Bundle Trust Board Public 4 May 2023

1	Opening BUSINESS
1.1	10:00 - Presentation of SOX certificates *April SOX of the month – Kay Dubach, Wessex Rehabilitation and Nadine Crook, Speech and Language Therapist * *April Patient Centred SOX – Alex Beck, Physiotherapist, Children's Orthopaedics*
1.2	10:10 - Patient Story *Presented by Judy Dyos*
1.3	Welcome and Apologies
1.4	Declaration of Interests, Fit & Proper / Good Character
1.5	10:30 - Minutes of the previous meeting held on 6 April 2023 *Minutes attached from previous meeting held on 6 April 2023* *For approval* 1.5 Draft Public Board mins 6 April 2023.docx
1.6	10:35 - Matters Arising and Action Log 1.6 Action Log Public Trust Board May 2023.pdf
1.7	10:40 - Chair's Business *Presented by Ian Green* *For information*
1.8	10:45 - Chief Executive's Report *Presented by Stacey Hunter* *For information* 1.8 CEO Report May 2023 v2.docx
2	ASSURANCE AND REPORTS OF COMMITTEES
2.1	10:55 - Clinical Governance Committee - 25 April *Presented by Eiri Jones* *For assurance*
2.2	11:00 - Finance and Performance Committee - 25 April *Presented by Debbie Beaven* *For assurance* 2.2 April Escalation Report from F and P.docx
2.3	11:05 - Trust Management Committee - 26 April *Presented by Stacey Hunter* *For assurance* 2.3 TMC Escalation Report for May Board V2.docx
2.4	11:10 - People and Culture Committee - 27 April *Presented by Michael von Bertele* *For assurance*
2.5	11:15 - Integrated Performance Report to include Exception Reports *Presented by Peter Collins* *For assurance* 2.5a IPR cover sheet - Trust Board 2023-05.docx 2.5b IPR May_23 FINAL.pdf
3	STRATEGY AND DEVELOPMENT
3.1	11:45 - Digital Strategy Update - deferred from March *Presented by Naginder Dhanoa* *For assurance* 3.1 TB Public Digital Strategy Annual Update Apr 2023.docx
4	FINANCIAL AND OPERATIONAL PERFORMANCE
4.1	Review of Trust Strategy Progress Report- Deferred to July *Presented by Lisa Thomas and Tony Mears* *For assurance*
4.2	12:00 - BREAK

5 QUALITY AND RISK

5.1 Risk Management Strategy 3 yearly report - deferred to July

6 GOVERNANCE

6.1 12:30 - NHS England Governance Publications Briefing

Presented by Fiona McNeight
For information

6.1a Cover_Sheet Board Briefing - changes to key governance documents May 23.docx

6.1b NHS England governance publications briefing to Trust Board May 2023.pdf

6.2 12:40 - Corporate Governance Statement NHSI Self- Certfication (FT4, G6, CoS7)

Presented by Fiona McNeight
For approval

6.2 Self Certification 2022_23.docx

6.2a Appendix 1_ Provider Licence Self Certification Proposed Response_2022_23.docx

6.2b Self-certification_template_FT4 2022_23.pdf

6.2c Self-certification_template_G6 2022_23.pdf

6.3 12:50 - Integrated Accountability and Governance Framework - deferred from April

*Presented by Fiona McNeight
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For information

6.3a Integrated Governance and Accountability Cover_Sheet May 2023.docx

6.3b Final DRAFT 2022_23 Accountability and Integrated Governance Framework March 2023 incl Appendix 1.docx

6.3c Appendix 2 Board and Committee Organisational Structure inc quality governance V3.14 April 2023.pdf

6.3d - Appendix 3 Board Committee ToR.pdf

6.3e- Appendix 4 Committee Effectiveness Report Template.docx

7 CLOSING BUSINESS

7.1 13:00 - Agreement of Principle Actions and Items for Escalation

7.2 Any Other Business

7.3 13:05 - Public Questions

7.4 Date next meeting

8 June 2023

8 Resolution

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

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 6th April 2023, MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

Ian Green (IG)	Chair
Rakhee Aggarwal (RA)	Non-Executive Director
Debbie Beaven (DBe)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
David Buckle (DBu)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director
Michael von Bertele (MVB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Stacey Hunter (SH)	Chief Executive
Judy Dyos (JD)	Chief Nursing Officer
Mark Ellis (ME)	Chief Finance Officer
Peter Collins (PC)	Chief Medical Officer
Melanie Whitfield (MW)	Chief People Officer

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Jane Podkolinski (JP)	Governor (observer)
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Jane Dickinson (JDi)	Deputy Chief Operating Officer
Alex Talbott (AT)	Associate Director of Improvement
Tony Mears (TM)	Associate Director of Strategy
John Gardiner (JG)	Learning Disability Liaison Nurse (item TB1 6/4/1.2)

ACTION

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

TB1 6/4/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

March SOX of the month: Respiratory Admin Team
March SOX of the month: Lindsey Boase, Denise Russell, Juliet Whatley, Longford Ward
March SOX of the month: Paul Jones, Senior Paediatric Audiologist
March Patient Centred SOX: Amanda Westwood, Medical Surgical Outpatients
March Patient Centred SOX: Freddie Gleadowe, Emergency Department

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

TB1 6/4/1.2 **Staff Story**

JDy introduced JG, Learning Disability Lead Nurse, who joined Board to provide an update on his experience since joining the Trust 5 months ago. JG explained that he had worked as a nurse for 14 years and is also a carer for his father and two children who have learning disabilities. JG summarised his first few months as really positive and noted that he had enjoyed his induction and meeting the team.

JG described the learning disability nurse (LDN) mantra as always considering the reasonable adjustments that can be made. JG indicated that best practice will one day mean there is no need for a LDN as it will be business as usual within healthcare.

JG noted the key items of work over the next few months, highlighting that in June the Trust embarks on rolling out Oliver McGowan Training to all staff. There will be challenges in terms of releasing staff but everyone understands the importance of this mandatory training and the impact it will have. JG noted that during his first few months he has had the opportunities to see how agile the team is in terms of supporting the patient's journey and provided an example of a non-communicative patient who had been through elective surgery. He explained that he already felt integrated into the team and that he is already working closely with colleagues to improve patient's experiences across the Trust.

JDy added that the team were delighted when JG was appointed and the benefits of appointing such a role can already be seen.

Discussion:

- DBu referred to the challenges in acute care and the amount of work required to improve the patient' experience with learning disabilities. JG noted that the Oliver McGowan training will go some way in raising awareness to all staff. There is also work ongoing around Hospital Passports and working with the community around pre-admission plans to make this a less stressful experience. This will provide an opportunity for ED to plan for ongoing potential admission. To do this, nurses and clinicians need to work collaboratively but there are always challenges.
- SH thanked JG for attending the Board to share his experiences. As a partner in the system, the Trust needs to demonstrate how it is making a difference in a measurable way and the Board need to start thinking about how those inequities are addressed. The training is a huge step and will contribute to a change in attitudes and behaviours.
- RA asked JG how the Board could work with him to enable others to see the value of people with a learning disability, as it should not define the person. Additionally, within the Integrated Care Board (ICB) how do we influence social care to be cognisant of those differences. JG noted that the challenge is getting the voice of the people concerned to influence the changes required.
- IG thanked JG on behalf of the Board noting the importance of his role in the Trust in reducing health inequalities.

TB1 6/4/1.3 **Welcome and Apologies**

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

- Lisa Thomas, Chief Operating Officer
- Lucinda Herklots, Lead Governor

TB1 6/4/1.4 Declarations of Conflicts of Interest

There were no declarations of conflict of interest pertaining to the agenda. However, the following items were noted:

- 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.

- IG advised that he had been appointed to the NHS Safety Commissioners Advisory Board. There are no conflicts of interest with any of the agenda items at the meeting.

- EJ noted that in relation to the Safe staffing paper, she currently sits on the Allocate Professional Advisory Board. There Board noted that there is no conflict with the agenda item.

TB1 6/4/1.5 Minutes of the Part 1 (Public) Trust Board meeting held on 9th March 2023

IG presented the public minutes from 9th March 2023 and the following key points were noted:

- Ian Crowley's name had been spelt incorrectly.
- ME noted that his point as part of the patient story had been that waiting times were still long as part of a cancer pathway, regardless of other pressures or not.
- EJ noted that she was the NED Maternity Safety Champion on p13/15, to distinguish between the executive and operational roles.

Subject to these amendments, the board approved the minutes as a correct record of the meeting.

TB1 6/4/1.6 Matters Arising and Action Log

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

TB1 12/1/2.5 Integrated Performance Report (IPR) (M8)/ Stroke - PC noted that he has suggested some amended wording to the Stroke team. Item closed.

TB1 9/3/3.3 Charitable Funds Strategic Update – TM and the trustees will discuss in the next few weeks. Item closed.

TB1 9/3/5.3 Maternity Quality and Safety Report Q3 22/23 - EJ explained that the National Chief Midwife has moved to a new role and she is therefore waiting to hear who she can contact to find out what is expected in terms of Maternity Board reports. JDy has also contacted the Maternity Improvement Associate.

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 6/4/1.7 Chair's Business

IG noted that he had continued to meet a broad range of colleagues in the last month as part of his induction period. The key focus for a number of colleagues in the last few months has been finalising the financial and operational plans for 2023/24 which is on this month's agenda.

IG noted that he is in the process of meeting with all Non-Executive Directors to set objectives and ensure those in NED roles have the most significant impact in terms of seeking assurance. This will be reported back to the Governor's Performance Committee meeting at the end of May.

There has been a significant amount of industrial action over the last few months, which has had an impact on the operational performance of the Trust. IG highlighted the junior doctor strikes in the coming week, noting the potential implications due to the length of time and the proximity to the bank holiday weekend.

TB1 6/4/1.8 Chief Executive's Report

SH provided a verbal update and highlighted the following key points:

- A few documents have been circulated to the Board in the last few days, including the Hewitt Report which was published earlier this week. The Board will address this as part of the strategy session at a Board Development Day. Additionally, IG attended the NHS Providers Chairs and CEO event and there were comprehensive slides which have been circulated. There are key points incorporated to underpin the conversations around the financial and operational planning.
- The Acute Hospital Alliance (AHA) had a face-to-face Committee in Common which included the ICB chair and CEO. The conversations were productive and group was clear around mutual expectations. A paper will come through to the Board in due course.
- It is expected that this industrial action will be more impactful than others experienced previously. This has been widely shared with representation made to senior leaders, elective representatives, and communities. There has been extensive planning over the past three weeks and thanks was given to Jane Dickinson, Ian Crowley, and their teams for their attempts to ensure a minimum level of cover is in place. The Trust has been able to externally assure on a minimum level. Thanks also goes to consultant colleagues and executives who have cancelled leave to ensure they're on site.

Discussion:
JDi noted her concerns in relation to the upcoming industrial action. There are ongoing conversations with partners to see how they can support and there is a huge amount of work being done by staff to support too. IG thanked JDi and the staff who have cancelled their leave to support the planning. IG noted that the Trust supports all junior doctors who are entitled to take industrial action but noted that the Trust's key priority during this time will be ensuring safe and effective care.

DBe asked how the Trust will support employees to rebalance after the intensive 10 days. All divisions have been asked to look at support. They have already highlighted areas that are lean over the period to ensure employees get regular breaks. As it is the end of the leave year, people have been able to take leave pre- strike action and where people are offering to cancel leave, the Trust is ensuring it is not always the same volunteers coming forward. The same applies to executive and DMT on call.

PC noted the potential for continued industrial action to divide staff and we are addressing this. The next Schwartz Round will be used to for staff to speak about this openly.

TB referenced a radio interview she had heard with Julian Hartley and noted that a stronger case could be made in relation to the impact of industrial action. TB noted that the NHS is currently being undermined and efforts need to be taken to keep that social contract in place.

MW referenced IG's point in his report around NED objectives, reminding the Board of the ongoing commitment to diversity and equality, which was set as an objective in all appraisals. MW noted the importance of championing this role and taking forward the inclusion agenda.

DBu noted that the reality of industrial action is that safety is generally maintained by cancelling other care. DBu asked if this information is published. SH noted that it is and she would include this in her next report.

IG thanked for the Board for the useful conversation, noting the continued challenges expected beyond the 10-day period after the industrial action.

TB1 6/4/2 **PLANNING**

TB1 6/4/2.1 **2023/24 Operational Plan**

ME presented the finalised 2023/24 Operational Plan and highlighted the following key points:

- The planning information has been through F&P in the last few months and it has been a particularly challenging round.
- The Trust is projecting to achieve all mandated standards for 2023/24 apart from – 92% bed occupancy and Elective inpatient activity 103% of 2019/20 activity. There are improvement plans in place to work towards achieving these standards including Reducing length of Stay, system plans increasing out of hospital care, and the building of a new ward to open Spring 2024.
- The plan is contingent on a 5% savings plan and this is reliant on working with partners outside the hospital, particularly on challenges like NCTR.
- There are some positives, including the new ward which will help occupancy and bed activity. Also, decarbonisation if viable, will support our green agenda. Additionally, the programme to implement a shared EPR across the three acutes and this will come back through Board.

- The key focus for 2023/24 is a continuation of a focus on workforce. Without a stable, skilled, and motivated workforce our plans will not be fully realised.

Discussion:
The Board noted that the plan had been through F&P Committee where they were asked to consider two proposals and subsequently there were further iterations which were then agreed between IG, DBe, ME and SH via email. The outcome is that the plan is balanced but high risk and has been submitted to the region. The Trust will then be given a System Oversight Framework (SOF) rating. SH asked FMc to circulate the SOF framework to the Board for information. **ACTION: FMc** **FMc**

SH explained that the first of system financial recovery groups happened this week and range of concerns have been raised around accountabilities where spend is over £100k. This will need to be proposed to the Trust formally and will come through F&P Committee and Board.

The Board discussed the large amount of work to do considering the financial year had already begun. SH commented that the Trust will work with the plan it has submitted, noting that work was already underway. The Board recognised that the £15.3m CIP in 2023/24 is a significant target and will require diligence, scrutiny and a culture that facilitates that level of activity.

DBu noted the national financial challenges and the risk against a 5% CIP, highlighting the concerns from a clinical perspective. IG explained that the Trust is committed to the 5% but the level of risk is acknowledged. ME noted that the team have implemented a governance structure around programme assurance (e.g., Length of Stay (LoS) and time to first outpatient appointment) and delivery. This includes the new Financial Improvement Group. ME noted he would bring this structure to the next F&P Committee.

SH noted the importance of careful engagement with employees around the savings plan. The Board noted that the activity described in the plan is the key focus but the challenge will be the pace of delivery. SH reiterated the need to deliver safe, effective services, noting that these savings will be going through a Quality Impact Assessment (QIA) process to provide balance and oversight.

TB commented that the plan is clear and the structure is logical, noting this was the strongest operating plan she had observed at the Trust. TB referenced the CIP savings, reflecting that the 5% ask is subsequent to 12 years of funding challenges. TB commented that there are opportunities identified but these require the necessary context. TB asked how Improving Together and the operating plan will work alongside each other to deliver a balanced outcome. SH explained that that the operating plan is strong because it has been developed using the Improving Together methodology. The actions to improve services is aligned to the agreed breakthrough objectives. The shifts to make in terms of how we deliver care links to the Trust's strategic initiatives. The Trust has also begun addressing corporate resource aligning to these priorities and the organisation has already started to see a benefit.

Decision:

The Board noted that they had delegated authority to F&P Committee who had reviewed the plan in detail prior to submission. Further iterations were agreed by IG, DBe, SH and ME and the plan was submitted on 30th March.

TB1 6/4/3 ASSURANCE AND REPORTS OF COMMITTEES

TB1 6/4/3.1 Clinical Governance Committee (CGC) 28th March 2023

EJ presented the report, providing a summary of escalation points from the meeting held on 28th March 2023. EJ asked for the report to be taken as read highlighting the key points as follows:

- The Board is required to consider maternity and neonatal staffing as part of the safe staffing report which is on the Board agenda today. There has been an improvement in how maternity information is triangulated from the division into the Committee. Going forward there is going to be a general template that all maternity departments will use to encourage benchmarking. This has been supported by FMc's work in relation to reviewing their quality governance.
- The Committee received a presentation from the Surgical Division. The committee felt there was good assurance around the division's focus on quality governance and improvement and that learning had been shared across the divisions who had presented at CGC to date. This is a valuable addition to the CGC agenda.
- The internal audit report referred from the Audit committee was presented and it was good to note that this was a positive and low risk report.

Discussion:
IG noted he had observed and was assured around the level of scrutiny that had taken place.

TB1 6/4/3.2 Finance and Performance Committee 28th March 2023

DBe presented the report providing a summary of escalation points from the meeting held on 28th March 2023. DBe asked for the report to be taken as read, noting that the key elements of discussion were around the operating plan. There were three recommendation reports for approval which received Committee support. These will be received in Private Trust Board for approval.

The report was noted.

TB1 6/4/3.3 Trust Management Committee 22nd March 2023

SH noted that this was a leadership meeting with the next full meeting on 26th April. There was a discussion around the bed reduction plan and MW led a discussion on the Staff Survey and what we expect to see in terms of the response.

Discussion:
LT felt positive regarding the engagement and commitment to the bed reduction plan to address LoS. JDi had meetings with divisions and there is a programme of work scheduled to move this work forward.

MW noted that she had felt there was less ownership of actions coming out of the Staff Survey and there is work to do in terms of improving this.

The report was noted.

TB1 6/4/3.4 **People and Culture Committee 30th March 2023**

TB provided a verbal update from the meeting held on 30th March. TB had chaired the meeting at short notice due to sickness. TB noted the following key points:

- The meeting was not quorate due to sickness. The Terms of Reference state there should be two NEDs and there was only one.
- The Committee supported the updated Terms of Reference subject to approval from MvB and RA.
- The Committee effectiveness report was received and it was agreed there has been improvement made over the last year to grasp the people agenda and embed better governance processes.
- The Committee spent time on key strategic areas of People Promise and progress was noted as part of the Improving Together work.

Discussion:
SH noted it was great to hear that MW, IC and the OD&P team from a leadership perspective have embraced the Improving Together methodology. MvB gave credit to MW and team for the transformation seen in the last year.

TB1 6/4/3.5 **Audit Committee – 22nd March 2023**

RH presented the report providing a summary of escalation points from the meeting held on 22nd March 2023. RH asked for the report to be taken as read but noted the following key points:

- There was a broad discussion re deep dives, noting that these have been reactive in the past but will now be scheduled ahead. There will be a focus on international recruitment and effectiveness. This is part of a broader set of assurances that Audit Committee will consider.
- The SFIs were supported and the Committee recommended approval to the Board.
- The Committee received three Internal Audit reports and spent some time discussing. This was a high-risk report but the Committee received assurance that management responses provided are appropriate and proportionate.
- The Counter Fraud return achieved a green rating this year except for component 12, in respect of Declarations of Interests which will achieve an amber rating.
- External Audit – ME assured the Committee that the detailed plan for the year-end audit as proposed by Grant Thornton was tight but achievable.
- The Committee discussed the going concern principle and the Committee recommended to the Board that the 2022/23 accounts should be prepared on the basis that SFT is a going concern.

Decision:
The Board approved that the accounts should be prepared on a Going Concern basis.

TB1 6/4/3.6 **Integrated Performance Report (IPR) (M10)**

JDy presented the Integrated Performance Report which provided a summary of January 2023 performance metrics. JDy took the paper as read but highlighted two key issues:

- As we head into another round of industrial action, it is important to highlight the impact on a number of performance metrics.
- Outpatients continues to be challenging in relation to waiting times and DM01.
- Challenges around pressure ulcers remains high and the Trust has implemented a new investigation process to ensure learning is identified and actions for teaching can be taken forward.
- Vacancy and sickness have marginally improved. However, the number of new starters has meant having to manage skill mix challenges.

Discussion:
EJ noted that the CGC and other Board Committees are sighted on all performance metrics and therefore nothing in the IPR comes as a surprise. EJ highlighted the good news around the heightened focus on falls and the continued improvement. EJ highlighted that another positive impact of reducing inpatient falls, aside from patient safety and experience, is a reduction in LoS.

SH commented that the 52-week wait position had deteriorated. The Board discussed and it was agreed there needs to be further work on this trajectory. SH asked JDi to liaise with LT and consider what might F&P might receive in terms of elective recovery and how are we planning to mitigate risks. **ACTION: JDi/ LT** **JDi/ LT**

Additionally, concerns around the operational response around protecting Stroke Beds is clear in the report. This needs to be revisited. PC noted that he would support JDi as the action discussed earlier was to improve the narrative that has been produced by the team. SH noted that further work is required to better represent the improvement in an objective way. **ACTION: JDi/ LT/ PC** **JDi/ LT/ PC**

DBu noted the complexities around stroke care and how this is managed can be reflective of how the Trust is delivering complex care in the Trust. PC assured the Committee that Sentinel Stroke National Audit Programme (SSNAP) data indicates that the Trust is benchmarking well against other organisations in the southwest. However, there is more work to be done to improve this service. SH noted that she was not assured there is consistent application of care within this patient cohort. IG noted that there is further work to be done and asked for an update to come back, as part of IPR, to see if there are further actions underway.

