	Number of Maternal Deaths per 100,000 Maternal Deaths	ONS	9.1 per 100,000 women who delivered	NA	>= 9.2	<= 9	Down	0.0	0.0	0.0	0
	Number of women requiring admission to ITU	6 month SFT rolling		NA	>= 2	= 0	Down	0	0	0	0
Insight	Number or Datix incidents - moderate or above	6 month SFT rolling		1	>= 2	= 0	Down	1	2	1	2
	Datix incidents moderate harm (not SII)	6 month SFT rolling		1	>= 2	= 0	Down	1	2	0	2
	Datix incidence SII	6 month SFT rolling		0	>= 1	= 0	Down	0	0	1	0
	HSIB referrals	6 month SFT rolling		0	>= 1	= 0	Down	0	0	1	1
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		0	>= 1	= 0	Down	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		0	>= 1	= 0	Down	0	0	0	0
Work force	Minimum safe staffing in maternity services :Obstetric cover	RCOG guidance		40	<= 39	>= 40	Up	40	40	40	40

	Midwife to Birth ratio	RCM;NHSR;BR +	1.28	1.32	>= 1.33	<= 1.32	Down	1.33	1.29	1.31	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			NA	>= 1	NA	Down	18.84	18.84	19.96	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	100	<= 94	>= 100	Up	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		NA	>= 2	= 0	Down	1	0	1	1
	Compliance with supernumerary status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	100	<= 94	>= 100	Up	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		NA	>= 2	= 0	Down	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		22	NA	>= 22	Up	10	26	10	22
	Service user feedback : Number of Complaints	6 month SFT rolling		1	>= 2	<= 1	Down	1	2	2	2
	Number of SOX	6 month SFT rolling		6	NA	>= 6	Up	4	7	3	4
Assurance	Progress in achievement of 10 safety actions(CNST)	NHSR	10	NA	<= 5	>= 10	Up	6	7	5	5
	Training compliance - MDT PROMPT %	NHSR	90%	NA	<= 84	>= 90	Up	82	93	91	NA

APPENDIX 4: PATIENT EXPERIENCE SURVEY

SALISBURY DISTICT HOSPITAL

Neonatal Unit Parent Questionnaire

Did your baby's admission to the unit go smoothly?

"The staff were efficient and kept us well informed of the processes and showed really high levels of sensitivity and compassion."

98.57% Agreed

Did you feel welcomed to the unit?

100% Agreed

"We arrived with the baby and our toddler. They even considered our toddler and took us to a room with lots of toys for him to be entertained. This has been very easy for us as we could concentrate on baby. Everyone was extremely friendly and welcoming."

Were you given any information about the Unit prior to your baby's admission?

Yes / No (0, 25, 50, 75)

72.5% Agreed

"Yes, when it seemed likely we'd be in NICU very soon and then at 35 weeks we came. No question was too silly, and every decision was explained or asked to us to choose/confirm the way ahead."

Were you updated regularly on your baby's condition?

Yes sometimes 5.7%
Yes definitely 94.3%

"We had hourly updates and help from the nurses, midwives, doctors, and consultants. They were extremely helpful on plans, dates, and expectations for going home."

Were you able to ask questions and receive answers in language you understood?

95% Agreed

"The staff here are so helpful and kind giving good advice to help us feel confident with the care of our babies, nothing is too much."

Did you feel able to voice any concerns you had about your baby to staff on the Unit?

67/70 agreed

"There was always someone available to talk to and ask questions. Everyone is so gentle and kind!"

Were you able to phone to speak to staff and/or visit your baby as much as you wanted to on the Unit?

Yes definitely (0, 25, 50, 75, 100)

"If it wasn't for the staff on this unit, I would have been separated from my daughter for a lot longer than I was."

Do you feel like you were given enough privacy?

"Staff would always knock before entering and would ask if I minded them being present if breastfeeding. I was always made to feel extremely comfortable"

Agreed

Do you feel you were prepared for your baby's discharge?

Yes to some extent 4.6%
Yes definitely 94.2%

"We feel so confident about leaving. We were extremely nervous about leaving until we moved to NICU. The nurses and midwives showed us everything in great details and were so patient and helpful."

On a scale of 1-10 (where 10 is the best) how would you rate the NNU at SDH?

0, 2.5, 5, 7.5, 10

Average score 10

What We Did Well?

"The level of care from start to finish has been impeccable. The love they have for the women and children is something I will be forever grateful for."

"Nursing staff were excellent in not only caring for my baby but communicating effectively and efficiently with us parents. Always available to help when needed."

"The private rooms allowing us to stay as much as we like. The family room and play areas were incredible. The kitchen areas allowed us to feel a sense of independence whilst staying on the unit. We received care from the same few members of staff, which meant we really got to know them and felt comfortable when they were helping us care for our baby."

"The incredible support day and night; answering our questions, understanding our concerns, explaining what's being done, breastfeeding support, and taking care of babies during the night so mum can I have some sleep"

"Excellent staff, care, support, communication, and facilities. The work of the Stars Appeal is fantastic"

"Personal approach- it can be lonely on the unit and having nurses that would come and talk, share funny stories and show large amounts of compassion was so helpful."