The Board discussed what has triggered an increase in pressure ulcers. JDy highlighted that there are themes around assessment issues and pressure

reducing equipment, which can be linked to having new employees. Additionally, increased bed moves means continuity is sometimes lost. Education is huge part of managing pressure ulcers and JDy noted that May is Tissue Viability month.

The Board discussed alerting metrics and how they are triangulated with the BAF and risk register when performance is declining month on month. The Board discussed how this links Improving Together which provides a framework for assessments. SH noted that from a leadership perspective, this is linked to the 'Go & See' work but agreed there needs to be a systematic method of triangulated this to the BAF.

RH referenced the operational plan and key performance indicators and asked how the Trust is tracking itself against the 11 targets. ME agreed that there should be visibility against these targets but the Board have agreed what key areas of focus are and there needs to be discipline in chasing improvements which will impact outcomes for patients. ME noted that some of targets are measured at system level. RH and ME to go through this outside of the meeting.

TB1 6/4/4 STRATEGY AND DEVELOPMENT

TB1 6/4/4.1 Digital Strategy Update

The Board noted that this had been deferred to May.

TB1 6/4/4.2 Improving Together Quarterly Update Report Q4

PC presented the report asking the Board note progress on delivery as the first phase of the improvement programme comes to an end. PC noted he would take the report as read but highlighted the proposed roadmap for the next 18 months of the programme which also indicated the important role Board members have in its successful delivery.

Discussion:
TB noted that a difficulty with the organisation being operationally challenged is engaging with employees and delivering training. TB therefore asked how many employees have been trained at this point against the expected figures. PC noted that he did not have the confirmed numbers but indicated that the Trust have trained less than expected. TB queried if the Trust is continuing to experience the same issue, what is providing us with the confidence that staff will receive training. PC highlighted the snowball effect of Improving Together as a measure of how embedded it is in the organisation. Whilst in the early stages, there is also a shift in people's attitude. The teams have segmented training up and there is a stronger commitment in divisional management teams and from executive colleagues to support this.

SH noted that more staff have been recruited but our metrics are not doing what we expected. There have been some genuine challenges in terms of delivery.

MW explained that since embarking on this cultural change programme, many people have experienced the initial KPMG training and all execs have been through this too. PC and AT have moved this work forward and there

has been a step change in how the methodology is being utilised across the Trust. From and OD&P perspective, the Communications team have worked hard to keep staff informed and this change journey has meant working at pace and spending more time challenging ourselves. IG noted how positive it was to hear the impact and how it is being applied. IG suggested that in the Board Improving Together sessions scheduled this year, there needs to be further thought on how the Board are providing leadership around utilisation of the methodology.

There was a query around the business case referenced in the report in relation to the operational management structure case. PC explained that the deployment of operational excellence requires the Trust to confirm the layers of the organisation. As a small organisation SFT did not have a separate speciality layer between front line and senior management. This business case will ensure there is the right triumvirate layer. SH explained that this is about restructuring the divisions to embed a triumvirate approach to managing specialties. The paper is still in circulation and will be presented to executives in the next few weeks. DBe acknowledged the requirement for this new structure but reiterated the need to understand the benefits in year to balance the position.

RA asked how the Board can assure itself that Improving Together actions are evidence based and how do we take an external view to bring in best practice. Additionally, how is Improving Together linked to workforce analysis in terms of workforce competencies to ensure this work is sustained and is the Trust sure what this resource looks like. PC explained that, as an improvement programme of operational excellence, there is a large evidence base of deployment globally. The methodology of Improving Together links to evidence in relation to staff engagement, patient care and outcomes improve. In terms of specific examples PC noted that the report is evolving and this can be built in. PC noted that he would welcome further feedback on the report outside of the meeting.

SH suggested that in one of the three Board Development sessions it might be useful to hear directly from a front-line team. **ACTION: PC/AT**

(The Board took a 30 min break)

TB1 6/4/5 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 6/4/5.1 Review of Standing Financial Instructions

ME presented the report which had been to the Audit Committee. The Board is asked to approve of the updates to job and organisational titles, and the correction to the placing of contracts delegated limits to those approved by Board in 2019 i.e.,

- The Director of Procurement delegated limit is now set to £350k excluding VAT (document previously stated £250k).
- Table 3 has been updated to be explicit the delegated limits exclude VAT.

Approved
The Board approved the SFIs.

TB1 6/4/6 QUALITY AND RISK

TB1 6/4/6.1 Q3 Learning from Deaths Report

PC presented the report which included a summary of learning from deaths and making improvements. The Board noted that the report had been discussed at length at CGC.

- As discussed at previous CGC meetings, the mortality data, particularly HSMR continues to be above the expected range. Therefore, PC will meet with the regional Chief Medical officer (CMO) to establish any further action that can be taken.
- PC noted that external scrutiny is difficult given the complexity but it is important to ensure the Trust is triangulating experiences across the system.
- PC reported that a new Trust Mortality lead had joined the Trust and will be working with PC on developing this report.

Discussion:
SH asked for a timeline for the discussion with the regional CMO. CGC are expecting feedback at the next meeting, however this is dependent on the impact of industrial action over the next month. EJ and DBu both supported the steps outlined to investigate further.

TB1 6/4/7 PEOPLE AND CULTURE

TB1 6/4/7.1 Nursing Skill Mix Review

JDy presented the report which asked the Board to note the findings of the Trust's position in relation to adherence to the monitored metrics on nurse staffing levels. This is a six-monthly report which is mandated to report to Trust Board. The following key points were noted:

- The demand the Trust has experienced means that temporary staffing has increased.
- As part of the winter plan there was an active decision to run long-line agency but this will be ceased at the end of April. Despite seeing an increase in spend the Trust still sit in the middle in terms of benchmarking. Not all additional duties that are advertised are filled.
- Positively Care Hours Per Patient Per Day (CHPPD) has increased, although the Trust benchmarks lower than neighbouring Trusts. The Trust is working within the Acute Hospital Alliance to agree principles of practice.
- For transparency, the report on maternity staffing is included as an appendix. There are currently 20 vacancies. However, a number of new starters are expected to start in the next few months but this will still result in 12-14 vacancies in the department. There is due to be another Birthrate + assessment soon. As highlighted previously, Continuity of Carer is not a process that the department can cover at this time and historically, rural trusts have struggled to support this model. Other work to help manage maternity vacancies include apprenticeships to midwifery.

Discussion:

The Board discussed staffing with SH commenting that numbers of staff were not triangulating in terms of organisational performance. The Trust has reduced the number of Health Care Assistant (HCA) vacancies and there are less beds open but the Trust is spending more on agency staff. Additionally, SH queried the turnover rate of 19% for HCAs, asking if this included another cohort of staff as the Trust has done a huge amount of work on recruitment and retention.

JDy acknowledged the challenge and noted that the pace of induction is a factor and that care hours have increased. SH reiterated that HCA alignment did not tally to what is being experienced in the Trust.

EJ noted that SH's point is important and triangulating this will occur via performance and workforce reports, to allow the Board to understand what is behind the staffing review data. EJ noted that the skill mix report is just about completing the review process.

DBu noted the positive work in seeing CHPPD improve.

EJ referenced continuity of carer, highlighting that the Ockenden report challenged if this should be a consistent national model. SH noted that the single maternity action plan had been published this week and that reconciliation through CGC will be helpful.

TB1 6/4/7.2 **National Staff Survey Results 2022**

MW presented the report, noting that this had been discussed previously in private Board. MW highlighted the following key points:

- Other organisations have made more progress than SFT
- The Trust has an above average response rate to the survey but remains in a disappointing position in relation to the overall results.
- SFT has seen a statistically significant improvement in the People Promise element of 'We work flexibly', but a significantly worse performance in 'We are always learning', and in relation to Staff Engagement.
- We have consistently recognised that training activity and appraisals have been impacted by the pandemic.
- There have been small improvements in inclusion and compassion. The majority of staff from a BAME background have a positive view but do record being treated less well by patients and staff.
- Strategic objectives attend to these areas and we are clear we want to a fair and equitable employer. However, the signals are concerning and the short-term intermittent absence is a sign that staff are disengaged.
- 22.4% of staff are coming from overseas so we have a duty of care that these people are welcomed and supported.
- The follow up work for this will come through People and culture but also needs to go through TMC. There will need to be further support for the line manager population.
- The challenge is ownership and ensuring change is enabled and there will be a series of divisional and corporate listening events.

Discussion:

The Board discussed appraisals and DBe asked what is stopping appraisals taking place. Pre-covid the Trust was scoring higher and given Improving Together is about empowerment and autonomy, what is preventing appraisals taking place. MW explained that the Trust took a decision to move to appraisal recording onto Electronic Staff Record (ESR) which is a less intuitive system, colleagues advise of being "timed out" in completion of the form. We recognise some people managers may have more appraisals to both complete and or sign off and this is an item of work which will be actioned as the establishment control and organisation structure template are completed later this year. Additionally, we are assured appraisal and well-being conversations are being completed but they are not recorded.

RH queried the poor results in advocacy and quality of care and asked for further detail. MW explained that people do come forward but they do not receive feedback that their concerns have been acted on or that in improvements that have taken place. It is acknowledged as an area of improvement when people do speak up.

SH noted that the Board need to be included at the listening events once they are organised. IG commented that everyone needs to take ownership. SH and IG to discuss a personal letter to all employees on the back of the results being published.

MvB noted that it is ultimately management responsibility to undertake these actions and does not sit within OD&P. SH summarised that the results were indicating some concerning themes over the last two years and action needs to be taken.

IG reiterated MvB's point around accountability for all managers and this will require support from the senior management team and Board to encourage an impactful and meaningful response.

TB1 6/4/8 GOVERNANCE

TB1 6/4/8.1 2023 Annual Review of Directors Interests/Annual Review of Fit and Proper Persons Test

FMc presented the report noting that as part of the Trust's licence agreement to publish the annual Register of Directors' interests to the Board. There is also a requirement for all Executive and Non-Executive Directors to complete an annual form of declaration confirming that they continue to be a fit and proper person. This has been completed and no concerns have been raised.

All decision-making staff identified as Band 8d or equivalent must also submit an annual return and current compliance is at 53%. There is no recommended. threshold to move compliance to a green rating. However, TIAA suggested a compliance level of 80% to achieve this. Ongoing actions to improve compliance were discussed at March's Audit Committee. FMc noted that the process of ensuring returns and collating responses was labour intensive.

Discussion:

The Board discussed the valued added from this process as it was consuming resource. The Board suggested finding out what others are doing and if there is any benefit of capturing this wider information.

TB asked for further assurance around the private practice as this is particularly one area where there might be some conflict. PC explained that job planning is not completed up together so it is not possible to give 100% assurance that the Trust is aware of all those who practice privately. Similarly to all declarations, we're relying on the individual to be transparent and declare.

EJ highlighted that the 'no action' was missing next to her name on the register and this had already been rectified on the master register.

TB1 6/4/8.2 Integrated Accountability and Governance Framework including Board Committee Terms of Reference

This was deferred to May's meeting.

TB1 6/4/8.3 Register of Seals Q4

The Board noted that there had been no new seals since last report.

TB1 6/4/9 CLOSING BUSINESS

TB1 6/4/9.1 Any Other Business

There was no further business.

TB1 6/4/9.1 Agreement of Principle Actions and Items for Escalation

IG highlighted the key areas of discussion, including:

- Focus on assurance around industrial action and arrangements in place.
- The Operating Plan has been approved the operating plan. Ongoing oversight will be required to ensure delivery.
- A good presentation received on Improving Together. There will be further board development sessions throughout the year.
- The Board discussed the shared responsibility around the Staff Survey and the concerning trends.

TB1 6/4/9.3 Public Questions

Jane Podkolinski thanked for everyone for their hard work and the level of assurance given.

TB1 6/4/9.4 Date of Next Public Meeting

Thursday 4th May 2023, Board Room, Salisbury NHS Foundation Trust

TB1 6/4/10 RESOLUTION

TB1 6/4/10.1 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

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 9/3/5.3 Maternity Quality and Safety Report Q3 22/23	~~06/04/2023~~ 04/05/2023	Eiri Jones, EJ	SH asked EJ, in her role as Maternity Champion, if she would contact the Chief Midwife to get further clarity on what is expected at Board.	**EJ explained that the National Chief Midwife has moved to a new role and she is therefore waiting to hear who she can contact to find out what is expected in terms of Maternity Board reports. JDy has also contacted the Maternity Improvement Associate.**	N	2
Trust Board Public	Sasha Grandfield	TB1 6/4/2.1 2023/24 Operational Plan	04/05/2023	Fiona McNeight, FMc	SH asked FMc to circulate the SOF framework to the Board for information.	**SOF Framework circulated. Item closed**	Y	3
Trust Board Public	Sasha Grandfield	TB1 6/4/3.6 Integrated Performance Report (IPR) (M10)/ Elective Recovery	04/05/2023	Jane Dickinson, JDi Lisa Thomas, LT	SH asked JDi to liaise with LT and consider what might F&P might receive in terms of elective recovery and how are we planning to mitigate risks.	**F&P received an elective recovery deep dive on 25th April. Item closed**	Y	3
Trust Board Public	Sasha Grandfield	TB1 6/4/3.6 Integrated Performance Report (IPR) (M10)/ Stroke	04/05/2023	Jane Dickinson, JDi Lisa Thomas, LT Peter Collins, PC	Concerns around the operational response around protecting Stroke Beds is clear in the report. This needs to be revisited. PC noted that he would support JDi as the action discussed earlier was to improve the narrative that has been produced by the team. SH noted that further work is required to better represent the improvement in an objective way.		N	2
Trust Board Public	Sasha Grandfield	TB1 6/4/4.2 Improving Together Quarterly Update Report Q4	08/06/2023	Peter Collins, PC Alex Talbott, AT	SH suggested that in one of the three Board Development sessions it might be useful to hear directly from a front-line team.		N	4

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of meeting:	4th May 2023		

Report tile:	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			

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 April 2023. The report highlights: • Key national communications for Board awareness and information • Operational context including impact of industrial action during the period • Relevant updates from key partnership activities including BSW Integrated Care System and the BSW Acute Hospital Alliance • Communication and engagement highlights

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	x
Other (please describe):	

1.0 Our Population

1.1 Operational Context

Whilst there is continued pressure for colleagues working in urgent care the last 6 weeks have seen positive improvements notably the number of escalation beds open has reduced, ambulance handover waiting times continue to improve and the time it is taking for patients who require a hospital admission to access a bed has reduced. The detailed performance is shared in the Integrated Performance Report. It is positive to see our teams' efforts across the Improving Together programme secure this progress ensuring we are using our resources effectively so patients can access timely care.

The progress colleagues have made with eliminating elective waiting times over 78 weeks has been sustained despite the impact of having to rearrange a considerable number of patients appointments due to junior doctor industrial action which is excellent. Our teams are making timely progress with the commitment in the 23/24 operational plan to reduce the number of people waiting more than 65 weeks for their planned care. The trajectory to recover the diagnostic 6-week standard (DMO1) is also showing sustained improvement.

Our teams are focused on delivering on their respective commitments agreed as part of our operational and financial plan which the Board signed off in April. From an operational perspective one of the early plans was to refresh the Same Day Emergency Care (SDEC) service to provide an alternative to admission to the Acute Medical Unit or the Short Stay Assessment Unit. This plan links to benefits in reducing length of stay, bed occupancy reduction and provides a better experience for patients. Whilst it is still early days the service has been operational throughout April (i.e., we have not resorted to using this area as additional inpatient beds) and as detailed in the IPR is delivering improvements in the 0-day length of stay. Whilst there is much more for us to do I know the Board will want to acknowledge this success.

There is more for us to do to continue to improve and we mustn't become complacent, but it is important that we take time to recognise that our teams 'are making a tangible difference to our recovery and key performance standards. At an individual patient level, the improvements make a significant difference to people and their families.

As Board members will be aware there has been further Industrial Action with junior doctors striking continuously for 96 hours from 11th April – 15th April 2023. Our clinical, operational and EPRR colleagues once again did a fantastic job in both preparing for the strikes and oversight of activities during that week. As Board members will appreciate this takes a considerable amount of time for our leadership teams. I would like to offer my thanks and appreciation to them and to all our colleagues who stepped in to cover during this period. I know for some colleagues this involved changing their personal plans to ensure that we had the minimum number of doctors available to maintain safe services.
Regrettably, we had to cancel and rearrange some of our elective work to release medical staff to cover the junior doctors who were exercising their right to take industrial action. The detail of the cancellations is set out below:

Union	Date	Procedures cancelled	OP appointments
BMA	11th April	8	110
	12th April	2	107
	13th April	8	140
	14th April	4	187
Totals		**22**	**544**

The Board will want to note that our data also demonstrates that the bookings for outpatient appointments were significantly reduced (circa 50%) because of the notification of strike action so the overall capacity lost was higher than the cancellation numbers.

I would like to apologise to any patients whom this impacted.

As colleagues will know the Royal College of Nursing (RCN) has rejected the pay offer made to Agenda for Change staff groups and has given notice of further strikes from 30th April- 2nd May 2023.The RCN has not made any provision for derogations in critical areas for example Emergency Department, Intensive Care or Emergency theatres which increases the level of risk. At the time of authoring this report we are using our EPPR framework to manage the preparations with daily Executive Gold calls which will continue until the strike has finished. We will have additional senior leadership presence on site during the strike as we have with the previous episodes of industrial action. I will provide a verbal update to Board during our meeting.

1.2 Financial sustainability

The organisation has a stretching financial plan this year seeking to deliver 5 percent /15.3m CIP as part of the overall Integrated Care System's financial recovery plan. The Chief Finance Officer is supporting the CEO in respect of strengthening our oversight of this key programme of work and set out in detail to the Finance and Performance committee the governance and reporting arrangements.

All systems and providers across England have been asked to resubmit plans on the 4th of May to NHSE and we will feedback to the Board any relevant information as required.

BSW ICS have set up a financial recovery group which reports to the ICB. This is meeting every 2 weeks and both myself and the CFO are members.

1.3 Robotic surgery

Board colleagues will know that we recently agreed a business case to procure a robot to provide an opportunity to develop robotic surgery on site. I am pleased to report that the Versuis robot has been delivered and our colleagues in the surgical division will now progress their plan to develop and implement their robotic programme. This is an excellent opportunity to enhance what we can offer to our local population.

2.0 Our People

2.1 Staffing

It is very encouraging to see the hard work of the Resources team starting to bear fruit as staff vacancies fell for the third month in succession, reducing from 10% in Dec to 7.2% and ensuring that the Trust has again this month had a positive inflow of staff compared to those leaving. Some of this inflow has been a result of targeted campaigns in key areas of need, for example Theatres have seen 46 new staff arrive since the campaign began in Apr 22 and HCA vacancies have reduced from 91 in Sep 22 to 24 this month. These data demonstrate that turning the right levers in our recruitment activity has a positive impact on Staff Availability, as demonstrated by reductions in Agency Spend this month.

The enabling area which supports all three driver metrics and will establish a clear sight picture on the establishment and support improved organisational design as well as generating greater grip on agency and bank spend, is progressing in accordance with the individual project plans for Establishment Control, E-Roster roll out and Temporary Staffing.

2.2 Retention of staff

Staff turnover remains higher than we would like, but our understanding of the reasons for individuals leaving are becoming more focussed through analysis of Staff and Pulse Survey results by Division, staff group and protected characteristics. Divisional plans have been developed and will become active from the end of April. Improving our uptake of exit interviews, targeted earlier in the leaving process is in progress, and work to

target career conversations with high turnover groups is also underway. The increased activity will both inform our future plans and re-assure existing staff that they are valued and heard.

I am pleased to say that we have agreed to bring four posts into our core establishment which have a significant impact on retention. Two provide support to HCA staff as they arrive in the Trust, a pilot has demonstrated the impact of this support on HCA turnover. The remaining two staff have provided instructional capacity to support the rollout of leadership development programmes for our line managers, maintaining this capability is essential in ensuring that Line Managers have access to training opportunities to improve their management skills.

3.0 Our Partnerships

3.1 National Communications

NHS E have undertaken a review of Delivery and Continuous Improvement over this last 12 months and shared their findings and recommendations in a publication on April 19th, 2023. This work is called **NHS Impact – Improving patient care together.** The review's recommendations were consolidated into three actions:

a) *Establish a national improvement board to agree a small number of shared national priorities on which NHSE, with providers and systems will focus improvement led delivery work*
b) *Launch a single shared NHS Improvement Approach*
c) *Co-design and establish a Leadership for Improvement programme*

Our Improving Together programme aligns well with the expectations detailed in the report to develop the organisational culture, leadership behaviours, operational management system and train people to use continuous quality improvement tools to deliver sustained improvements.

This was launched at the NHSE CEO spring event which covered other pertinent issues which I will provide a verbal update about in our private session.

3.2 BSW Integrated Care System

The BSW Integrated Care Board has signed off the system operational and financial plans which the Board have been appraised of over this last period.

The Integrated Care Partnership has launched the BSW Integrated Care Strategy which sets out a vision for the next five years. This is focused via three clear objectives:

1) Focus on prevention and early intervention
2) Fairer health and well-being outcomes
3) Excellent health and care services

Colleagues can access the document here https://bswtogether.org.uk/aboutus/our-integrated-care-startegy

3.3 Provider Collaborative - Acute Hospital Alliance (AHA)

The work programme continues the detail of which was shared via the AHA report distributed to Board members in April. The committee in common (CIC) have received a copy of the governance review that it commissioned via Aqua and have asked the AHA programme executives to review the report and prepare a response in relation to future opportunities for the CIC.
The Chair and I will want to discuss this with Board colleagues once the AHA executive have had an opportunity to consider this.

3.4 Other partnerships, communications and engagements

3.4.1 Intranet

At long last, after many ups and down, the Trust has launched its new Intranet, known as SALi. The new site holds both new and old information and is supported by new technology providing a better user experience, improved search function and the ability for it to be updated by local teams not just colleagues in informatics. I recommend everyone looks and feeds back to the communications team on sft.intranet@nhs.net. The site will continue to be developed over the coming weeks.

3.4.2 Anniversary activity

This year is both 80 years since the hospital opened as a US Military Hospital and the 75th anniversary of the NHS being founded in 1948. To celebrate these events the hospital is holding an open day over the 21st and 22nd July where we will invite the community to come and visit the site and see what we do and how we do it. There will be stands from all parts of the hospital plus from partners such as the blue light services and the Army. In addition, we are working with Salisbury Cathedral to organise a service of celebration on 25th June to which the community will be invited. As part of this service we will premier new work from poets Martin Figura and Saili Katebe and writer Paula B Stanic.

3.4.3 Main Entrance graphics

The doorway at the Main Entrance has had a refurbishment with the application of new wall graphics that highlight our vision and hopefully help bring this to life. I would encourage Board members to go and look when you get the opportunity.

3.4.4 Work experience returns

For the first time since 2019 we are planning to see work experience placements back on site. This is an exciting opportunity to support learners who may be interested in a career in the NHS and helps us connect to more people in our local communities.

3.4.5 National Awards

Our communications team and Clinical Psychologist Dr Kate Jenkins were finalists at the national Smarter Living Award for the COVID Recovery Project. While they didn't win the award, I am told they won the after party.

NHS Salisbury NHS Foundation Trust

Report to:	The Trust Board	Agenda item:	2.2
Date of meeting:	4 May 2023		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	18 April 2023 25 April 2023
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven (NED)			
Executive Sponsor: (presenting)	Debbie Beaven (NED)			
Appendices	n/a			

Recommendation:

The Finance and Performance Committee met twice in April. On 18th April an exceptional meeting was held to consider the decarbonisation project award (as delegated by the Board on 28th March 2023), and on 25th April.

The Trust Board are asked to consider the following recommendations from the Committee:

1. **Refurbishment of Whiteparish Ward** – the Committee was asked to consider a direct award of a Design and Build contract for the refurbishment of Whiteparish Ward.

   We are assured that the procurement process was fully compliant and in accordance with SFIs. The Committee challenged the impact on cost and timescales of issues such as those experienced with the New Ward build in a later paper (asbestos, bats, and material inflation) and received assurance that inflation had been built in. However, the need for a contingency plan should completion go beyond October '23 when bed pressures are expected to peak again, was highlighted.

   There is consensus that this is a necessary project, which has been built into our capital plan. It is the first ward refurbishment in 6 years and a "good news" story.

2. **Provision of Clinical Insourcing Managed Service Gastroenterology** – a proposal for a contract was tabled. The plan that went to Board in 22/23 was to recruit substantive roles, however this has not been successful in delivering the 7 Gastroenterologists needed, although it is recognised that we now have 2, which is progress. There are more potential candidates in the pipeline, mainly from overseas, some of whom are not fully qualified. The debate highlighted that the ambition to build our own in-house team will continue to be challenging, even within the next 11 months, and that it would be sensible to run a market procurement process for this service in 23/24. It was felt that this would also ensure there was some competitive tension with the current incumbent.

   The proposal for this essential service is supported for the committee as it is fundamental to patient safety. We are assured that the costs are already in our financial plan for 23/24. Given the ongoing challenges in recruitment the Committee requested a plan for the future of Gastroenterology to be presented at a future CGC meeting.

3. **Community Diagnostic Centre Business Case** – the Committee received an overview from Peter Collins, in his capacity as BSW Diagnostic lead, explaining the CDCs are funded nationally and aim to drive improvement and enhancements in clinical diagnostic centres, to reduce the "hijacking" to elective capacity and to help address the inequalities of access to diagnostics.

   The ICB have approved the business case, and the Committee questioned its role in the approval process given that the CDCs are a system asset with both capital and operational costs funded nationally. It was explained that there is a potential financial risk (considered to be minimal) if we are not able to properly utilise the centres, for example residual staff costs.

   SFT will be co-commissioner and co-signatory to the contract and is therefore accepting a share of any risks. The Committee agreed that this should be tabled at Board for full transparency and it was suggested that it is added to the strategic projects report being prepared.

   The governance of projects funded by the ICB where we are co-commissioners has created some confusion and we heard that the model has not matured yet. As there are likely to be more of these in future, we will explore the governance structure and process in a future Board development session.

4. **Mobile Scanners Contract –** similarly to the CDC business case, and as an integral part of the ICB approved CDC strategy, the contract for the mobile scanners was brought to the Committee for consent to act as co-commissioner, accepting the financial risks and activity benefits. This will be tabled with in the strategic projects report for Board awareness and full transparency.

5. **New Ward Budget position –** The committee was asked to consider the essential allocation of additional capital funds (to come from 24/25 budgets), to enable the new ward to be completed. The ward will be complete at the end of March 24, with the additional likely to be in the next financial year in the area above the ward, however if other sources of funding become available before then, the expectation is to complete it all by the end of the year.

   The Committee challenged the overspend, enquiring why the extent of the asbestos was not included in the original asbestos survey. We heard that what the Trust did was "good practice", but that the quality of the survey was inadequate and that this is being dealt with the organisation and might result in some financial recompense, however it is likely to be a long way short of the additional costs being incurred. The Committee heard of a number of issues that contributed to the significant overspend and in response we asked for the Estates leadership to share their learnings with us in the next meeting, particularly given the number and scale of capital projects being managed. A proposal to bolster the estates report to include an update on all major capital projects was welcomed.

Executive Summary:

The Board are asked to note the following items from the F&P meetings in April:

1. **Decarbonisation Project Award** - in accordance with the delegated authority given by the Board on 6th April, the exceptional F&P meeting on 18th April, received the proposal to award the decarbonisation contract to the preferred supplier. The Committee was satisfied with the procurement process and outcome and agreed to the award, but asked that headline contractual terms, KPIs and conditions, together with an assessment of financial risk if carbon savings are not delivered come back for Committee review ahead of any contract being formally signed, to ensure transparency and oversight for this long term contract.

2. **Electronic Patient Pathways (ewhiteboard programme)**
   On 25th April we received an update on the progress of the programme, which moves into user testing phase on 9 May. The programme aims to:

   - Maximise the current eWhiteboard functionality to replace paper-based oversight of bed state with a real time position.
   - Improve the timeliness and visibility of criteria to reside information.
   - Reduce the risk of a patient's pathway or data being captured incorrectly or duplicated at the point of transfer or discharge.
   - Improve electronic audit of a patient's pathway, accurately identifiable on the eWhiteboard.
   - Improve patient experience and journey from admission through to discharge.
   - Enable decreasing Los and bed occupancy.

   The Committee heard that leadership sponsorship and user education is essential to ensuring engagement and benefit realisation. There was some challenge around the data quality and timeliness issues and the Committee heard that "floor walkers" will provide support in addressing data quality concerns, explaining the cause of the issue and how to remedy, which is key to improving confidence and increasing engagement. The committee will receive an update on the effectiveness of the implementation in July 2023.

3. **Theatre Operational Update –** we had a positive update on the improvements being made with theatre operational targets, particularly around utilisation which is now on target. There is still progress to be made on other metrics such as late starts, which although has seen a 10% reduction is still some way from target. Some of the metrics show that with a push on day cases we could deal with approx. +140 cases per month.

   Improvements will continue with a 3 main workstreams: booking and scheduling, operational efficiency, and team engagement. We heard that there will be a focus on 3 specialities a quarter. These improvements will support our elective recovery, which has some way to go given that we are 2nd lowest in the region when compared with 2019/20 activity levels.

   We heard that we are on track to deliver 16 open theatres by Jan '24, with 13 currently open, and progress continues

4. **IPR** – Nothing significant to report. The metrics are fairly stable, which is encouraging given the operational challenges in the last few months, but there remains the question on when things will improve. The Committee asked for some trajectories to be added to the IPR where possible.

5. **Financial report** – the main point to note is that we showed a breakeven position at the end of the year as a result of non-recurrent funding. The report showed capital overspend on building projects and considering the new ward experience the Committee requested more detail on the overspend.

6. **CIPs –** The Committee was pleased to receive the report which showed the CIP reporting structure and proposed accountability, along with a template for reporting the progress made on CIPs for the Committee's attention each month. We look forward to seeing data in the next month's report.

7. **Subsidiary reporting** – the report on subsidiary governance and performance was well received and informative. The Committee have requested a simplification of the financial performance reporting each quarter.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	2.3
Date of meeting:	4 May 2023		

Report tile:	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			

Recommendation:

The Board is asked to note the report from the Trust Management Committee.

Executive Summary:

The Trust Management Committee was held on the 26th of April 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 eight business cases and 2 policy approvals.

TMC members had the opportunity to review this and support decisions and approvals which are detailed in this report.

The committee noted 2 business cases which have been agreed via Chairs action since the last TMC meeting as they were time sensitive. Details are provided below:

Business case 1: Increase in research nurse capacity.

This business case was to support a modest increase of 0.53 wte which will enable the department to change their head of service role from 0.47wte to 1 wte. The expansion of the role will be recovered by additional income generated through increased research activity. It will also support the team to increase awareness and participation in research and our ambition to set up a research board in 23/24.This was approved via Chairs action with the Chief Finance Officer at the end of March.

2) Diabetes specialist nurse and dietitian business case

This case set out the need to sever the Service Level Agreement with Wiltshire Health and Care (WHC) for the provision of Diabetes specialist nurses to support the community diabetes service. WHC have not been able to fulfil their obligations in this contract due to an inability to recruit on a consistent basis to this specialist support. This is directly impacting patients with insulin pumps and other more advanced treatments and technologies and risking the hospital team's ability to achieve the HbA1 targets for people with Type 1 Diabetes.

Given the impact to patients and the broader risks this was approved by Chairs action with the Chief Finance Officer on the 29th of March and shared with TMC for noting.

The following business cases came to TMC for a decision. TMC noted whereby this already had access to the funding needed secured via the operational planning round and which would need to be priotised against the funding for new investments available within the 23/24 plan. TMC members are aware that the requests for new investment are significantly higher than the available budget and therefore there will need to be prioritisation.

3)Gastroenterology Sustainability
This case will be received by the Board via the Finance and Performance committee who reviewed this case on the 23rd of April. TMC members discussed the case and Board will want to note that they also agreed to recommend this to the Board for approval

4) Physicians Associates
The business case has been developed by the Medicine Division following a comprehensive workforce review commissioned by the Chief Medical Officer. This specific proposal is to introduce 4 new Physicians Associate roles across ED, Acute Medical Unit and the Frailty service. Whilst the roles will be new to SFT they are well established across the NHS in both secondary and primary care settings. The plan is to recruit x 4 and provide the relevant induction and mentorship over the initial period to ensure they are well supported, and the teams can understand their impact and contribution to services. This will be a cost pressure in year 1 which will be mitigated beyond this as they be able to fulfil service gaps that we are currently covering with high-cost locums and agency doctors. They will be a more consistent member of the team which provides additional benefits. **TMC approved this case**

5) OSCE training
This business case was put forward by corporate nursing and the education team who have identified an opportunity to support people at SFT working as Health Care Assistants (who hold a registered nurse qualification from overseas) to undertake their OSCE training enabling them to join the NMC register in the UK. This supplements the International Nurse recruitment which we deliver with a third party and offers a way to develop existing talent. The costs outlined in the case demonstrate it is less costly than international recruitment. **TMC agreed this case and want the formal approval to be considered alongside other business cases in the pipeline as part of the prioritisation process that will take place in May's TMC.**

6) Portering Rota Review
The facilities team have undertaken a review of the capacity and responsiveness of the portering service which recommends a modest investment of 110k pa. The case provided detailed information about workload, availability and benchmark information from other hospitals all of which identified the requirement for this investment. TMC noted that porters are key members of the team whom we rely on in respect of managing patient flow in and across the hospital. **TMC approved this business case.**

7) Additional Dermatology activity
The surgery division brought forward a case to outsource some medical Dermatology outpatient activity to ensure that patients in the service can be managed within the current 78-week performance standard which Board will recognise needs to improve to a maximum of 65 weeks during this next year. The trust hasn't been able to recruit sufficient Dermatologists (this is a nationally recognised challenge) and therefore there are significant numbers of people in the backlog waiting list. This proposal will secure an additional 1500 appointments to minimise the impact of long waits for patients and the risks of the Trust breaching the performance standards. There is a cost pressure of circa 50k. TMC noted that there is concurrent work across the Acute Hospital Alliance to review the options for service delivery in the mid to long term given all 3 trusts have a shortage albeit that does not negate the need to offer the people on the current waiting list appointments. **TMC approved this business case**

8) BSW Eye Care Diagnostic Hub
This business case has been led by one of SFT's Ophthalmologists with multi sector representation from colleagues across the BSW partnership. The proposal is to create a Community Eyecare Diagnostic Hub in Salisbury city centre aligned to the national best practice to utilise optometrists as primary decision makers. This is supported by BSW Eyecare Professional Network and will release secondary care ophthalmology services to address the backlog of work that needs to take place in a hospital. It will also support the capacity needed to manage the increase in demand (national forecast for BSW growth is 20 percent over the next 8 years). The case detailed how this would be managed from a workforce perspective and the financial requirements which are supported by the tariff. **TMC noted what a great piece of work this is aligned to providing care in the community and approved the case**

TMC approved an update to the Prevent Policy & the BSW ICS Procurement Policy. TMC also approved the Integrated Governance & Accountability Framework 2023.

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	x
Other (please describe):	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	4th May 2023		

Report tile:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Sections approved by responsible committee: - Operational performance and resources: Finance and Performance Committee - Quality and care: Clinical Governance Committee - Workforce: People and Culture Committee			
Prepared by:	Louise Drayton, Performance and Capacity Lead Amanda Hardie, Head of Performance			
Executive Sponsor: (presenting)	Peter Collins, Chief Medical Officer			

Recommendation:

The Trust Board are asked to note the Trust's performance for Month 12 (March 2023)

Executive Summary:

Overall performance is consistent with previous months, the Trust continues to manage the balance between urgent care pressures on bed occupancy against the need to see and treat more people waiting for planned care. The Trust faced additional challenges in March following industrial action impacting the cancellation of services, and the capacity of staff to manage both strike action and the much-needed transformational change to address key performance and quality improvement opportunities.

The key planned care metrics of time to first outpatient appointment and the total elective waiting list have increased slightly. Whilst disappointing, this is unsurprising given the level of cancellations in quarter 4 of 2000 patients who have subsequently been re-booked. The areas of biggest challenge remain Oral Surgery, Gastro, Colorectal, Gynaecology and ENT. The Trust remains focused on theatre productivity work to maximise the number of patients we can see and treat through a limited bed capacity, the number of escalation beds open in DSU has reduced giving more capacity to meet planned care day case targets. Outpatients remain a focus with the Trust looking ahead to 2023/24 with an aim to reduce outpatient follow ups in line with the national standards.

Diagnostics has improved in month with 69.4% achieving the 6-week standard. There was a reduction in breaches in MRI and Ultrasound particularly. Cardiology Echo services have maintained excellent performance with zero reported breaches for the third month in a row. Diagnostic improvements are an ongoing area of focus with additional MRI capacity planned for April 2023 which will further improve the DM01 trajectories in coming months.

Urgent care continues to be below performance trajectories, staffing challenges particularly in the nursing skill mix do challenge the ability to achieve the process and pathway changes all recognised to improve flow. The biggest challenge remains flow from ED into the wider hospital, where bed occupancy remains high, moves are happening later in the day leaving a higher number of patients in ED impacting capacity to see and treat new patients. The protection of a Medical

SDEC area started at the end of March and initial data shows an improvement in flow. Ambulance handover delays remain fairly static with some improvement in March.

The focused quality metrics show ongoing challenges, pressure ulcers have remained high in March, the Trust has implemented a new investigation process to ensure learning can be identified and actions for teaching can be taken forward. Infection control metrics show a static position which is positive although the Trust is not being complacent in taking key actions forward.

From a workforce perspective agency spend remains high at 7.4% of the total pay bill compared to a target of 3.7%. Underneath sickness remained static at 4.4%, and turnover reduced slightly although it is high at 14.0%. The vacancy rate continues to slowly creep down to 7.2%. The ability to appropriately establish our workforce is vital to the success of the financial and operational plan in 2023/24.

The financial position reflects the challenges outlined above, the level of agency spend and number of beds open drives a significant proportion of the challenges. The YTD control total position was a deficit of £12.461m, which is a small surplus of £39k when the additional £12.4m funding from BSW is taken into account.

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

Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

March 2023

Summary

March 2023

Salisbury NHS Foundation Trust

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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)?

NHS Salisbury NHS Foundation Trust

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

NHS
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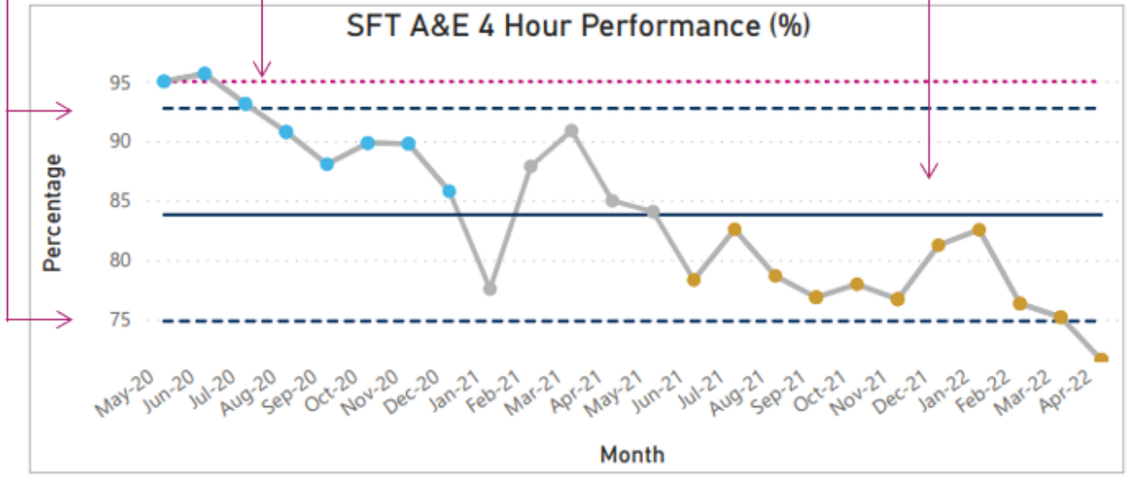
Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of "normal"

There should always be a minimum of 15 months worth of data

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

The solid grey line shows the mean value for the dataset



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

Salisbury NHS Foundation Trust

Our Priorities

Population

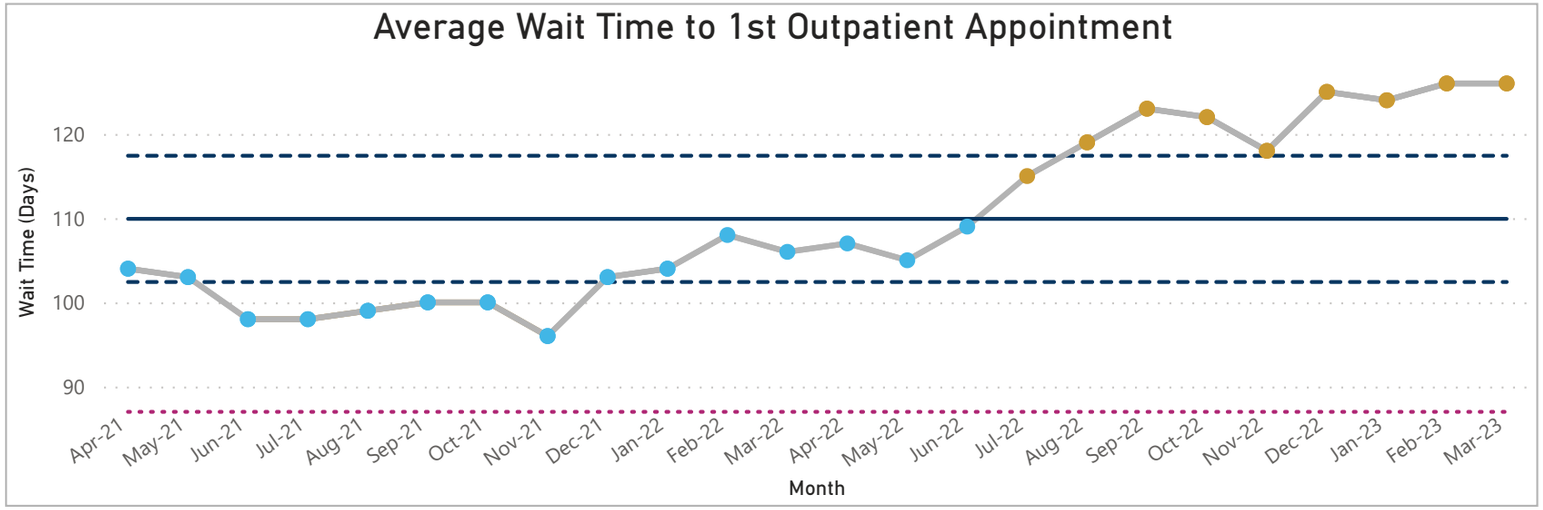
Partnerships

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 a stable position between February and March (126 days), but remains above the local target of 87 days. This is a better position than anticipated in light of the volume of activity that has been cancelled as a result of the Industrial Action.
- 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 2 week wait and Urgent referrals, and by longest wait, in line with NHSE requirements.
- SFT continues to have success in driving down its longest waits, achieving the national 78 week wait target, despite the industrial action (IA), 1 month ahead of the national ask. This was maintained throughout March, with good progress for April to date despite the planned Junior Doctors IA.
- Over 52 week waits continued to see an increase in March driven by a number of specialties, predominantly Dermatology, Plastics, Rheumatology, Gastroenterology and Cardiology. These increasing waits across these specific specialities served to offset some of the improvements experienced across others.