You Said – We Did

You Said	Theme	We Did
"Food was always cold, got the wrong stuff from what we ordered Need to feed both parents."	Food availability/was served cold	Neonatal manager to discuss with catering team on a solution
" I felt like I was being criticised rather than taught" "Inconsistency in opinions of doctors with regards to discharge"	Improving Communication	• Moving towards an allied health care professional meeting in conjuction with peadiatric ward round. Discussion with senior nursing staff on how we can promote compassionate communication.

SALISBURY DISTRICT HOSPITAL

Maternity Bereavement Experience Feedback

Based on 6 family's opinions

"We were informed about all our options. The midwife also gave us matching teddies for our children at home which have been so comforting."

"Everyone was so kind to us through the difficult time".

100% STRONGLY AGREE
We were cared for in an appropriate environment during the delivery of our baby

100% STRONGLY AGREE
Staff communicated with us in a sensitive way

100% STRONGLY AGREE
We felt confident in the staff caring for us

100% STRONGLY AGREE
We were able to be involved in any decisions about our baby

We were fully informed about what would happen to our babies once we had left the hospital

84% Strongly Agree

"A phone call from my consultant the same evening I arrived back home made me feel so calm and looked after. He took 15 minutes of his time to make sure I was ok."

We were given the opportunity to spend the time we wanted with our babies

100% Strongly Agree

We were given all the choices we would ever require. From the colour of their blanket, to whether we wish to see the baby, what would like them to be called etc. Absolutely faultless

We felt the our babies were always treated with respect and sensitivity

100% Strongly Agree

"The maternity staff treated us and our babies with such care and respect."

We were given the opportunity to create memories with our babies without feeling rushed

84% Strongly Agree

Helpful - not feeling rushed with our babies - having the Benson Suite to spend time with our babies

WERE YOU GIVEN GUIDANCE AND SUPPORT WHEN WE ASKED ABOUT NEXT STEPS FOR YOUR BABY?
84% Strongly Agree

WERE YOU GIVEN TIME AND OPPERTUNITY TO EXPRESS WISHES FOR YOUR BABY?
84% Strongly Agree

DID YOU FEEL ASSURED THAT GP AND COMMUNITY MIDWIFE HAD BEEN INFORMED OF LOSS BEFROE YOU LEFT THE HOSPITAL ?
100% Strongly Agree

WERE YOU PROVIDED WITH ALL THE SUPPORT NUMBERS THAT YOU NEEDED AT DISCHARGE?
100% Strongly Agree

WERE YOU ABLE TO ACCESS BEREAVMENT COUNSELLING WITH US?
84% Strongly agree

93% of all answers in questionnaire strongly agreed

SALISBURY DISTRICT HOSPITAL

Maternity Day Assessment Unit Survey

What has brought you to DAU today?

Reason	Value
Reduced movement	40
Bleeding	5
Obstetric review	7.5
Blood pressure	7.5
Postnatal check	2.5
Abdominal pain	15
Suspected UTI	2.5
Other	20

How long did you wait before you saw a midwife?

1hour+ 9.8%
31-45mins 12.2%
0-15mins 53.7%
16-30mins 21.9%

Did you feel you had to wait longer than you should have?

Yes
No
Don't know

0 20 40 60 80

"Clear regular communication and kept me updated and calm. Brilliant friendly staff!"

Other 21.2%
Yes- Doctor 39.4%
No 24.2%
Yes- Blood results 9.1%

If you had to wait, do you know what you were waiting for?

"Always kept me informed and comfortable."

Did you feel that the waiting area was appropriate?

No 18.9%
Yes 81.1%

"The initial greeting onto DAU made me feel welcomed. I received a quick service and felt very reassured"

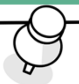
The average length of appointment in DAU

160 mins

On a scale of 1-10 (where 10 is the best) how would you rate your experience at DAU today?

0 2.5 5 7.5 10

What we did well?



"Whenever I've been in, I've felt very well taken care of and everyone's always been so kind."

"Communication was from the midwife on what was happening and what I had to wait for"

"I was seen very quickly by a reassuring midwife and Dr. In and out in an hour- makes me feel much more confident about calling in future with any concerns."

"The team were very professional, supportive and put my mind at ease in regard to the reduced movements."

"Caring, reassuring staff, easy to talk to about any worries"

You said... We did...

Patient feedback	Theme	Action
"It was a boiling hot day and think a water cooler would help. Also keep doors/windows open to cool down"	Cooling measures for hot weather	Installation of water cooler; Procurement of fans
"If there is going to be a long wait and low risk, let mother's go home and receive a phone call"	Triaging and assessing efficiently	Following appointment of Core team, BSOTS training will be offered to all staff; Re launch of BSOTs
"No opportunity to eat a meal"	Availability of food	Possibility of securing a vending machine.
"Privacy is a bit of an issue, can hear everything going on."	Confidentiality concerns	Consider privacy screens for bed spaces; Explore solutions to secure DAU's reception

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board- Public	Agenda item:	5.4
Date of meeting:	9th March 2023		

Report tile:	Maternity Survey 2022			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Maternity Survey and action plan approves at • Awaiting presentation at Patient Experience Steering Group • Maternity Safety Champions January 20th 2023 • Maternity Governance 15th November 2022 • Headlines included in quarter 2 22/23 quality and safety report • CGC 28th February 2023			
Prepared by:	Joanne Hayward - Director of Maternity and neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Committee are asked to note the following presentation of the action plan in response to the Maternity Survey 2022.

Executive Summary:

The Maternity Survey was conducted in January and February of 2022.

300 women were included in the survey and 182 women responded. The response rate was 61% which is significantly higher than the average national response rate , for this survey, of 48%.

The demographics represent are in line with the demographics of the Salisbury population.

The Mean rating Score was 79.2% which is lower than the same survey in 2021.

SFT scored in the top 20% of Trusts on 15 questions and in the bottom 20% of Trusts on 5 questions out of a total of 59 questions.

Things we performed well in :

- Awareness of medical history
- Time to ask questions
- Partners/companions involved in care (94%)

Opportunities for improvement:

- Language that was understood
- Treated with respect and dignity
- Cleanliness of unit

An action plan is included which has been approved within the specialty and will be monitored through maternity governance. This plan will be implemented by the Family Experience Midwife.

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

Maternity survey 2022

J Cowan Director of Maternity and Neonatal services.

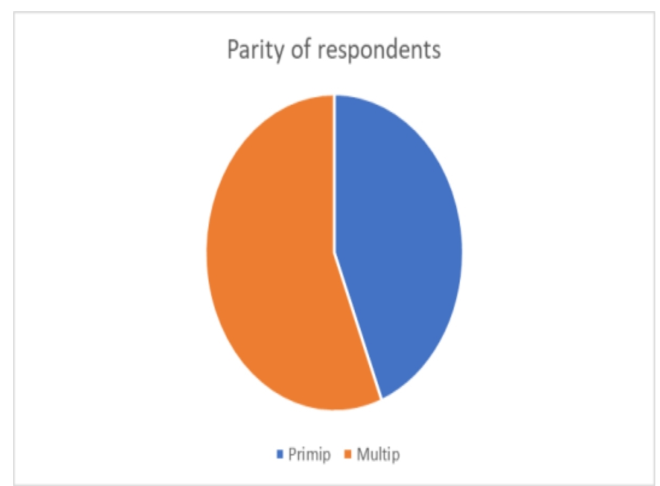
EXECUTIVE SUMMARY

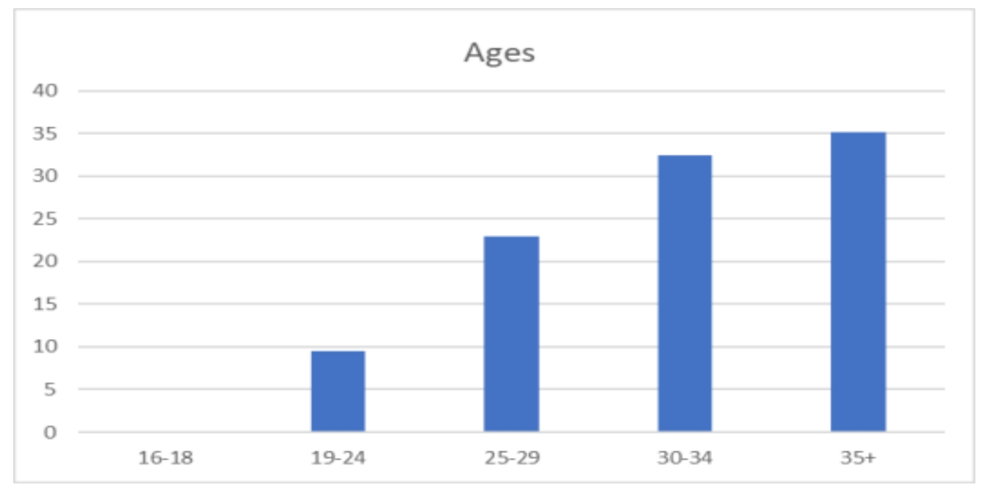
This report summarises the headline findings of the **2022 National Maternity Survey**.

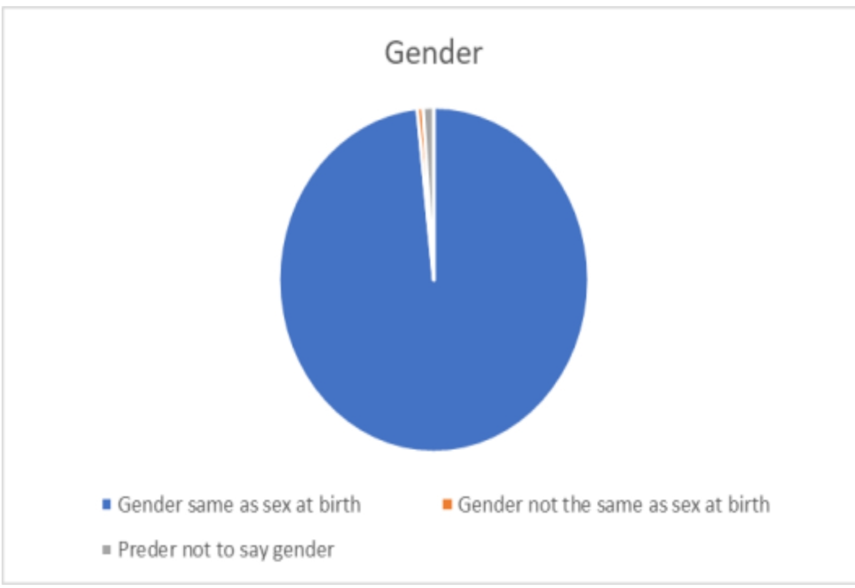
- The National Maternity Survey is required by the CQC for all NHS Trusts providing maternity services.
- Women receiving maternity services in January and February 2022 were selected for the survey.
- 300 women were included in the survey and 182 responded **(61%)**. The Patient Perspective average response rate for all 31 Trusts it surveyed was 48%.
- The average Mean Rating Score was **78.2%**, lower than in 2021.
- You scored in the **top 20% of Trusts** on **15** questions and in the **bottom 20% of Trusts** on **5** questions out of a total of 59 questions.
- **1** question showed **at least 10% improvement** on the 2021 score, and for **1 question** the score was **worse by 10%** or more.