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 (to be presented at the next TMC).
- The OPD Workshop was held as planned on 30th March, with all Divisions represented. A number of actions are being taken for completion throughout April to identify top five key contributing specialities, those requiring further support, initiate a weekly OPD huddle to provide additional focus, understanding of challenges and provide additional support as required.

Risks and Mitigations

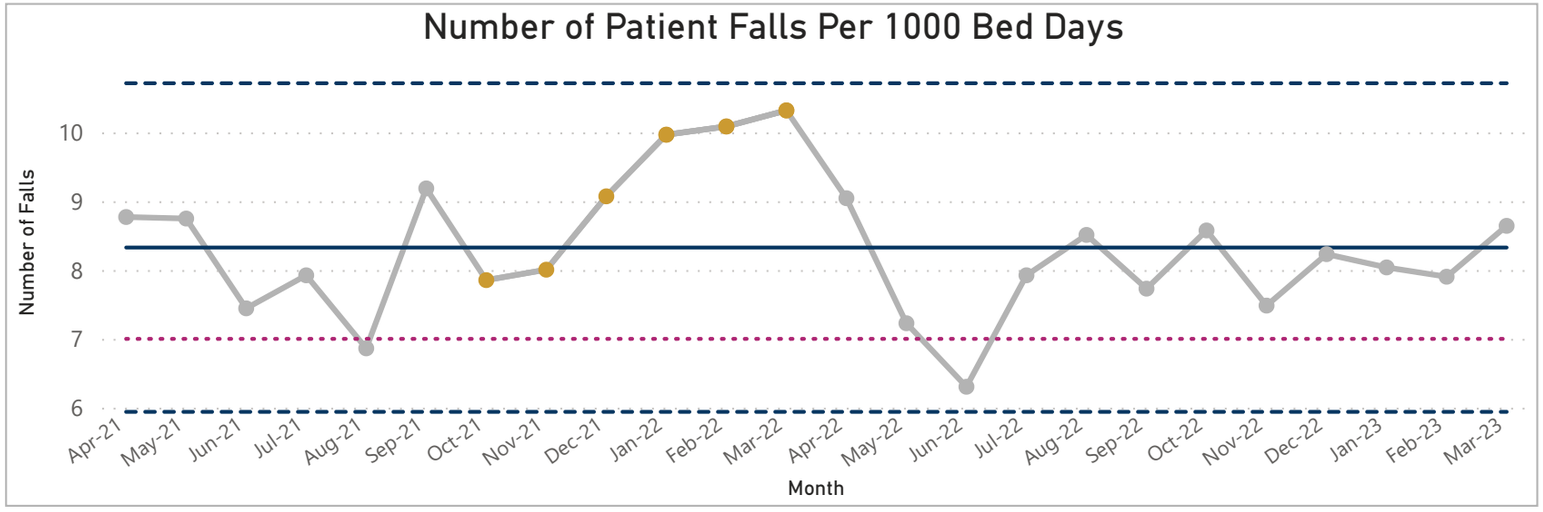
Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality/pathway level, however the performance team are supporting this work with the Divisions and specialities. Resource limitations at both DMT and Speciality level have been raised and a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

In March there were 4 falls with moderate or above harm: Post-operative spinal haematoma, fractured sacrum, fractured head of humerus and 1 fractured neck of femur (major).

Although the figures per 1000 bed days have risen slightly, the falls for quater 4 last year per 1000 bed days was at 11 and fractures per 1000 bed days have dropped from 0.33 to 0.25 for the quater.

Actions (SMART)

- Formal education continues for staff at induction and for some ward teams. Education at the bedside for staff, relatives and patients has dropped due to the falls lead dropping her hours. The E-documentation is now checked away from the bedside. With the recruitment of a falls assistant, it is hoped that the training programme will recommence in the summer with a new half day of training being offered to ward staff.
- The lead will be meeting with the medical division in April to discuss the roll out of bay watch-support needed from senior nurses, therapists and Lead Clinicians to introduce and sustain.
- There will be a meeting in April with the Deputy Chief Nursing Officer to discuss support, training and data collection to progress the targetted decrease.
- Themes continue to be, Lack of lying and standing BP, although month-on-month figures are improving with therapy staff in elderly care taking an active role in assisting with this, commencing in April.
- Bed rails and falls risk assessments continue to be to a poor standard with some nursing staff finding the transition to electronic documentation difficult.
- Staffing vacancies, sickness and industrial action have made the management of the skill mix on wards a challenge.
- The "sensible slipper trial" continues on Durrington Ward with audit results expected at the end of April.

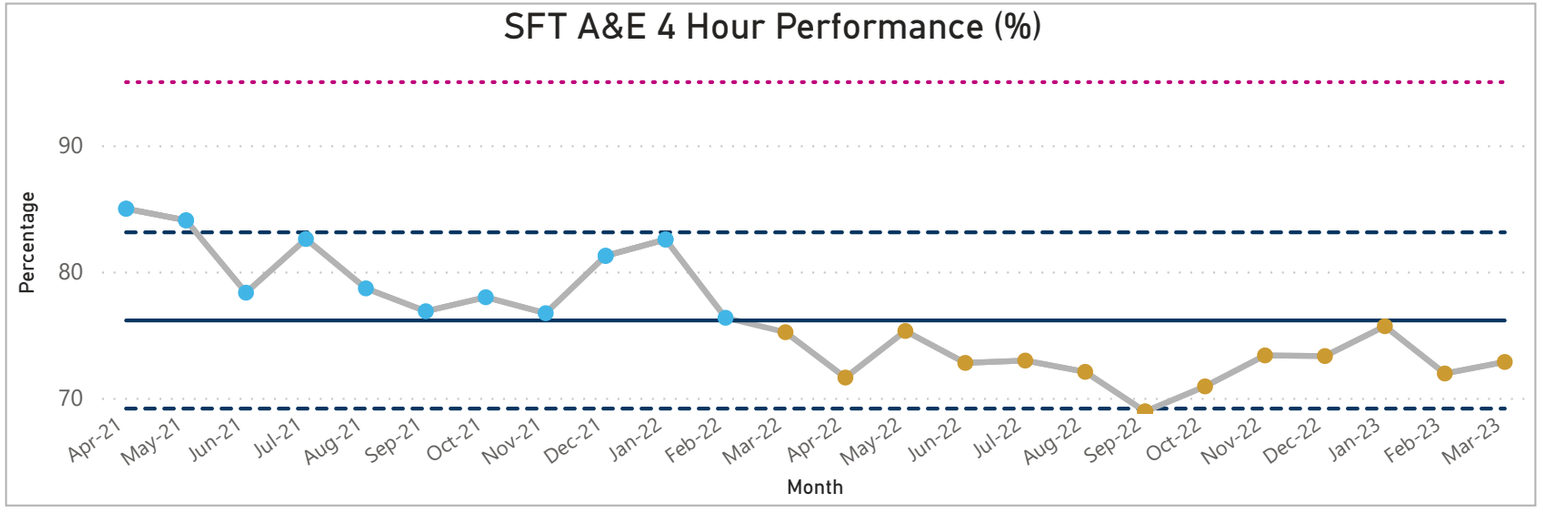
Risks and Mitigations

Need for permanent assistance into the falls reduction post.

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month:	72.8%
Attendances:	6217
>12 hrs in ED Breaches:	54

Understanding the performance

"• The performance against the 4-hour standard improved slightly in M12 despite an increase in overall attendances in M12 of 348. M12 saw an increase in all Types of attendances, Types 1 and 2 increasing by 3 per day, and Types 3 and 4 by an average of 12 per day, compared to M11. The ED conversion rate has remained fairly static at 27.4%.

• The number of 12-hour breaches reduced significantly to 54 in M12 compared to 91 in M11. This improvement is despite flow out of the department remaining challenged with the Trust discharging an average of 10% of patients before midday and 41.9% of patients after 17:00. This late discharging can contribute to a lack of movement out of the department until the evening.

• M12 saw an improvement in the average time to initial assessment of 29 minutes compared to 34 minutes in M11. M12 also saw a continued trend of improvement with the average time patients wait in the Emergency Department from decision to treat to admission decreasing to 7.7 hours. This still equates to the loss of 5.5 ED spaces per day but is a significant improvement when compared to M9 where the average time from DTA to admission was 10.5 hours.

• Expected patients diverted to ED increased in M12 to 130 compared to 122 in M11. Despite this small increase we have seen a decrease in the number of medical patients diverted to ED from M11 to M12, this averages a difference of 1 patient per day.

Actions (SMART)

• The streaming trial took place in M12 and during the trial data showed there was a 13-minute improvement on time to initial assessment, 15-minute improvement in time to triage and a 55-minute improvement for time in department for admitted patients. The trial has shown large improvements to ED KPI's. Nursing staff are undergoing triage training to support sustained implementation of streaming and the Matron has requested NHSEI support to assist with the implementation of streaming.

• The protection of Medicine SDEC started at the end of M12 and although data is in preliminary stages, we have already seen an increase in 0-day length of stay (LOS) in AMU from 24.0% in M11 to 32.5% in M12 and 0-day LOS in SSEU has increased from 37.3% in M11 compared to 43.4% in M12.

• The ED Senior Leadership Team (SLT) has created an ED Improvement Dashboard following actions given from NHSE, to clearly identify a robust workforce Action Plan and to address SII Actions. A period of Intensive support has been requested by the ED SLT to drive improvements and the ability to support High Priority Actions.

Risks and Mitigations

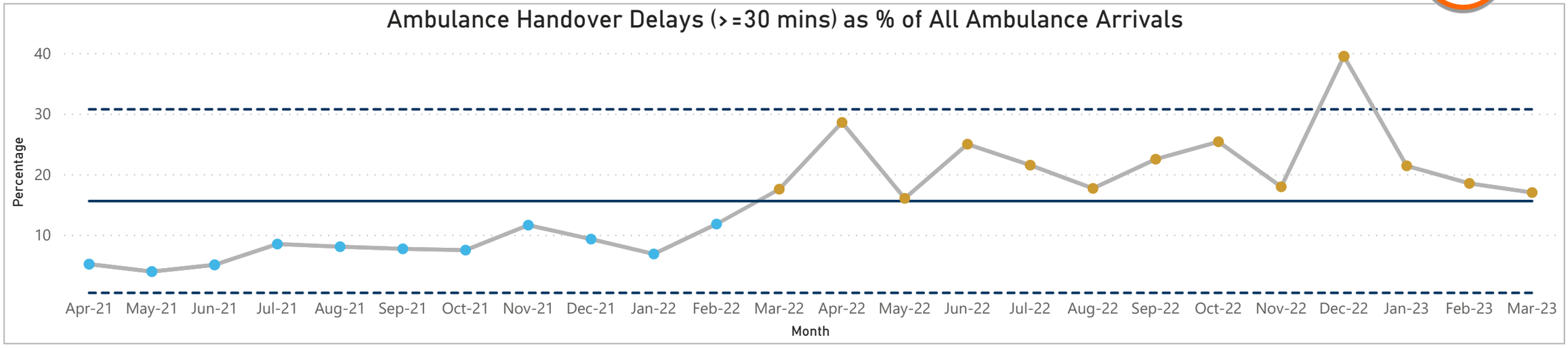
• Nursing staffing vacancies remain high with a 35% vacancy rate for RN's and 43% for HCA's. The department successfully recruited 3 Band 6 WTE (1 internal and 2 external candidates) and 3 Band 5's in M12. A full review is needed against the Royal College of Emergency Medicine (RCEM) standards to ensure appropriate numbers of skilled and banded nurses are within establishment.

• M1 will see further Industrial Action from Junior Doctors with a 4-day planned strike following a 4-day Bank Holiday Weekend. With a reduced workforce this may impact 4- and 12-hour performance targets, but the department has successfully planned rotas to mitigate the risk.

• Timely flow of the Emergency Department continues to impact 4- and 12-hour performance targets, with high bed occupancy levels continuing across the Trust. In line with NHSEI actions and RCEM Standards, the Paediatric area is now formally segregated from the Adult Department and is no longer used for adult escalation The ED SLT will investigate further options in M1 to identify a new area for escalation

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance

M12 saw the number of ambulance conveyances remain consistent at 37 per day. Performance also remained stable with 18.6% patients waiting between 30 and 60 minutes to offload and 81.4% of patients waiting between 15 and 30 minutes to offload. The department continues to work collaboratively with SWAST partners to off load patients within allocated performance targets.

The Agreement to protect Medicine SDEC from escalation which started in M12 continues to have a positive impact on the medical take being diverted to ED, with only patients of a respiratory nature being diverted to ED due to infection control constraints. This enables SWAST to convey patients to the most appropriate area, minimising delays to offload at the Front Door.

Actions (SMART)

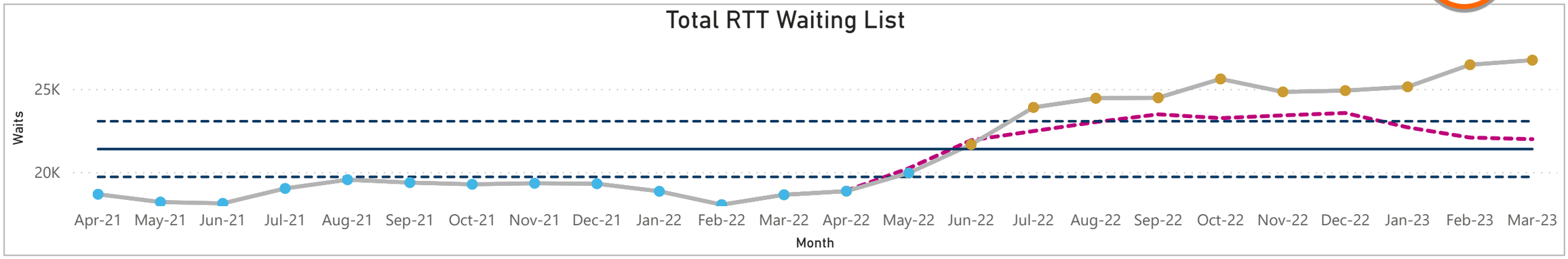
- A review of the ED footprint will take place in M1 by the ED SLT to identify an area to cohort patients in times of surge due to the removal of the paediatric area from the adult escalation plan.
- Review of current processes to ensure all patients receive a timely clinical review when being held in ambulances is a high priority action for the ED SLT and will be undertaken within M1.

Risks and Mitigations

- Junior Doctor Industrial Action will impact on flow and performance which may result in a decreased ability to offload ambulances within a timely matter. Mitigations have been put in place to increase nursing staffing levels where possible to minimise the risk if the need to reverse queue is required.
- The current HALO service at SFT is compromised with there soon to be a 70% vacancy. From M2 SFT will only have 1 WTE HALO provided by SWAST. An update from SWAST has been requested with regards to recruitment.
- Workforce challenges with both nursing and medical workforce gaps remain challenging in the ability to stream and RAT patients to meet KPI's and ensuring patients are offloaded in a timely manner. The ED SLT are working hard on developing a robust recruitment and retention strategy.
- Respiratory conditions continue to pose challenges in offloading patients whilst awaiting suitable closed cubicles to minimise infection control risks within the department and ensuring correct isolation processes are followed.
- High bed occupancy and staffing challenges across the Trust, resulting in poor flow out of the department, continue to hinder capacity within the Emergency Department, currently losing on average 5.5 spaces per day. This remains the biggest challenge in being able to offload patients in a timely manner. The continued protection of Medicine SDEC and use of the Discharge Lounge is proving beneficial in generating earlier flow out of the department, which assists the decompression of the Emergency Department.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Longest Waiting Patient (Weeks)	120	99	99	95	98	94	95	87	83	85	73	75

Understanding the performance

The Total RTT Waiting list size position at the end of March stood at 26,736 an increase of 276 from February (26,460). This has resulted in a further slight deterioration with the Trust being 4,755 behind plan. This, however, needs to be put into the context of the impact of the industrial action by the NMC in Qtr 4, which resulted in circa 2000 appointments being cancelled and rebooked into new slots.

Aside from the IA, there are a small number of specialties that account for a disproportionate proportion of the waiting list increase since April 2022. Of the top five specialties with the greatest increase in their respective waiting list four are Surgery, being comprised of the following: Oral (1st), Gastronenterology (2nd), Colorectal (3rd) and ENT (5th). Gynaecology have the 4th greatest increase in waiting list size since April 2022. These collectively continue to account for circa 50% of the in-year increase.

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 are a number of specialities that have remained below their current YTD average, including a number of specialities with considerable operational and staffing pressures, e.g. Dermatology.
- A number of actions planned for March have either been delayed or only partially implemented including:
  - Dermatology Paper to TMC (now April, discussion re consideration and approval out-with the meeting)
  - Introduction of additional capacity via 7 PAs of GPwSI into ENT - partially implemented with some operational challenges, currently being mitigated, but delaying full implementation. Update to be provided in April IPR
- 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.

Risks and Mitigations

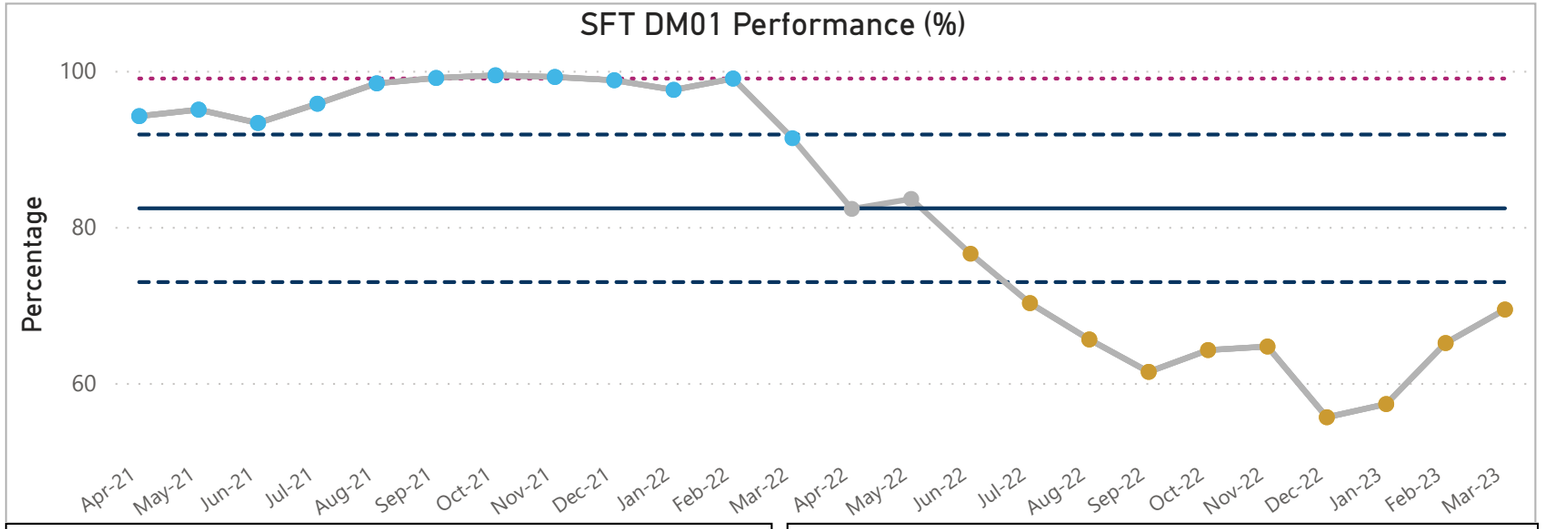
The risk of the planned Junior Doctor Industrial Action (April) remains, with the threat of additional IA further into Q1. Whilst mitigations are in place to support safety for those most clinically urgent patients, the volume of activity affected cannot be entirely mitigated.