Full results including tables, free text comments, trends and benchmarks can be found at www.patientperspective.co.uk

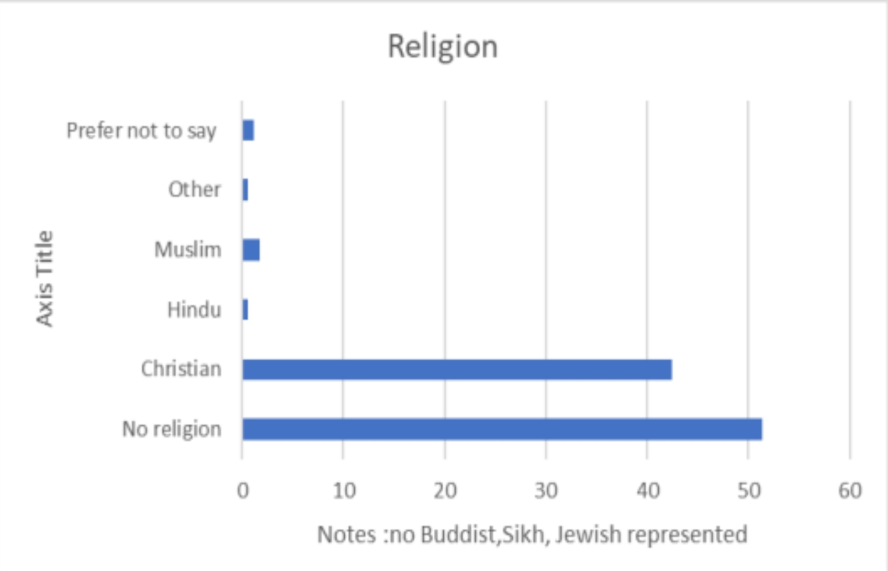
Demographics.





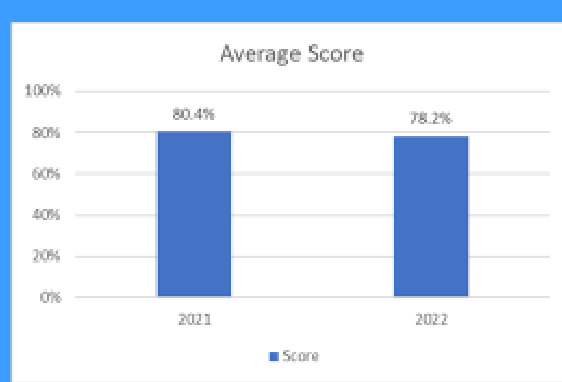

Gender
Gender same as sex at birth
Gender not the same as sex at birth
Preder not to say gender

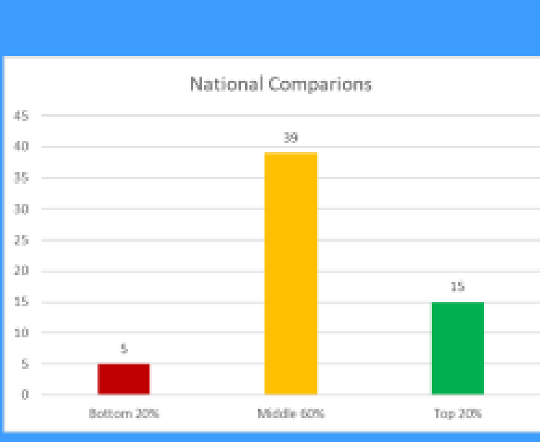
NHS
Salisbury
NHS Foundation Trust

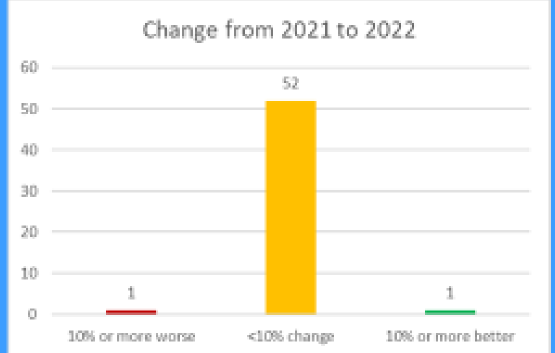

Religion
Prefer not to say
Other
Muslim
Hindu
Christian
No religion
Axis Title
0
10
20
30
40
50
60
Notes :no Buddist,Sikh, Jewish represented

Beatrice
Birth
Centre

RESULTS DASHBOARD
NATIONAL MATERNITY SURVEY 2022







18 February, 2023

www.patientperspective.org

Questions and scores #1

Salisbury NHS Foundation Trust					
Question	Question Text	2021 Score	2022 Score	Change since 2021	National Comparisons
Antenatal Care					
B3_1	Were you offered a choice about where to have your baby: Yes – a choice of hospitals	46%	48%	<10% change	Middle 60%
B3_2	Were you offered a choice about where to have your baby: Yes - at home	27%	23%	<10% change	Middle 60%
B3_4	Were you offered a choice about where to have your baby: No – I was not offered any choices	81%	83%	<10% change	Middle 60%
B4	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	65%	62%	<10% change	Middle 60%
B5	At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	61%	60%	<10% change	Middle 60%
B8	During your antenatal check-ups, did the midwives appear to be aware of your medical history?	69%	70%	<10% change	Top 20%
B9	During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	86%	89%	<10% change	Top 20%
B10	During your antenatal check-ups, did your midwives listen to you?	89%	89%	<10% change	Middle 60%
B11	During your antenatal check-ups, did your midwife ask you about your mental health?	89%	91%	<10% change	Top 20%
B12	Were you given enough support for your mental health during your pregnancy?	90%	88%	<10% change	Middle 60%
B13	During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	93%	88%	<10% change	Top 20%
B14	Thinking about your antenatal care, were you spoken to in a way you could understand?	93%	90%	<10% change	Bottom 20%
B15	Thinking about your antenatal care, were you involved enough in decisions about your care?	88%	88%	<10% change	Middle 60%
B16	During your pregnancy did midwives provide relevant information about feeding your baby?	62%	62%	<10% change	Middle 60%
B17	Did you have confidence and trust in the staff caring for you during your antenatal care?	n/a	81%	n/a	Middle 60%
B18	Thinking about your antenatal care, were you treated with respect and dignity?	n/a	90%	n/a	Bottom 20%

Questions and scores #2

Question	Question Text	2021 Score	2022 Score	Change since	National
Your labour and the birth of your baby					
C4	Were you given enough information on induction before you were induced?	75%	70%	<10% change	Middle 60%
C5	And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	n/a	65%	n/a	Middle 60%
C6	Were you involved in the decision to be induced?	87%	86%	<10% change	Middle 60%
C7	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	90%	86%	<10% change	Middle 60%
C12	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	91%	94%	<10% change	Top 20%
C14	Did the staff treating and examining you introduce themselves?	92%	92%	<10% change	Top 20%
C16_1	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during early labour	90%	92%	<10% change	Top 20%
C16_2	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the later stages of labour	97%	94%	<10% change	Middle 60%
C16_3	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the birth	98%	99%	<10% change	Middle 60%
C16_4	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, shortly after the birth	94%	93%	<10% change	Top 20%
C16_5	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: No, not at all	84%	83%	<10% change	Top 20%
C17	If you raised a concern during labour and birth, did you feel that it was taken seriously?	84%	81%	<10% change	Middle 60%
C18	During labour and birth, were you able to get a member of staff to help you when you needed it?	90%	89%	<10% change	Middle 60%
C19	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	93%	90%	<10% change	Middle 60%
C20	Thinking about your care during labour and birth, were you involved in decisions about your care?	90%	86%	<10% change	Middle 60%
C21	Thinking about your care during labour and birth, were you treated with respect and dignity?	94%	91%	<10% change	Middle 60%
C22	Did you have confidence and trust in the staff caring for you during your labour and birth?	92%	89%	<10% change	Middle 60%
C23	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	62%	65%	<10% change	Middle 60%
C24	During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	n/a	77%	n/a	Middle 60%

Questions and scores #3

Question	Question Text	2021 Score	2022 Score	Change since 2021	National Comparisons
Postnatal care					
D2	On the day you left hospital, was your discharge delayed for any reason?	62%	61%	<10% change	Middle 60%
D4	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	80%	73%	<10% change	Middle 60%
D5	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	78%	71%	<10% change	Bottom 20%
D6	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	86%	82%	<10% change	Middle 60%
D7_1	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: Yes	27%	38%	10% or more better	Top 20%
D7_2	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as they were restricted to visiting hours	52%	54%	<10% change	Top 20%
D7_3	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as there was no accommodation for them in the hospital	91%	89%	<10% change	Middle 60%
D8	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	89%	83%	<10% change	Bottom 20%
Feeding your baby					
E2	Were your decisions about how you wanted to feed your baby respected by midwives?	91%	92%	<10% change	Top 20%
E3	Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	75%	74%	<10% change	Middle 60%
Care after birth					
F1	Thinking about your postnatal care, were you involved in decisions about your care?	n/a	82%	n/a	Top 20%
F2	If you contacted a midwifery or health visiting team were you given the help you needed?	89%	84%	<10% change	Middle 60%
F5	Would you have liked to have seen a midwife...	75%	68%	<10% change	Middle 60%
F6	Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?	81%	78%	<10% change	Middle 60%
F7	Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	90%	85%	<10% change	Middle 60%
F8	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	89%	84%	<10% change	Middle 60%
F9	Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	86%	86%	<10% change	Middle 60%
F11	Did a midwife or health visitor ask you about your mental health?	98%	98%	<10% change	Top 20%
F12	Were you given information about any changes you might experience to your mental health after having your baby?	75%	71%	<10% change	Middle 60%
F13	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	88%	79%	<10% change	Middle 60%
F14	Were you given enough information about your own physical recovery after the birth?	74%	69%	<10% change	Middle 60%
F15	In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	73%	68%	<10% change	Middle 60%
F16	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	70%	46%	10% or more worse	Bottom 20%
F17	In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	80%	81%	<10% change	Top 20%

Questions ?