With a view to placing an enhanced level of both focus and support a OPD workshop was held on 30th March, to explore the challenges facing the divisions in improving this position, with planned outputs to include intensive support of a limited number of key specialities (driving the position), and a weekly OPD huddle to ensure pace of delivery and ongoing support as necessary.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 69.4%

Waiting List Volume: 3283

	Performance	Breaches		Performance	Breaches
MRI	64.3%	380	CT	99.0%	5
US	59.2%	1080	DEXA	100.0%	0
Audio	64.3%	86	Cardio	100.0%	0
Neuro	100.0%	0	Colon	65.6%	73
Flexi Sig	46.3%	43	Gastro	88.2%	20

Understanding the performance

Overall DM01 performance improved in M12 as compared to M11 (increase from 65.12% to 69.41%). This was against a background of a reduced waiting list but does represent a decrease in the number of breaches of 420 patients (total breaches decreased from 2107 patients impacted to 1687 patients impacted).

Modality breach numbers for the core modalities non compliant against the standard reported as follows:
MRI - 380 patients in M12 compared to 433 in M11
USS - 1080 patients in M12 compared to 1430 in M11
Audiology - 86 patients in M12 compared to 107 in M11
Endoscopy - 136 patients in M12 (static on M11)

Actions (SMART)

1) CDC MRI and CT mobile unit on site and being managed for bookings by Radiology booking (in place from 1/4/23). Anticipate MRI performance against DM01 to be restored by end of M2
2) USS DNA rate improvement project to get underway from M1 - DNA % not increasing month on month but activity numbers increasing so impacting more patients. Telephone reminder system being reviewed, email letters, reminder processes etc.
3) Long waiter validation occuring routinely and 20+ weeks now reviewed to proactively plan for zero 26 week waiters across all specialties.

Risks and Mitigations

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

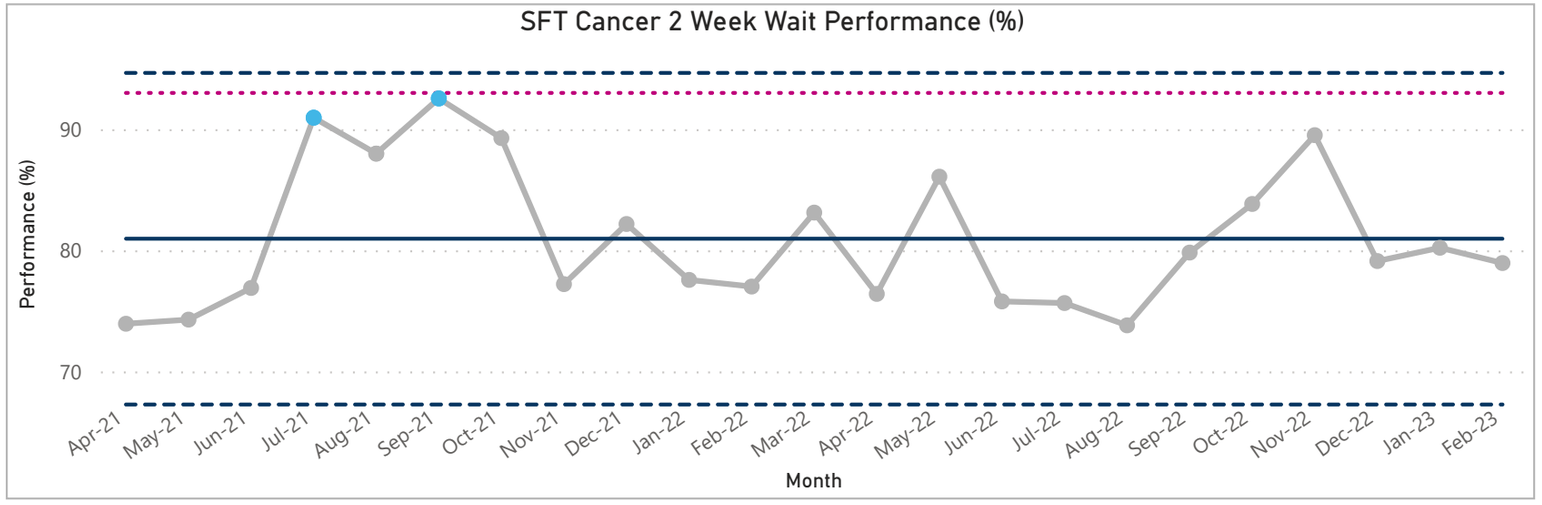
Recruitment ongoing. Admin resource within Radiology and Endoscopy experiencing some reourcing issues which is challenging for booking and overall booking efficiency (further constrained by postal strikes etc.) Recruitment plans in place.

DNA rates and ability to reduce. Will learn from improvements made in Child Health Outpatients and work with IT/digital on interface and reminder services etc.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	79.0%	769	974	205
Two Week Wait Breast Symptomatic Standard:	95.7%	22	23	1

Understanding the performance

The Trust's performance for February 2023 was 79%, the Trust continues to be challenged against this metric with a compliance set at 93%. The breakdown of breaches is shown below:

- Suspected Skin Cancer – 100 Breaches
- Suspected Lower GI Cancer – 40 Breaches
- Suspected Head and Neck Cancer – 24 Breaches
- Suspected Breast Cancer – 17 Breaches
- Suspected Urological Cancer – 12 Breaches
- Suspected Upper GI Cancer – 6 Breaches
- Suspected Gynaecological Cancer – 3 Breaches
- Suspected Lung Cancer – 3 Breaches

The average waits for first appointment within the most challenged tumour sites are:

- 16.2 days Average wait for first seen from Suspected Skin Cancer referral
- 11.9 days Average wait for first seen from Suspected Lower GI referral
- 13.1 days Average wait for first seen from Suspected Head and Neck referral

The main themes of the breaches were:

- Outpatient capacity – 142 Breaches
- Patient choice – 37 Breaches
- FIT Delay – 18 Breaches
- Administrative Delay – 9 Breaches
- Clinic Cancellation – 1 Breach

Actions (SMART)

Skin and Lower GI are the lowest performing sites.

Skin actions

- Recruitment of additional consultants, this process is underway and successful candidates are expected to begin in Oct 23.
- Lack of provision for community dermatology – currently being reviewed by Surgical division although this a longer term negotiation.
- Review required of strategic direction of service and discussions required with UHS around Plastics SLA and negotiation required to release capacity locally.
- Audit of Synapsis advice and guidance (A&G). Provisional discussions around GP education for tele-dermatology to help with patient flow into SFT. Current lack of dermatology cover for A&G for medical tele-dermatology.

Lower GI actions

- In Feb there where challenges due to sickness of Endoscopy Nursing which limited to the number of lists weekly. This was resolved at the end of Feb 23.
- Implementation of the FIT pathway with primary care; monthly audit to ICB to ensure engagement ongoing with primary care where challenges are highlighted. This is an ongoing audit monthly.
- In February there was challenges with the ID Medical contract which limited the creation of additional lists. The was resolved in Mar 23.

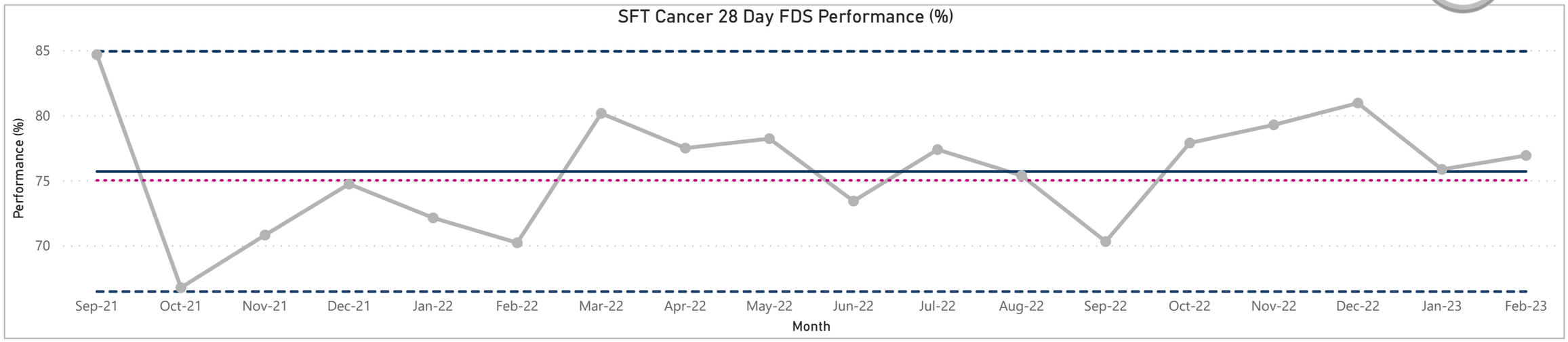
Risks and Mitigations

- Industrial action threatens capacity in outpatients and endoscopy and the impact of this is managed by the Divisions to limit capacity losses where possible.
- Endoscopy capacity confirmed BAU for staff sickness at end of February as endoscopy nurse on phased return.
- Dermatology Capacity remains challenged into March. Additional lists have been facilitated to enable increased activity and support backlog of referrals waiting to be seen. Any lists dropped due to industrial action are being converted to outpatient activity to also increase capacity.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



Understanding the performance

The Trust's performance for the 28-day faster diagnosis standard was 76.9% which is the 5th consecutive month of success against this standard. This performance is supported by success against the standard against some of the Trust's larger tumour sites:

- Skin 28d Performance – 98.1%
- Breast 28d Performance – 97.9%
- Head and Neck 28d Performance – 81.3%
- Upper GI 28d Performance – 77.4%
- Lung 28d Performance – 75.7%
- Colorectal 28d Performance – 75.4%

The Trust still has challenges within the below tumour sites for 28d Performance:

- Gynaecology – 63.3%. Average days to patient informed 29 (88 Patients). Breach reasons include administrative delay to letters, delays to diagnostics.
- Urology – 20.5%. Average days to patient informed 55.4 days (119 Patients). Breach reasons include administrative delay to letters, complex diagnostic pathways, delays to diagnostics.

Actions (SMART)

- Gynaecology continues to see a peak in referral numbers over the past 3 months. An average of 30% increase in referrals over the same period last year. This increased workload has resulted in challenges in reassuring patients. This has been discussed at CIG and plans for pathway GAP analysis with the support of Cancer Services is underway and expected to be completed by end of April.
- Benign faster diagnosis letter will support with expedited time to reassure patients this is currently awaiting implementation and guidance with Cancer Navigator. This is expected by end of April 2023.
- Urology benign pathway clinic letter awaiting final sign off, this has been escalated to surgical DMT for approval. This will support ensuring expedited timeframes for patients to be reassured and is expected by end of April 2023.
- Funding has been submitted to SWAG Cancer Alliance for Early Diagnosis nurse to support current CNS team and support performance against the 28d Faster Diagnosis Standard.
- Weekly Cancer Improvement Group will support with engagement from DMT and work streams feeding in from Cancer PTL Meeting and onto Cancer Board. We are using BPTP Milestones alongside the CQUIN data submitted to measure the success of the current pathways and supporting services with service improvement.

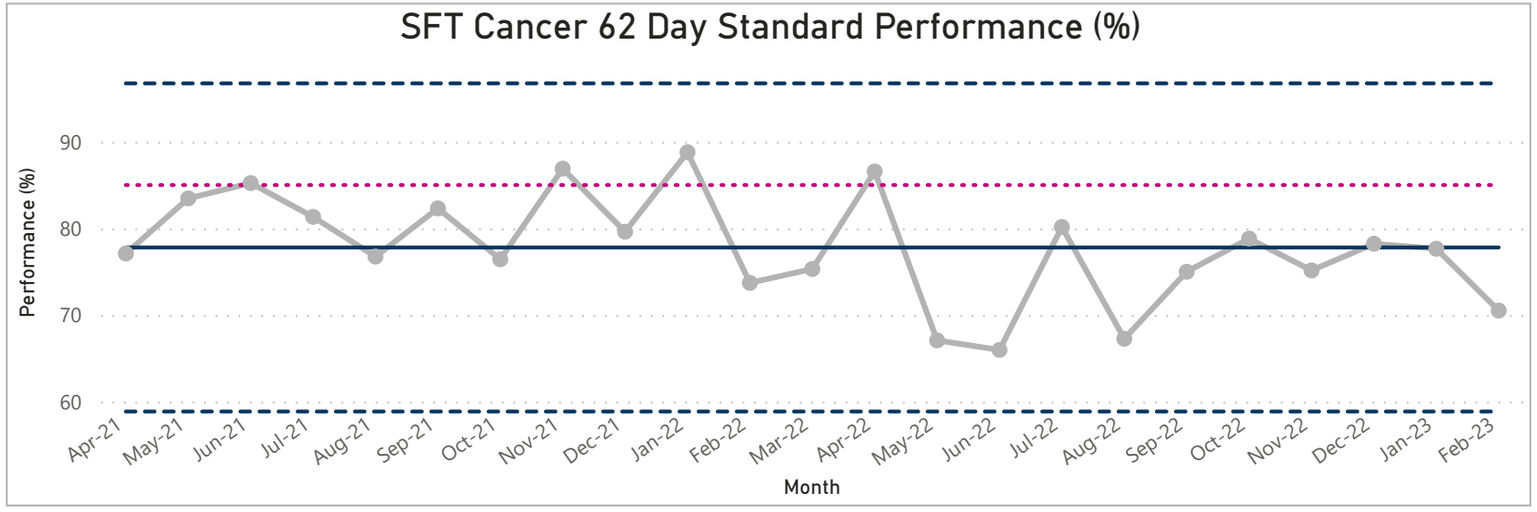
Risks and Mitigations

- Increased referral numbers for Gynaecology raised to ICB, Bath seeing similar increase in referrals. Gynaecology to review process for triage of PMB Referrals to see if there is scope to return patients to primary care.
- Challenges with getting benign faster diagnosis letters signed off, anticipating sign off by end of April 2023 to support faster diagnosis performance for both Urology and Gynaecology this has been escalated to Surgical Division and Gynaecology operational management
- Risks associated with Prostate Biopsy capacity. Unable to ascertain if there is enough capacity. Escalated to surgical DMT to review as D&C work unable to support due to set-up of theatre lists. Current plans to set up tasks and finish group for Urology to support service improvement by May 2023.
- Industrial action threatens capacity in outpatients and endoscopy and the impact of this is managed by the Divisions to limit capacity losses where possible

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	70.5%	55	78
62 Day Screening:	53.3%	4	8

Understanding the performance

The trusts 62d Performance for February was reported at 70.5%. The breaches across tumour sites have been outlined below as well as the delay reasons.

- Colorectal 62d Breaches – 7.0 (2.0 Complex diagnostic pathway, 2.0 Healthcare delay to diagnostic test, 1.0 Administrative delay to booking TCI, 1.0 Equipment breakdown and 1.0 Inconclusive diagnostic result)
- Urology 62d Breaches – 6.0 (2.0 Healthcare delay to diagnostic test, 1.0 Complex diagnostic pathway, 1.0 Elective capacity inadequate, 1.0 Administrative delay to booking TCI and 1.0 Inconclusive diagnostic result)
- Skin 62d Breaches - 3.5 (2.0 Complex diagnostic pathway, 1.0 Healthcare delay to diagnostic test and 0.5 Other reason)
- Gynaecology 62d Breaches – 3.0 (2.0 Healthcare provider delay to diagnostic test and 1.0 Complex diagnostic pathway)
- Breast 62d Breaches – 1.0 (Healthcare provider delay to diagnostic test)
- Haematology 62d Breaches – 1.0 (Administrative delay to rebooking TCI)
- Upper GI 62d Breaches – 1.0 (Elective capacity inadequate)
- Head and Neck 62d Breaches 0.5 (Complex diagnostic pathway)

The main themes taken from the breach reasons are diagnostic challenges with 14.5 breaches involving delay to diagnostics or complex diagnostic pathways.

Actions (SMART)

- Challenges were raised in January and February with Colorectal theatre capacity due to annual leave as well as the impact of DSU Closure in January. Action has been monitored by the Cancer Improvement Group and no further challenges with capacity are anticipated.
- Urology continues to be challenged with the diagnostic element of the pathway. This is monitored at the Cancer Improvement Group and the planned task and finish group will involve stakeholders within the pathway to review bottlenecks within the pathway.
- Skin have seen challenges with the pathway for patients who undergo a biopsy as opposed to straight to excision due to Histopathology turnaround times impacting the services ability to complete both biopsy and excision within the 62d clock. Breach reasons have been shared with the service to review for 1st CIG Meeting of the month.
- PET-CT Delays for Salisbury patients attending scans at Oxford have also been problematic with issues with tracer failing impacting patients and pushing scans out to 6-8 weeks. Currently looking at provision for PET-CT at Salisbury but implications due to funds needed to set-up; this has been raised to the Cancer Alliance for support.
- Delays with the diagnostic element Urology Pathway continue to be a risk. The task and finish group is to be implemented to try and drive service improvement by May 2023.

Risks and Mitigations

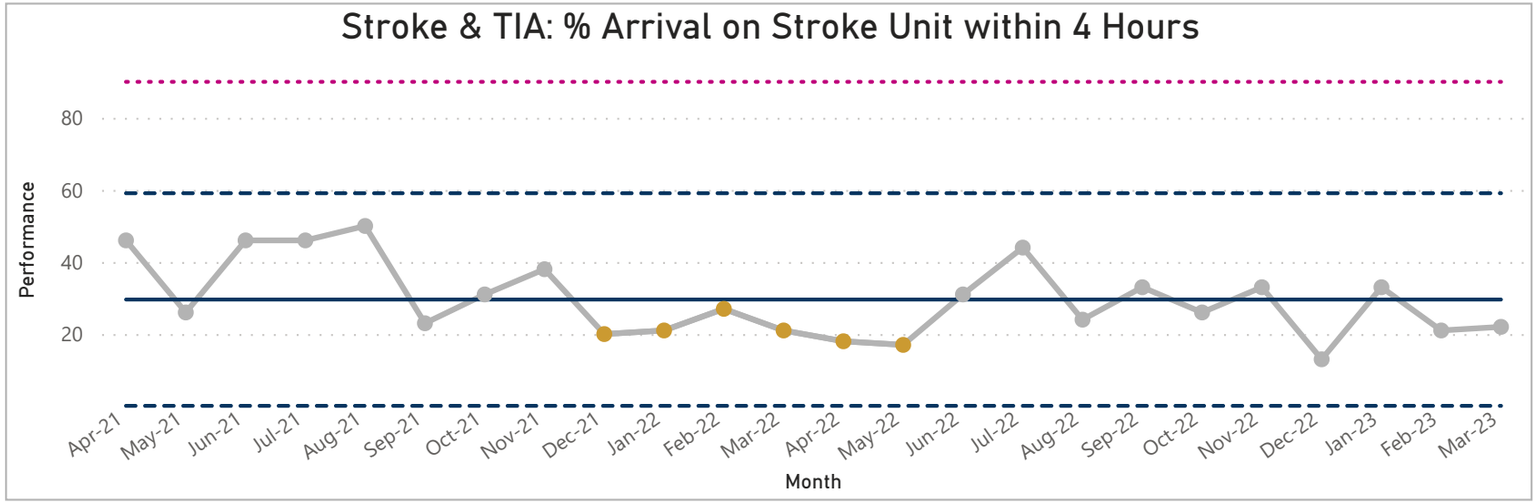
- Industrial action threatens capacity in outpatients and endoscopy and the impact of this is managed by the Divisions to limit capacity losses where possible.

- PET-CT Delays for Salisbury patients attending scans at Oxford have also been problematic with issues with tracer failing impacting patients and pushing scans out to 6-8 weeks. Currently looking at provision for PET-CT at Salisbury but implications due to funds needed to set-up; this has been raised to the Cancer Alliance for support.

- Pathway delays within Colorectal / Urology are currently providing us with challenges at the start and middle of the pathway. The trust has requested funding to support performance from the Cancer Alliance in the form of 3 Early Diagnosis nurses for Colorectal, Urology and Upper GI. These roles will help with the early part of pathway to try and ensure patients are reassured or given a diagnosis of cancer sooner.