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	7.1
Date of meeting:	9 March 2023		

Report tile:	Constitution Annual Review 2023			
Status:	Information	Discussion	Assurance	Approval
		✓		✓
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

The Trust Board is asked to:

- Consider and support the amendments to the constitution.
- Discuss and agree the composition of appointed governors and recommend any changes to the Council of Governors

Executive Summary:

The constitution is reviewed and approved by the Trust Board and Council of Governors on an annual basis. After a review by the governance team, the following amendments have been made:

- Minor formatting changes that are highlighted in the tracked changes.
- Paragraph 32.3 updated to reflect NED terms of office (2 x 3-year terms plus a 1 x 2-year term).
- Annex 4 – Composition of the Appointed Governors updated to reflect the distinction between local authority and partnership organisations.
- Annex 7 – Item 11.3 updated to include ‘external stakeholder’ in the composition of future Nominations Committees. This is based on guidance published by NHSEI and the most recent recruitment of the Chair and Non-Executive Director included an external stakeholder in the process.

The Board is also asked to consider the composition of the Appointed Governor category in Annex 4 (p.24) to establish if the current partnership organisations are appropriate. Appointed governors are representatives of organisations with whom NHS Foundation Trusts have a strong relationship. To align with the NHS Act 2006 (schedule 7) the Trust’s constitution is required to identify the stakeholders entitled to appoint representatives to the Council of Governors. Should the Board decide to amend this list of partnership organisations, this will also have to be presented to the next Council of Governor’s meeting in May for approval.

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

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 2023
Approved by:	Council of Governor's/ Trust Board
Date Approved:	
Next Due for Revision:	January 2024
Date Policy Becomes Live:	

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	Small amendments to wording to provide consistency in document
2.3	Head of Corporate Governance	March 2022	Further small amendments following CoG.
2.4	Head of Corporate Governance / Membership Manager	January/ February 2023	Amendments to NED terms of office, nominated governor categories and nominations Committee composition and Annex 4

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Amendment history – 2013 to 2023

- **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.
- **2021**
  - Wiltshire Clinical Commissioning Group (CCG) is now called Bath and North-East Somerset, Swindon and Wiltshire (BSW)
- **2022**

- Amendments to Annex 6 and Annex 9 to update Governor and Board disqualification criteria.
  - Document renumbered.
- **2023**
  - Minor formatting updates.
  - Item 32.3 updated to reflect NED terms of office (2 x 3-year terms plus 1 x 2-year term).
  - Annex 4 – Composition of the Appointed Governors updated to reflect the distinction between local authority and partnership organisations.
  - Annex 7 – Item 11.3 updated to include 'external stakeholder' in the composition of future Nominations Committees.

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~~ three 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~~ nine years in all.

15.3 An appointed governor may hold office for a period of up to ~~3~~ three years and may then be re-appointed but shall not hold office for more than ~~9~~ nine 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~~ nine 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 an initial term~~s~~ of up to ~~4~~ three years, which may be renewed by the Council for a further term of up to ~~4~~three years, and may be renewed thereafter for a two year term~~such term~~, ~~if any, as~~ which will bring the total length of service to ~~8~~ eight years. Where a director has served ~~8~~ eight years, his appointment may be renewed for a further one 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 Northwest ▪ 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)

Public Governors

1. There shall be 15 public governors as set out in Annex 1.

Staff Governors

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.

Appointed Governors

3. There shall be 6 appointed governors:

Local Authority

3.1. As stated in paragraph 9(4) of the Schedule 7 of the 2006 Act, Wiltshire Council may appoint one governor by notice in writing to the chair, signed by the senior executive of the Council. For the avoidance of doubt, the person appointed shall be a councillor of Wiltshire Council.

Partnership Organisations

3.2. There shall be five partnership organisations (or successor organisations) who may appoint one governor by notice in writing, signed by the chief executive (or equivalent) of that organisation and delivered to the chair. These partnership organisations are decided by the Board of Directors and Council of Governors.

3.2.1. There shall be one governor appointed by Wessex Community Action.

3.2.2. 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.

3.2.3. Bath and North-East Somerset, Swindon, and Wiltshire (BSW) Integrated Care Board

3.2.4. NHS Dorset Integrated Care Board

3.2.5. Hampshire and Isle of Wight Integrated Care Board

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

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2. Timetable
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PART 3: RETURNING OFFICER

4. Returning officer
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9. Nomination of candidates
10. Candidate's particulars
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PART 10: ELECTION EXPENSES AND PUBLICITY

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60. Election expenses
61. Expenses and payments by candidates
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63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
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PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event

PART 1: INTERPRETATION

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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

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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 inside it,
- (b) the ID declaration forms, if required,
- (c) the list of spoilt ballot papers and the list of spoilt text message votes,

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[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote

(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, Chairman or chief executive of another NHS Foundation Trust or NHS Trust; However, a governor (other than the lead governor) may be a governor or non-executive director (other than chairman) 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 governorships or directorship and governorship;
4. A person whose physical or mental wellbeing is such that their ability to act as a governor of the Trust is materially affected;
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;

4. A person who has had his name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list and, due to the reason(s) for such removal, he is considered by the Trust to be unsuitable to be a Governor.

ANNEX 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(See paragraph 19)

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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~~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
- 1 External stakeholder

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~~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.
6. A person who has had their name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list and, due to the reasons(s) for such removal, they are considered by the Trust to be unsuitable to be a Director.

Report to:	Trust Board (Public)	Agenda item:	7.2
Date of meeting:	9th March 2023		

Report tile:	Trust Board Annual Cycle of Business 2023/24			
Status:	Information	Discussion	Assurance	Approval
				✓
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:
The Trust Board is asked to approve the 2023/24 cycle of business for both public and private Board.

Executive Summary:

The Trust Board and Committees are asked to review their cycle of business on an annual basis to ensure all participants are prepared in advance and to inform each meeting agenda.

Following the approval of the new meeting schedule for Board and Committees in February 2023, the cycle of business has been redrafted to remove meetings in March, June, August, and December and ensure report authors are content with the new schedule.

As this will be the first year the Trust has 8 full board meetings, it is expected that there will be small amendments to the cycle of business, depending on reporting schedules from subgroups to Committees and then Board.

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):	

Private Trust Board
Annual Business Cycle 2023/24

			Q1			Q2			Q3			Q4		
			Apr-23	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Board Administration	**Sponsor**	**Author**			Development Day		Development Day			Development Day				Development Day
Opening Business														
Resolution	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Apologies for absence	Chair	Verbal	✓	✓	✓	✓		✓	✓		✓	✓	✓	
Declarations of interest	Chair	Verbal	✓	✓	✓	✓		✓	✓		✓	✓	✓	
Minutes from the last meeting	Chair	Head of Corporate Governance	✓	✓		✓		✓	✓		✓	✓	✓	
Matters arising and action log	Chair	Head of Corporate Governance	✓	✓		✓		✓	✓		✓	✓	✓	
Approve next years cycle of business	Chair	Head of Corporate Governance											✓	
Register of attendance	Chair	Head of Corporate Governance	✓			✓			✓			✓		
Chairman's business	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Chief Executive report inc BSW update	Chief Executive	Head of Communications		✓		✓			✓		✓		✓	
Quality and Risk														
Clinical Review/SII Report	Chief Nursing Offcier	Head of Risk Management	✓			✓			✓			✓		
Legal and Litigation Report	Chief Nursing Officer	Head of Legal Services	✓					✓						
Annual Quality Report and External Auditors Assurance (Quality Accounts)	Chief Nursing Officer	Head of Clinical Effectiveness		✓										
Strategy and Development														
Campus Development Progress Updates	Chief Operating Officer	Campus Project Programme Lead	✓			✓		✓			✓		✓	
Estates Technical Services Quarterly Update (aligned to H&S report on public agenda)	Director of Estates	Director of Estates				✓			✓			✓		
Strategy Progress Update **(TBC ?private report required)**	Chief Operating Officer	Associate Director of Strategy												
Financial and Operational Performance														
Annual Report and Accounts (including AGS)	Chief Finance Officer	Deputy Director of Finance		✓	✓									
Operating Plan 2024/25	Chief Operating Officer	Associate Director of Strategy											✓	
Approval of the 2023/24 budget	Chief Finance Officer	Deputy Director of Finance		✓										
Concluding Business														
Agreement of principal actions	Chair	Verbal	✓	✓	✓	✓		✓	✓		✓	✓	✓	
Any Other Business	Chair	Verbal	✓	✓	✓	✓		✓	✓		✓	✓	✓	
Date of Next Meeting	Chair	Verbal	✓	✓	✓	✓		✓	✓		✓	✓	✓	
Hospital tasting menu	Chair	Eating							✓					