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	C	

Understanding the performance

The national target for arrival on stroke unit within 4 hours is 90%; March '23 month-end performance of 22% (a slight increase in comparison with February '23, 21%). The impact of high bed occupancy trust-wide has had an impact on timely availability of beds on the stroke unit. The length of stay (LOS) for patients on the stroke unit has increased from February, with February having an average LOS of 18 and March LOS at 20. This is due to some long stay patients being discharged.

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

Staffing vacancies for Farley remain high. We have 2 overseas nurses who have joined our team and will be taking their OSCEs in May. Throughout February there were several occasions where staff were moved to support other wards due to a lack of staff across the division. This is 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. 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 in turn will ensure timely transfer of priority patients from ED staff, date to be confirmed.

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 the 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 then in ED.

3.A Standard operating procedure will go live on 17/4/23 which provides an overview of the stroke pathway from presentation to transfer to the stroke unit. The purpose of this is: to emphasis immediate CT head scan and immediate referral to 'stroke alert' bleep for all suspected stroke patients identified at triage, rather than just the 'FAST' positive patients; clear guidelines for alerting stroke doctors and contacting stroke ward team and site management team about stroke admission as soon as suspected; earlier prompt to start bed management process; clear guidelines for identifying Farley patients appropriate for transfer to another ward; clear guidelines for escalation spaces on stroke unit to enable rapid transfers and avoid delays.

Risks and Mitigations

Hyperacute stroke patients are at risk of worsening outcomes without access to specialist care in the appropriate time frame, which in turn increases length of stay. To mitigate this, there are monthly meetings with the working group to discuss: the 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; any staffing issues. These meetings will enable us to facilitate bed moves when a potential stroke patient has been identified in ED more promptly when bed capacity allows.

Risk of significant staffing shortages, particularly during periods of significant operational pressures when stroke nurses are moved to support other clinical areas. We have staff nurses redeployed to other areas currently. This has an impact on stroke services ability to receive patients from ED, especially those that are thrombolysed and require 1:1 input due to the delays in handovers in both transferring patients off the ward and admitting patients onto the stroke unit. 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 trusts operational position. The service hopes to ensure adequate allocation of beds for stroke patients to improve transfer time and identification of patients suitable for transfer to allow allocation for stroke patients.

Maternity

Are We Safe?

01/03/2023 <- Reporting Month (Input the first of the REPORTING month)

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	SFT Assurance Dashboard	Guidance	Standard	RAG Target 2021-22 Q4	RAG rating: Red	RAG rating: Green	Improvement Direction	Rolling 6 months: Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-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)			NA			Down	0	0	0	0	0	1	0.16
	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	5.7	1.0
	Number of neonatal deaths : 0-28 days			NA			Down	0.0	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	0.0
	Medical termination over 24 +0 registered			NA	NA	NA	Down	0	0	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths			NA			Down	0	0	0	0	0	0	0
	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	0.0	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	Datix incidence SII	6 month SFT rolling		0	>= 1	= 0	Down	0	0	1	0	1	1	0.5
	HSIB referrals	6 month SFT rolling		0	>= 1	= 0	Down	0	0	1	0	0	1	0.3
	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	Obstetric cover - labour ward	RCOG guidence		40	<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR+	1:26	1.30	>= 1:28	<= 1:26	Down	1:33	1:29	1:31	1:31	1:27	1:30	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			NA	>= 1	NA	Down	18.84	18.84	19.96	20.9	20.9	21.9	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	0	1	1	2*	2	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		15	NA	>= 15	Up	10	26	10	10	10	31	16
	Service user feedback : Number of Complaints	6 month SFT rolling		1	>= 2	<= 1	Down	1	2	2	1	3	1	1.7
	Number of SOX	6 month SFT rolling		4	NA	>= 4	Up	4	7	3	3	6	17	7
Assurance	Progress in achievement of 10 safety actions(CNST)	NHSR	10	NA	<= 5	>= 10	Up	6	7	5	5	5	5	5.5
	Training compliance - MDT PROMPT %	NHSR	90%	NA	<= 84	>= 90	Up	82	93	91	93	92	91	NA

Understanding the performance

Midwifery vacancies remain relatively static with just one retirement this month, however births were higher this month impacting on midwife to birth ratio.

Datix relating to workforce at 2 – relating to missed breaks.

One new SII commissioned, Referred to HSIB as per criteria.

Increased compliments and SOX this month.

Actions (SMART)

Midwifery staffing vacancies being addressed via recruitment drive and targeted recruitment support. New landing page for recruitment and incentive going live this month.

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

Multi disciplinary team meeting was had in February and plan to achieve CNST compliance formulated for 2023.

Risks and Mitigations

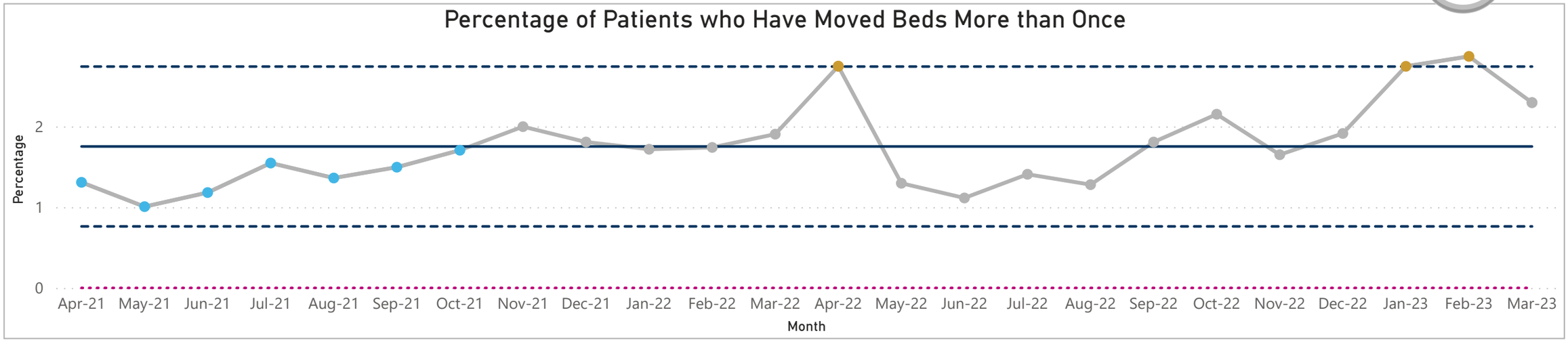
Staffing – Recruitment drive in progress.

International recruitment in process, 5 midwives to complete OSCE in May and July.

Overercruited by 2 WTE labour ward coordinators. This will provide balance and support to a workforce that is predominantly junior. They will join the workforce in June.

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance

- This month has seen a decrease in the overall number of patients who have moved beds more than once per admission. This is still an increase compared to the same period last year.
- Patients transferring to beds at the South Newton site continues from the Acute Trust. There has been a rise in transfers back to the Acute Trust from this bed base.
- There is ongoing work with the teams to promote patients being treated within the right clinical area for their correct clinical speciality.
- The number of medical outliers within the Trust has increased throughout the month of March 2023, which is the result of creating speciality capacity within acute wards, directly impacting on the number of moves per patient.
- The continued use of escalation beds within Day Surgery and Breamore has resulted in the inability to use the discharge lounge area effectively to promote early release of beds to non-elective admissions in the day to support the reduction of patient moves.

Actions (SMART)

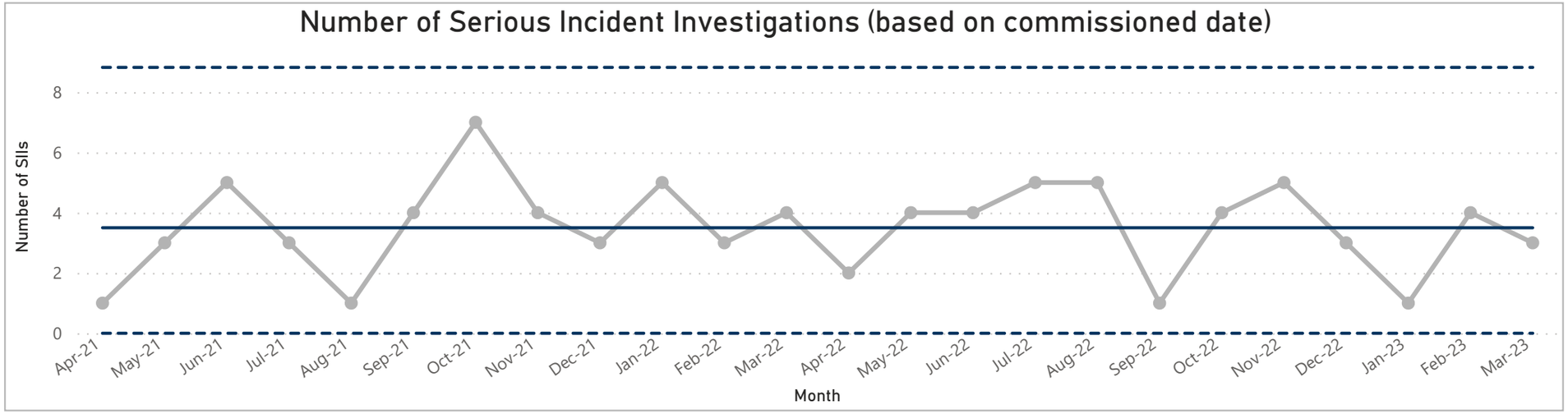
- Ongoing work to identify clinically appropriate patients to be transferred to South Newton with the medical matrons and the site team.
- There is the continuing trial of SDEC and the triaging of medical patients early in their admission to ensure they are moved to the most appropriate clinical area and this work continues throughout the Medical division.
- E-Whiteboard work is continuing to be able to identify the patients that have already moved to help minimise any future moves to improve overall patient experience.
- Progressing working practices with Farley Stroke unit to try to improve the SSNAP 4-hour targets, with the use of the Assessment room and CDMU to accommodate the new acute strokes within the unit within the target time.

Risks and Mitigations

- There has been continued support and effective communication with speciality teams despite the ongoing challenges with staffing across the trust throughout March.
- Sustained pressure with demand and capacity resulting in an impact on the Trust's escalation beds, which the Trust aims to come out off completely to enable the upcoming work within clinical areas and support flow.

Incidents

Are We Safe?



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance

3 SIIs commissioned in March

SII 553 - Wrong side eye surgery (child) - not a never event.
SII 554 - Delayed cancer diagnosis
SII 555 - Intrapartum death (case taken by HSIB).

Actions (SMART)

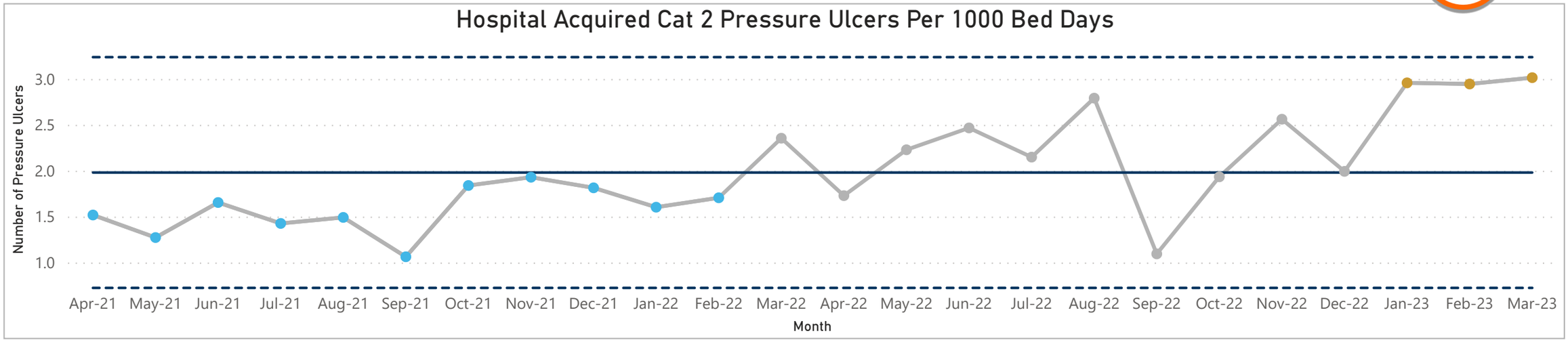
- Following the commissioning of an SII, the incident willbe investigated as per Trustprotocol.
- The current time frame set for the completion of these reportsis 60 working days.

Risks and Mitigations

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

Pressure Ulcers

Are We Safe?



Understanding the performance

- Hospital acquired PU numbers for March are again high, 45 Cat 2 PU's, 1 Cat 3, 1 unstageable and 14 DTI's (61 total).
- 62 pressure injuries were noted on admission to SDH; this is an all time high for the Trust. Ward staff have been vigilant and prompt in reporting these injuries allowing timely intervention by the Tissue Viability (TV) team.

Actions (SMART)

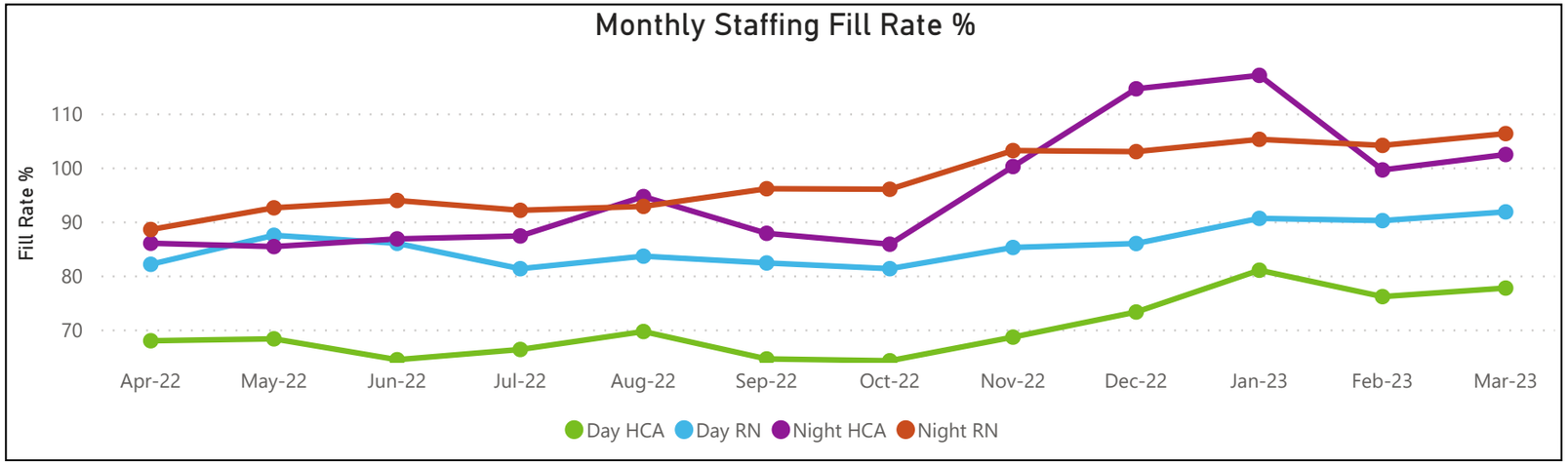
- The majority of our DTI's were noted at the foot/ankle. TV to discuss with Orthotics regarding staff training and easier access for offloading equipment
- New mattress extenders have been trialled successfully and will be appearing on the wards imminently.
- SWARM paperwork has been emailed to all wards where DTI and Unstageable injuries have occurred. Once completed, ward-level investigation will be carried out by the TV team. the team will look for themes and trends to allow focused support for these areas.
- "Focus on TV" month planned for May
- There was a focussed TV meeting with senior clinical leaders where actions have been identified to address the current trends and issues. Follow up meetings with ward leaders are planned.

Risks and Mitigations

Nil

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	89%	109%	78%	111%
AMU	82%	123%	73%	92%
Breamore	139%	107%	53%	180%
Britford	89%	100%	98%	102%
Chilmark	81%	97%	77%	76%
Downton	128%	134%	81%	142%
Durrington	91%	112%	75%	105%
Farley	83%	102%	70%	90%
Hospice	95%	101%	90%	107%
Laverstock	85%	110%	73%	109%
Longford	87%	113%	80%	91%
Maternity	92%	96%		
NICU	103%	101%	96%	
Odstock	112%	113%	101%	102%
Pembroke	95%	100%	89%	91%
Pitton	140%	155%	82%	125%
Radnor	68%	71%	34%	74%
Redlynch	93%	118%	73%	95%
Sarum	85%	107%	93%	
South Newton	91%	100%	87%	96%
Spire	115%	158%	75%	106%
Tisbury	79%	97%	67%	82%
Whiteparish	85%	106%	76%	103%

Understanding the performance

Slight improvement on all 4 markers from last month, but normal variation. Fill rate affected by ward leaders pulling back unrequired demand, failure to do this has negative impact on fill rate. CHPPD is 7.8 in month (7.4 when ICU/NICU excluded) against planned of 8.3 (7.8) – this is a marginal improvement on last month.

Actions (SMART)

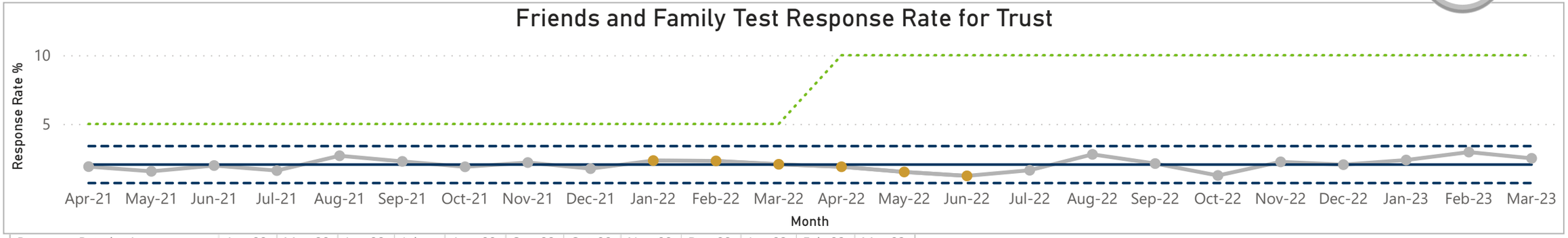
Implementation of uplift of Band 2 HCA to Band 3 has been implemented in March, and project group continues to meet to manage individual issues.
Executive agreement to extend to bank workers – anticipated implantation to be completed by June 2023.
Ward assistant project: final candidates coming into post, review being undertaken to ensure KPIs in place to measure impact.
Winter incentive due to end in April 23 – executive agreement to extend until end of April.
Agreement for 90 additional international recruits (50 for theatres) to be in place by end of September.
Business case submitted to extend retention lead for HCAs and provide additional support to international nurses to improve OSCE pass rate (currently 45% first time pass rate)
Enhanced care and RMN provision – review meeting held in April – ongoing work to reduce reliance on high cost agency.

Risks and Mitigations

On-going turnover rate for HCAs and RNs impacting on effectiveness of recruitment
Domestic and international recruitment campaigns (mitigation)
OD+P led work on retention, turnover and inclusion (mitigation)
HCA recruitment and retention lead – fixed term (mitigation)

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
FFT Response Rate - A&E	0.2%	0.0%	0.2%	0.1%	0.3%	0.4%	0.3%	1.1%	0.3%	0.8%	1.6%	1.0%
FFT Response Rate - Day Case	4.8%	4.6%	3.3%	4.6%	8.9%	6.8%	3.1%	2.5%	1.4%	0.3%	2.0%	2.5%
FFT Response Rate - Inpatient	5.7%	7.1%	6.8%	7.5%	10.9%	11.4%	5.1%	10.5%	5.8%	11.5%	13.0%	3.2%
FFT Response Rate - Maternity	11.5%	0.9%	0.4%	1.6%	7.8%	1.1%	1.2%	0.0%	2.6%	2.2%	3.7%	1.4%
FFT Response Rate - Outpatient	1.3%	0.8%	0.6%	0.9%	1.5%	0.9%	0.9%	1.6%	2.0%	2.0%	2.2%	2.1%

Understanding the performance

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible. Negative feedback is review by the ward and PALS, twice a year.

FFT responses are noted to be steadily increasing. Staff are still being encouraged 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 has fluctuated slightly.

Actions (SMART)

Medium-term action:
Delay in the rollout of digital provider (see risk/mitigations) will now require interim actions to be developed.