Public Trust Board
Annual Business Cycle 2023/24

			Q1			Q2			Q3			Q4		
Item	**Sponsor**	**Author**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Board Administration **Opening Business**					Development Day		Development Day			Development Day				Development Day
Apologies for absence	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Declarations of interest	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Presentation of SOX certificates	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Patient story	Director of Nursing	Various		✓				✓			✓		✓	
Staff story	Director of OD & People	Various	✓			✓			✓			✓		
Minutes from the last meeting	Chair	Head of Corporate Governance	✓	✓		✓		✓	✓		✓	✓	✓	
Matters arising and action log	Chair	Head of Corporate Governance	✓	✓		✓		✓	✓		✓	✓	✓	
Approve next years cycle of business	Chair	Head of Corporate Governance											✓	
Register of attendance	Chair	Head of Corporate Governance	✓			✓			✓			✓		
Chairman's business	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Chief Executive report inc ICS update	Chief Executive	Head of Communications	✓	✓		✓		✓	✓		✓	✓	✓	
Assurance and reports of Committees														
Committee escalation reports	Executive Director	NED Chair of Committee	✓	✓		✓		✓	✓		✓	✓	✓	
Integrated Performance Report (inc, operational perf, workforce, finance, quality, safer staffing and Wiltshire Health & Care)	Chief Executive	Executive Directors	✓	✓		✓		✓	✓		✓	✓	✓	
Quality and Risk														
Board Assurance Framework and Corporate Risk Register (aligned with corporate priorities)	Chief Nursing Officer	Director of Integrated Governance	✓			✓			✓			✓		
Patient Experience Report	Chief Nursing Officer	Head of Complaints		Q4/Annual Report				Q1			Q2		Q3	
Quarterly Learning from Deaths Report	Chief Medical Officer	Head of Clinical Effectiveness	Q3			Q4/Annual Report			Q1			Q2		
DIPC Report	Chief Nursing Officer	Lead Nurse Infection Control				Annual Report						✓		
Risk Management Strategy (3 yrly, due 2023, 2026, 2029)	Chief Nursing Officer	Head of Risk		✓										
Annual Maternity Survey	Chief Nursing Officer	Chief Nursing Officer	✓											
Quarterly Maternity Quality and Safety Report	Chief Nursing Officer	Chief Nursing Officer	Q3			Q4		Q1			Q2			
In-Patient Survey Results	Chief Nursing Officer	Chief Nursing Officer							✓					
Research Annual Report	Chief Medical Officer	Head of R&D				Annual Report								
Strategy and Development														
Green Plan Progress Report **(reporting annually to Jan TMC) Update to be appended to the TMC esacaltion report for information**	Chief Operating Officer	Head of Facilities											✓	
Digital Plan Update	Chief Digital Officer	Chief Information Officer									✓			
Improving Together Quarterly Update Report (Vision Metrics/ SI/ BO)	Chief Medical Officer	Associate Director of Improvement	Q4			Q1			Q2			Q3		
Financial and Operational Performance														
Review of Trust Strategy Progress Report	Chief Operating Officer	Associate Director of Strategy		✓				✓				✓		
SIRO Annual Data Security & Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR)	Chief Finance Officer	Chief Information Officer				✓								
Standing Financial Instructions	Chief Finance Officer	Chief Finance Officer	✓											
Charitable Funds Strategic Update	Chief Finance Officer	Chief Finance Officer						✓					✓	
People and Culture														
Nursing Skill Mix Review - agreed with FH January and July	Chief Nursing Officer	Deputy Director of Nursing				✓						✓		
Guardian of Safe Working Annual Report	Chief People Officer	Guardian of Safe Working (RS)						Annual Report						
Equality & Diversity Annual Report	Chief People Officer	Head of Diversity and Inclusion				Annual Report								
National Staff Survey Results	Chief People Officer	Deputy Directof of OD & People	✓											
Medical Revalidation and Appraisal Annual Report **Including Statement of Compliance**	Chief Medical Officer - Move to July for 2023	Chief Medical Director							Annual Report					
Freedom to Speak Up Guardian Annual Report (quarterly to People & Culture Committee	Chief People Officer	FTSUG Lead				✓								
Health & Safety Annual Report (**Aligned with ETS reporting**)- TMC bi monthly and Board quarterly	Chief People Officer	Health and Safety Manager	Q4 - Annual Report			Q1			Q2			Q3		
Education & Development Annual Report - **proposal by MW to merge OD&P reports into one**	Chief People Officer	Associate Director Education, Inclusion, Comms & Engagement							Annual Report					
Medical Education Performance Report	Chief Medical Officer	Director of Medical Education										Annual Report		
Governance														
Annual Report and Accounts (to be approved prior to submission to parliament)	Director of Corporate Governance	Director of Integrated Governance/ Head of Corporate Governance				✓								
External Well-Led Review								✓						
Annual review of Board and Committee effectiveness	Director of Corporate Governance	Director of Integrated Governance						Annual Report						
Annual review of Directors Interests/ Annual Review Fit and Proper Persons Test	Director of Corporate Governance	Director of Integrated Governance/ Head of Corporate Governance	✓											
Review of Board Committee Terms of Reference	Director of Corporate Governance	Director of Integrated Governance/ Head of Corporate Governance	✓											
Integrated Accountability & Governance Framework	Chief Executive	Director of Integrated Governance/ Head of Corporate Governance	✓											
Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance	Chief Operating Officer	EPRR Manager										Annual Report		
Register of Seals	Director of Corporate Governance	Director of Integrated Governance	Q4			Q1			Q2			Q3		
NHSI Self-Certification (FT4, G6, CoS7)	Chief Finance Officer	Director of Integrated Governance		✓										
Annual Review of the Constitution	Chief Executive	Director of Integrated Governance	✓											
Approve Board and Committee dates for next year	Director of Integrated Governance	Head of Corporate Governance							✓					
Closing Business														
Agreement of principal actions	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Any Other Business	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Public Questions	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Date of Next Meeting	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	
Resolution	Chair	Verbal	✓	✓		✓		✓	✓		✓	✓	✓	