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

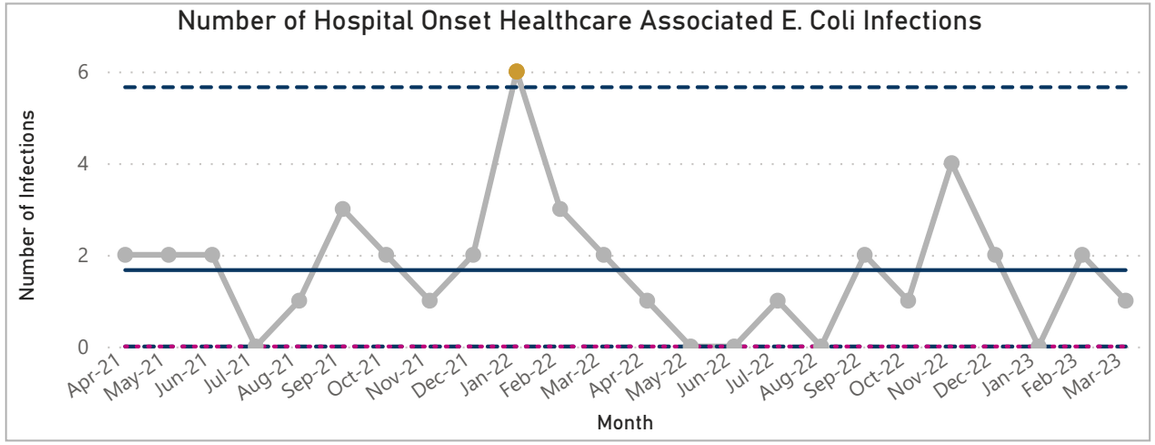
Risks and Mitigations

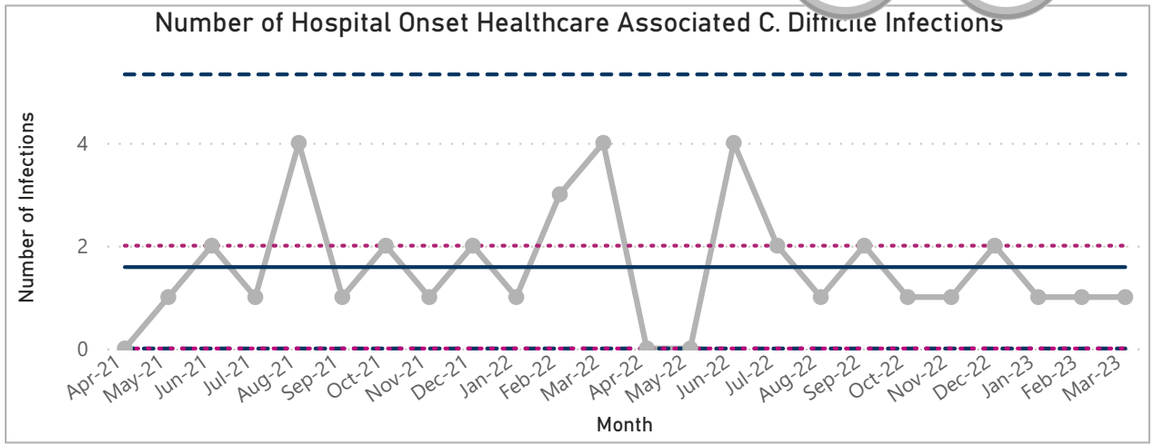
Continued low response rate due to limited methods for accessibility and the reliance on staff to promote completion of a physical card, this is directly impacted when there are staff shortages and operational pressures. The current method requires manual input and theming, which there is limited resource to undertake. Theming on a large scale is near impossible with the usual manual approaches - this makes presenting insightful data for the Trust difficult to assure.

Implementation of the new IT solution has had to be delayed due to capacity within the Informatics team to assist with set-up and roll out. This has been agreed by Execs to delay until this capacity is available - estimated for December 2023. We will now begin working on interim solutions to boost response rates, however it should be noted that we will continue to be unable to achieve robust theme analysis of this data during this time.

Infection Control

Are We Safe?





Understanding the performance

There has been one hospital onset healthcare associated reportable E.coli bacteraemia infection, 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 29 cases against a target baseline set of no more than 23 cases). Unfortunately, there have been three hospital onset healthcare associated MSSA bacteraemia infections this month, which are being investigated by the divisions to establish any themes.

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

Two additional face-to-face IPC sessions completed, as requested by the Practice Education team which has included International Nurses.

Year	2021-2022	2022-2023
MSSA Bacteraemia Infections: Hospital Onset	12	10
MRSA Bacteraemia Infections: Hospital Onset	0	0

Actions (SMART)

Alternative approach for staff in ward areas to complete hand hygiene education and assessments remains ongoing. Changes to original plan were agreed last month, to further evaluate the process within the surgical division. Initial feedback has been positive with further review planned this month.

Ongoing action on the 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 can take ownership and progress any actions or identified learning. It remains the responsibility of the ward/area/department lead and division to complete this.

Some case investigations are still outstanding, which is being followed up with the divisions. Of the reviews completed, themes identified are: use of the Diarrhoea Pathway and escalation; and timeliness of sending samples. The 'Share & Learn' Chair is scheduled to meet with the Deputy Chief Nursing Officer/s to feedback progress and agree any further requirements for this group.

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 SFT IP&C Working Group

Risks and Mitigations

Sustained clinical workload for IPC nursing team including ongoing COVID-19 outbreaks and continued diarrhoea activity within the hospital, impacting on ability to focus on other HCAI prevention work.

New IPC nursing staff member commenced in a secondment post last month, requiring intensive support. In addition, existing IPC team members have been on leave which has unfortunately had an impact on overall team performance. (Of note: this has included a Consultant Microbiologist on unexpected absence).

An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes (Of note: Trust trajectories for 2023/24 have not yet been published).

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	Dec-22
Crude Mortality	63	76	62	68	69	65	64	79	94	86	84	84	88	84	77	88	82	73	75	77	102
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	100.95	102.07	100.85	101.29	102.46	102.85	103.49	106.41	105.02	101.59	104.62	107.26	109.94	109.80	111.50	112.70	113.40	113.40	114.80		
HSMR Trust	110.91	108.00	109.43	107.97	107.96	109.00	109.66	109.88	113.00	113.00	109.08	111.34	116.00	115.00	117.20	118.00	119.10	119.00	120.90		
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	98.21	100.17	101.28	101.78	101.88	102.61	102.69	102.81	102.70	104.38	105.48	107.66	106.80	106.05	106.48	106.90	106.98	107.03	106.64		
SHMI Trust	103.39	105.00	106.29	106.22	106.22	107.07	106.90	106.67	106.77	108.47	109.13	111.34	110.00	110.00	110.01	111.00	111.16	111.00	111.06		

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.

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 SHMI for the 12-month rolling period of November 2021 to October 2022 for Salisbury District Hospital is 106.64.

The HSMR for the 12-month rolling period of November 2021 to October 2022 for Salisbury District Hospital is 114.8.

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
Mixed Sex Accommodation Breaches	9	9	14	0	0		Special Cause Improving - Run Below Mean	X	7
DM01 Waiting List Volume	5555	6040	5515				Special Cause Concerning - Two Out of Three High		
Pressure Ulcers Hospital Acquired Cat 2	46	41	45				Special Cause Concerning - Two Out of Three High		
Total Number of Compliments Received	68	39	68				Special Cause Concerning - Run Below Mean		
Ambulance Handovers 30-<60 mins	152	139	144				Special Cause Concerning - Run Above Mean		
Ambulance Handovers 60+ mins	136	120	144		0		Special Cause Concerning - Run Above Mean	X	24
ED 12 Hour Breaches (Arrival to Departure)	77	91	54		0		Special Cause Concerning - Run Above Mean	X	24
Proportion of patients spending more than 12 hours in an emergency department	2.1%	2.4%	1.3%				Special Cause Concerning - Run Above Mean		
Trust Performance RTT %	64.8%	61.8%	60.2%		92%		Special Cause Concerning - Below Lower Control Limit	X	24
Average Patients with No Criteria to Reside	172	174	156	35			Special Cause Concerning - Above Upper Control Limit	X	24
% of Inpatients Undergoing VTE Risk Assessment	98.7%	%	%		95%		Common Cause Variation	X	2
Average hours lost to Ambulance Handover delays per day	14	18	13		0		Common Cause Variation	X	24
Cancer 31 Day Performance Overall	97.0%	89.3%	89.7%		96%		Common Cause Variation	X	2
Cancer 62 Day Screening Performance	82.1%	54.8%	53.3%		90%		Common Cause Variation	X	6
RTT Incomplete Pathways: Total 52 week waits	578	694	768	545	0		Common Cause Variation	X	3
Stroke & TIA: % CT'd within 1 hour	42.0%	62.0%	30.0%		50%		Common Cause Variation	X	1
Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	828	480	651	150	0		Common Cause Variation	X	24
Total Number of Complaints Received	9	25	22		0		Common Cause Variation	X	10

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance

Metrics in relation to the urgent care pathway continue to alert, namely ambulance handovers and long waiting times in the Emergency Department. Despite alerting progress has been made with several metrics. There has been a reduction in the number and proportion of patients in the Emergency Department for longer than 12 hours. Ambulance handover delays remain challenging, There was some reduction in the number of patients remaining in the hospital but not meeting the criteria to reside, although this remains significantly above target levels.

The diagnostic waiting list size has alerted as two of the last three months have been high. There has been a notable reduction this month, in part due to additional support sourced for Ultrasound, which is the highest volume diagnostic modality.

VTE assessments are currently in the process of moving to being captured electronically with reporting of the data in the process of being established. Data is not currently available but is expected to resume in the short term.

Actions (SMART)

Actions in relation to ambulance handovers, ED, stroke, pressure ulcers, diagnostic, cancer and elective waiting times are identified on the related key performance indicator page earlier in the report.

System working to reduce the number of patients remaining in a hospital bed that could be supported elsewhere continues, with programs of work to increase the provision of discharge to assess and virtual ward capacity.

Risks and Mitigations

Industrial action has resulted in disruption to progress being made in the recovery of elective waiting times. Further action will reduce the impact of improvement work further and the ability to maintain urgent and cancer activity may be compromised if derogations of critical activity are not supported by unions. Close working at specialty level to mitigate losses in activity as far as possible and protect urgent elective activity.

The reliance on improvement work to reduce bed occupancy and both elective and non elective waiting times is heavily dependent on the system ability to reduce the proportion of acute beds occupied by patients that no longer require acute care. There has been some improvement in M12 which is expected after the Winter months, but further improvements are pivitol for the Trust to be able to deliver the activity and standards identified in the operational plan for 23/24. Planned Care and Emergency and Unplanned care (UEC) Boards have been established to drive improvements using the Improving Together approach to sustain and imbed improvements.

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
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	26.0%	32.0%	23.0%				Common Cause Variation		
Ambulance Arrivals	1057	1039	1155				Common Cause Variation		
Ambulance Handovers 15-<30 mins	268	291	324				Common Cause Variation		
Cancer 2 Week Wait Breast Performance	87.0%	90.0%	95.7%		90%	H	Special Cause Improving - Two Out of Three High	✓	0
ED Attendances	5863	5619	6217				Common Cause Variation		
Neonatal Deaths Per 1000 Live Births	0	0	0		0	L	Special Cause Improving - Run Below Mean	✓	0
Number of High Harm Falls in Hospital	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 3	0	0	1				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0			L	Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 104 week waits	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
RTT Incomplete Pathways: Total 78 week waits	7	0	0	0	0	L	Special Cause Improving - Below Lower Control Limit	✓	0
Serious Incident Investigations	1	4	3				Common Cause Variation		
Stillbirths Per 1000 Total Births	13	0	6				Common Cause Variation		
Total Incidents (All Grading) per 1000 Bed Days	52	59	61				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

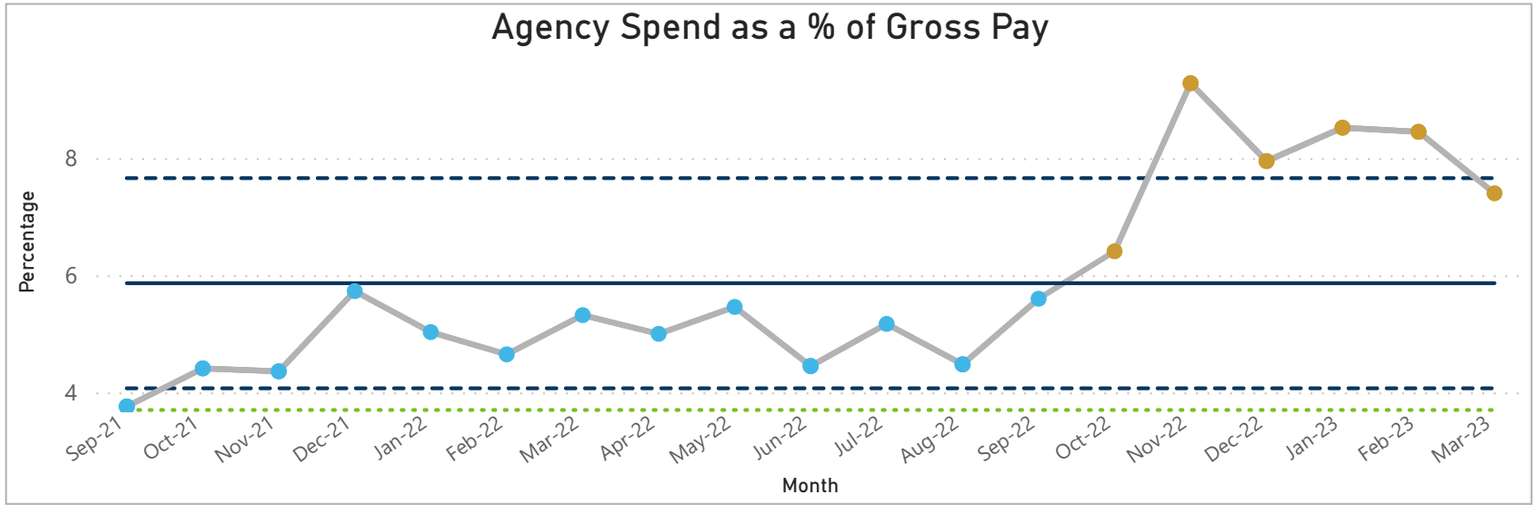
Partnerships

People

Staffing Availability

Target 3.7%

Breakthrough Objective



We are driving this measure because...

Insufficient substantive clinical staff are available to meet safe staffing levels. The Trust is currently unable to consistently meet Green staffing levels across all shifts and for a significant number of shifts has to resort to the use of expensive agency staff, which has led to an unsustainable overspend. Agency spend against total staff pay costs is currently averaging 5.9% against a 3.7% target and rising.

Understanding the performance

Against the target of 3.7%, Agency spend fell to 7.4% in March, a monthly spend of c£1.4M. Nursing staff spend accounted for £750K, down from £855K with Medical Staff spend rising from £299K to £316K – These 2 categories represent 76% of Agency spend.

Medicine Division remain responsible for over 50% of Agency spend, with a 15.9% of Agency spend against total pay budget.
Areas with the highest Agency spend are Stroke, Elderly Medicine, Emergency Medicine and Theatres.

Turnover, vacancies and absence are driver metrics for this breakthrough objective. Turnover and vacancies have maintained downward momentum, with spend reduction likely to be a result of reduced vacancies, noting that Strike Action will have complicated the picture due to reduced activity, but also reduced staffing levels.

Actions (SMART)

Establishment Control: E-Roster roll out will commence from Apr 23, and run through for 18 months and the first division (Medicine) to reconcile establishment with finance ledger on ESR will be complete by Jun 23. Oversight of the establishment will enable organisational design, improve visibility of vacancies across the Trust and improve workforce productivity.

Recruitment Services: Actions under the overhauling recruitment work are delivering efficiencies into the recruitment process and improving attraction campaigns.

Temporary staffing: The first elements of temporary staffing improvements are being designed, these will concentrate on recruiting into the Bank, centralising booking mechanisms and setting consistent pay rates with suppliers.

Risks and Mitigations

Corporate Risk – Sustainable Workforce
Mitigations:

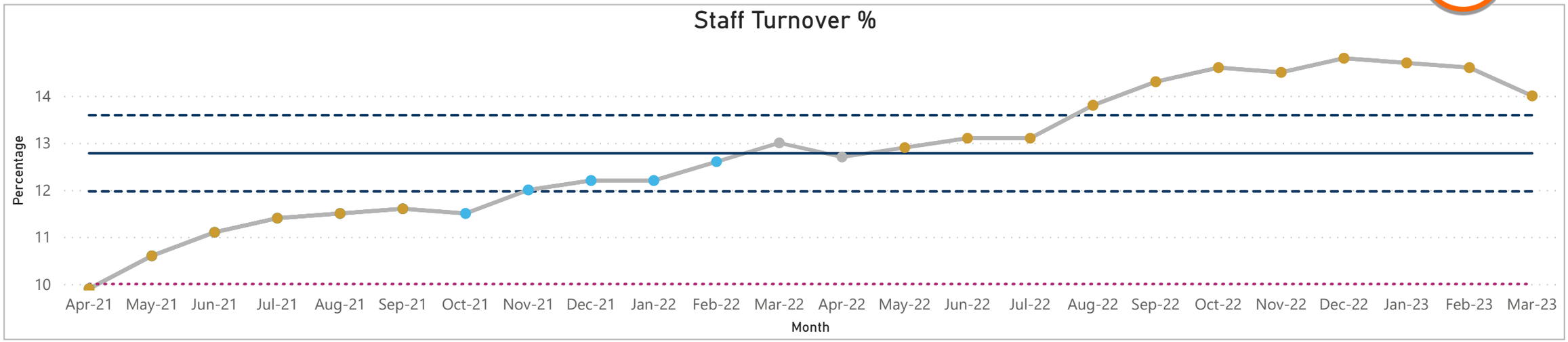
Line Managers insufficiently trained to support people promise and absence management initiatives - The roll out of Leadership training courses targeting band 4-6 and 7-8 mangers commenced in Feb 23, alongside specific modules designed to improve management skills.

Vacancies not sufficiently understood – Support to DMT to establish organisational design and prioritise vacancies to enable effective targeting of attraction campaigns.

Workforce - Turnover

Target 10%

People



Understanding the performance

In February, 34.72(FTE) left the Trust, with 62.45 (FTE) staff starting work, a more positive ratio than last month, which has further reduced the rolling average to 14.02%, the best position since Aug 22 and further evidence of the downward trend in 2023.

All Divisions remain red against the Trust 10% target. Surgery and CSFS remain closest to the 10% target at 12.65 and 13.22% respectively. The highest level of turnover is with Women and New Born, which sits at 18.69%, although as the smallest Division, the impact of individual moves is higher.

25% of 42 staff leavers completed a full exit questionnaire, with remaining staff completing partial exit information through completion of ESR reasons for leaving, where a third of staff cited Relocation and Work-life Balance as the reason for leaving. Five staff left at retirement age.

Actions (SMART)

Appraisals and Career Conversations, identified in Staff Survey as particular areas of concern remain a challenge. A target to deliver career conversations with RNs in the 45-55 age group by 31 Mar has not been met. Less medicine, the divisions are all above 80% with a plan to complete in April. Medicine have the largest challenge, have focussed on over 50s and will seek to catch the remainder of Staff in April.

To support exit interviews, a new electronic survey form is being created, aiming to improve access and increase participation. This tool will be offered as part of a refresh of exit interview processes led by HRBPs.

Staff survey results have been analysed and packs have been distributed to Divisional Management Teams, with action plans requested by Apr 23. The data has been divided by Division, profession and protected characteristics to enable effective management of action plans.

Risks and Mitigations

Corporate Risk – Sustainable Workforce.

Improved toolkits to support Line Managers to deliver appraisals and other conversations have been delivered.

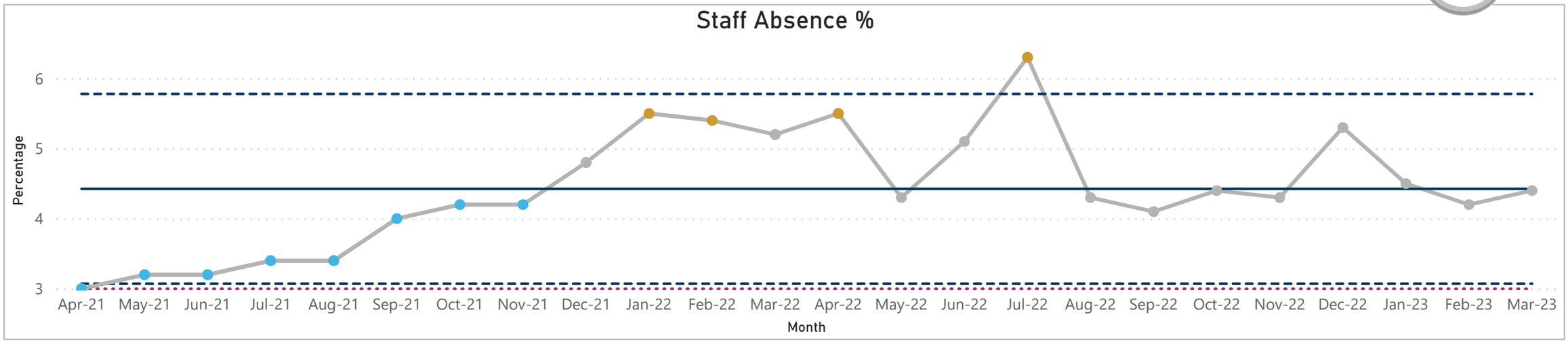
Divisional Staff Survey Action Plans

Line Manager Training interventions

Workforce - Sickness

Target 3%

People



Understanding the performance

Sickness absence was recorded as 4.37% for March, a small rise, breaking the downward trend in 2023. Only the corporate area CSFS sat below 4%, with W&NB accounting for the biggest rise from 3.6% to 5.8%. Principle increases for the month were Mental Health conditions and Cold, cough and flu.

Staff from Additional Clinical Services remain the staff group with the highest absence rate. This group includes HCAs, Therapy assistants and Radiography helpers.

Sickness accounted for 4,956 FTE days lost to the Trust, of which 3,162 were for short term absence in March. Mental Health issues again accounted for circa 25% of all absence in the month.

Actions (SMART)

Absence Management: The direct support pilot for 3 wards in Medicine (Pitton, Redlynch and Laverstock) commenced on 20th March. A report on the impact is due in late Jun. Several areas where improvements could be made to policy, processes and management of absence cases have been identified. These ideas will be refined with the aim of introducing improvements in Apr 23.

Well-being conversations to all staff are being led by the new cohort of Ambassadors, the ambitious target to meet a conversation with all staff by Apr 23 has not been met, but the target has stimulated much increased activity, which is very positive. The next step is to draw in both WB Ambassadors and Mental Health First Aiders to provide feedback from their activity in the last quarter, this will be reported to the wellbeing committee in May

Risks and Mitigations

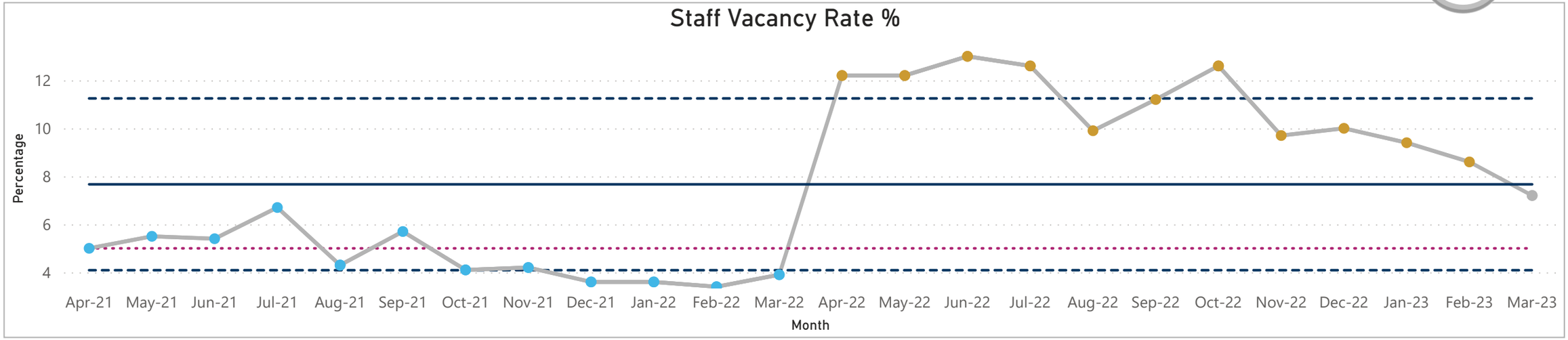
Corporate Risk – Delivery of OH service
OH staffing has improved. A band 7 lead has now been recruited, starting in May. Increased counselling and physio hours are required. Delivery of a health intelligence capability is planned for Summer 23.

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

Target 5%

People



Understanding the performance

The vacancy rate in March stood at 7.22% maintaining the downward trend in 2023. The Trust welcomed 59 starters this month an FTE increase of 52.49. This is positive news and the third month running where starters have outnumbered leavers, which is starting to address the deficit of staff generated by establishment uplift in Apr 22.

Nursing staff remain the staff group with the highest number of vacancies, although the number has again reduced this month from 121 to 116 FTE.

Theatres Staff and Housekeeping are the departments with the greatest vacancies.

Actions (SMART)

The new managers toolkit will be live End Apr.

New bulk recruitment processes for HCA led to 160 offers between Aug 22 and Feb 23, of which 149 were accepted, which has reduced vacancies in this area from 91 in Sep 22 to 24 – excellent progress in an historically high turnover area.

46 new starters have joined theatres teams as a result of the attraction campaign launched in Apr 22. Vacancies remain and the campaign has been refreshed, and a decision to attract international nurses for theatres agreed.

The campaign to attract housekeeping assistants led to 55 offers from August 2022 to February 2023 when the advert closed. A refreshed campaign will re-open in Apr 23.

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
Mandatory Training Rate %	90.2%	89.7%	89.3%	90.0%	85%		Special Cause Improving - Run Above Mean	X	2
Medical Appraisal Rate %	85.8%	86.3%	85.1%	90.0%			Special Cause Improving - Run Above Mean	X	24
Non-Medical Appraisal Rate %	63.9%	62.9%	62.5%	86.0%			Special Cause Concerning - Below Lower Control Limit	X	24

Watch Metrics: Alerting Narrative

People

Understanding the performance

Mandatory training activity at 89.3% completion, above the 85% national target, but the second consecutive month that it is below the Trust improvement target. The impact of operational pressures in the hospital and close down of training courses and education centre rooms to support operational activity during the strike period in February and March are the main reasons behind this drop.
Medical appraisal rates remain just under the 90% target and will be addressed once Junior Doctor strike action has concluded.
Non-Medical appraisals remain some way below target at 62.5 %, and falling monthly. Ineffective management of appraisals remains an area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff. Time to complete is the most common challenge to increasing this rate.

Actions (SMART)

Mandatory Training: Comms activity to remind staff of their training responsibilities will be delivered through Line Managers Communications briefs, and wider Trust Broadcast, as well as individual e-mails from the MLE system to those out of date. Post strike activity, additional classroom space in the Education Centre and Library will be made available to enable completion of on-line and in person training sessions.

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. The first of a series of Appraisal Workshops has been delivered for Line Managers, with more in the forward programme. The option of completing paper forms (currently used by Facilities) is being explored in Medicine Division, alongside the wider simplification of the process through a new policy, which will seek to share ownership of appraisals between line managers and staff. This policy is expected to be delivered in May 23.

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

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

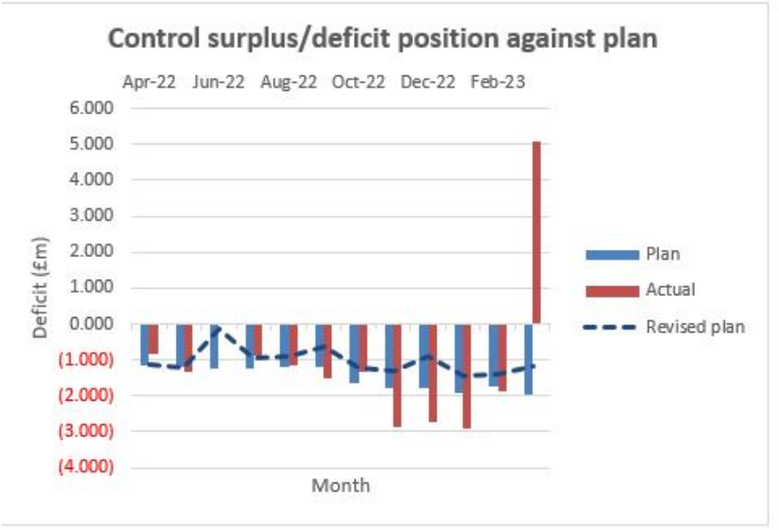
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	March '23 In Month			March '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	38,876	16,930	264,007	282,360	18,353	260,775
Other Clinical Income	717	2,133	1,416	8,573	13,906	5,333	8,573
Other Income (excl Donations)	2,891	12,309	9,418	34,540	50,008	15,468	34,540
Total income	**25,554**	**53,318**	**27,764**	**307,120**	**346,275**	**39,155**	**303,888**
Operating Expenditure							
Pay	(17,059)	(33,409)	(16,351)	(202,661)	(226,666)	(24,005)	(199,429)
Non Pay	(7,956)	(13,185)	(5,229)	(96,646)	(112,947)	(16,301)	(96,646)
Total Expenditure	**(25,015)**	**(46,595)**	**(21,580)**	**(299,307)**	**(339,613)**	**(40,306)**	**(296,075)**
EBITDA	**539**	**6,723**	**6,184**	**7,813**	**6,662**	**(1,151)**	**7,813**
Financing Costs (incl Depreciation)	(1,722)	(1,651)	71	(20,213)	(19,023)	1,190	(20,213)
NHSI Control Total	**(1,183)**	**5,073**	**6,256**	**(12,400)**	**(12,361)**	**39**	**(12,400)**
Add: impact of donated assets	(68)	629	697	(816)	953	1,769	(816)
Add: gains/(losses) on transfers by absorption	0	0	0	0	(329)	(329)	
Surplus/(Deficit)	**(1,251)**	**5,702**	**6,953**	**(13,216)**	**(11,738)**	**1,478**	**(13,216)**
NHSI Control Total including BSW ICB support	**(150)**	**6,106**	**6,256**	**0**	**39**	**39**	**0**



Understanding the performance

In Month 12 the Trust recorded an in month control total surplus of £5.1m against an original deficit target of £1.2m - a favourable variance of £6.3m. The YTD control total position was a deficit of £12.361m, which is a small surplus of £39k when the additional £12.4m funding from BSW is taken into account

Pay costs include the technical adjustments required by the Department of Health and Social Care for the NHS pension adjustment and non-consolidated pay offer. The underlying position was an increase of £0.1m which includes the impact of the Band 2 to Band 3 local pay agreement (£0.7m) offset by the changes to the annual leave assessment at year end and central pay provisions, including but not limited to, clinicians pensions and employment issues. Non pay costs increased significantly in month due to the impact of year-end stock levels, central assessments of outstanding costs and drugs costs due to additional clinical activity which are not income backed

Actions (SMART)

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

Risks and Mitigations

Income & Activity Delivered by Point of Delivery

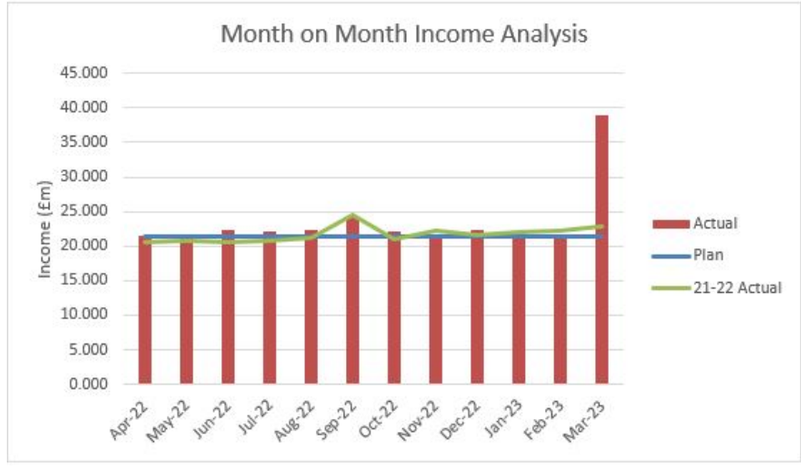
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	March'23 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	10,740	10,139	(601)
Day Case	20,407	19,540	(867)
Elective inpatients	13,310	13,674	364
Excluded Drugs & Devices (inc Lucentis)	22,076	23,908	1,832
Non Elective inpatients	70,019	72,540	2,521
Other	90,518	106,959	16,441
Outpatients	36,937	35,600	(1,337)
TOTAL	**264,007**	**282,360**	**18,353**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	156,540	168,688	12,148
Dorset ICB	26,241	26,150	(91)
Hampshire, Southampton & IOW ICB	21,396	21,396	-
Specialist Services	37,742	38,961	1,219
Other	22,088	27,165	5,077
TOTAL	**264,007**	**282,360**	**18,353**

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	70,566	72,327	1,761	67,996	4,331
Day case	23,397	22,394	(1,003)	20,581	1,813
Elective	3,312	3,261	(51)	2,830	431
Non Elective	28,838	26,840	(1,998)	27,829	(989)
Outpatients	256,929	254,523	(2,406)	268,120	(13,597)



Understanding the performance

The Trust is ahead of the Clinical income plan year to date due to BSW ICB ERF and pay award funding, overperformance within NHS England Specialised services cost and volume high cost drugs and devices and income relating to the non consolidated pay award offer. Dorset ICB income has been adjusted for the agreement on the Sleep service.

A&E activity was higher in March than in February but with more attendances at the A&E department and Walk-in-Centre. Day case activity in March was 493 more cases than in February with more activity undertaken in Ophthalmology (115 cases), Plastic Surgery (61 cases) and in Gastroenterology (183 cases) . Activity in Elective inpatients was on plan in month and there were 33 more cases undertaken than in February. Non Elective activity was higher than in February by 258 cases across most specialties. Outpatient activity was higher than in February by over 3,500 attendances with more activity across most specialties and specifically in Plastic Surgery (575 appointments) and Ophthalmology (446 appointments).

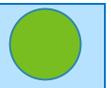
Actions (SMART)

The contracts with ICBs and NHS England have been signed by all parties.

Risks and Mitigations

Cash Position & Capital Programme

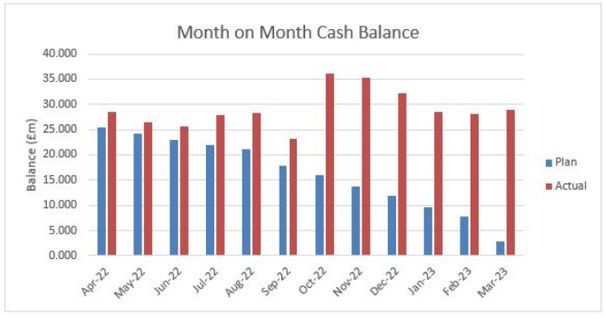
Capital Spend: 

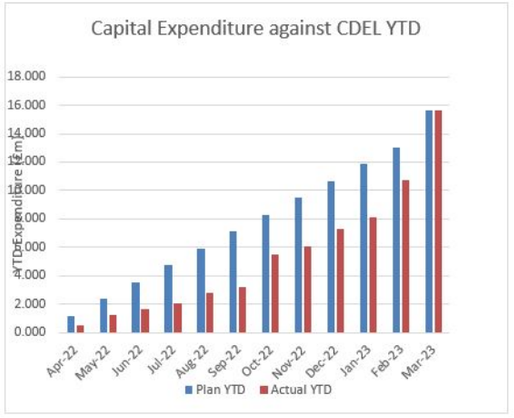
Cash & Working: 

Finance and Use of Resources

	Closing Balance March 2022 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,939	7,954	15
Debtors	14,296	24,999	10,703
Cash	33,447	28,891	(4,556)
TOTAL CURRENT ASSETS	**55,682**	**61,844**	**6,162**
Creditors	(46,637)	(58,026)	(11,389)
Borrowings	(1,102)	(641)	461
Provisions	(1,235)	(474)	761
TOTAL CURRENT LIABILITIES	**(48,974)**	**(59,141)**	**(10,167)**
TOTAL WORKING CAPITAL	**6,708**	**2,703**	**(4,005)**

Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Mar-23	**12,413**	10,193	311	950	959
Feb-23	**7,443**	4,654	331	1,064	1,394
Jan-23	**6,700**	4,509	766	198	1,427
Movement vs prev mth	*4,970*	*5,539*	*(20)*	*(114)*	*(435)*





Schemes	Annual Plan £000s	March'23 YTD Plan £000s	March'23 YTD Actual £000s	March'23 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	3,684	3,684	2,937	747
Building projects	3,048	3,048	4,534	(1,486)
IM&T	3,828	3,828	3,833	(5)
Medical Equipment	4,072	4,072	3,963	109
Other	1,025	1,025	384	641
Total CDEL schemes	**15,657**	**15,657**	**15,651**	**6**
National Funding				
TIF - New ward	*2,048*	*2,048*	*2,048*	0
Discharge Lounge	*546*	*546*	*530*	16
Non Obstetric Ultrasound devices	*85*	*85*	*76*	9
MRI Acceleration Upgrades Siemens	*178*	*178*	*178*	0
Additional Endoscopy Equipment	*301*	*301*	*301*	0
Pathology LIMS	*682*	*682*	*282*	400
Digital Pathology	*564*	*564*	*915*	(351)
Cyber Capital - Network Switches	*45*	*45*	*60*	(15)
Image Sharing	*30*	*30*	*30*	0
IT Home Reporting Workstations	*140*	*140*	*150*	(10)
Patient Portal Allocation	*155*	*155*	*155*	0
Total National Funding	**4,774**	**4,774**	**4,725**	**49**
GRAND TOTAL	**20,431**	**20,431**	**20,376**	**55**

Understanding the performance

Capital expenditure on both CDEL and nationally funded projects increased markedly in Month 12 as projects came to completion in line with the forecast. Total expenditure on CDEL schemes was £6k under plan for the year, taking into account agreed additional BSW allocations, and spend on nationally funded projects was £55k under plan. There were overspends on specific Digital diagnostic projects, agreed with NHS England, to offset an acknowledged and agreed underspend on the Pathology LIMS programme.

Cash reserves remain high following the receipt of additional payments from BSW in Month 12, despite the increases in both capital and revenue expenditure.

Actions (SMART)

£600k additional capital allocation was confirmed for Digital schemes and Power Tools.

Risks and Mitigations

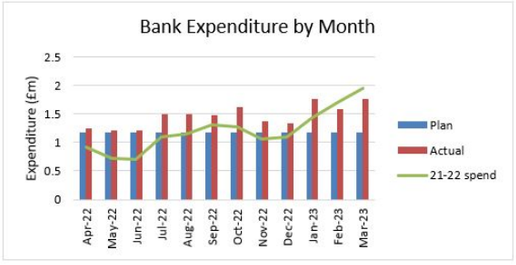
Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

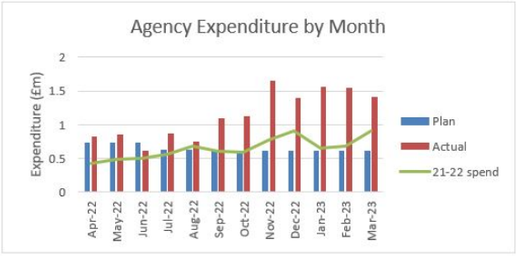
The constraint of both available cash and system capital expenditure limits gives rise to both a mid- and long-term risk to the Trust. The context of digital modernisation programmes, along with an ageing estate and medical equipment means the Trust's five year capital requirement is well in excess of 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





	March'23 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	179,460	194,621	15,161
Pay - Bank	14,276	17,593	3,317
Pay - Agency	7,737	13,665	5,928
Other (eg. Apprenticeship Levy)	1,188	787	(401)
TOTAL	**202,661**	**226,666**	**24,005**
Medical Staff	53,440	54,757	1,317
Nursing	48,093	57,846	9,753
Support to Nursing	14,629	18,994	4,365
Other Clinical Staff	33,351	31,451	(1,900)
Infrastructure staff	51,960	54,768	2,808
Other (eg. Apprenticeship Levy)	1,188	8,851	7,663
TOTAL	**202,661**	**226,666**	**24,005**

	March'23		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	479.84	(10.8)
Nursing	1,103.6	1,157.18	53.6
Support to Nursing	515.1	610.79	95.7
Other Clinical Staff	689.8	633.21	(56.6)
Infrastructure staff	1,461.1	1,431.75	(29.3)
TOTAL	**4,260.2**	**4,312.8**	**52.6**

Understanding the performance

- Pay costs in month include the technical adjustments required for the NHS pension adjustment and non-consolidated pay offer. The underlying position was an increase of £0.1m which includes the impact of the Band 2 to Band 3 local pay agreement (£0.7m) offset by the changes to the annual leave assessment at year end and central pay provisions, including but not limited to, clinicians pensions and employment issues.
- Bank costs increased by £188k and Agency costs reduced by £130k. This resulted from the cessation of the use of Support to Nursing agency staff in month which has been offset by substantive recruitment and the use of bank staff to support patient complexity. Staff turnover has remained at 14%against a target of 10% and Agency costs remain at a level 70% higher than the average for the first 6 months of the year.
- The full year pay savings target was £7.1m against which total achieved pay savings were £3.5m - an adverse variance of £3.6m, with £0.25m recurrent delivery and £3.2m relating to non-recurrent savings from vacancies.
- An increase in substantive staff of 62 WTE mainly within Support to Nursing staff (of 33 WTE) has resulted in the vacancy rate falling from 9 to 8%. The staff groups with the highest vacancies are AHP, Scientists and Technical staff (12%) and Registered Nursing (11%). The level of unfilled shifts remained constant at 5% in March but there were reductions in the fill rate for Consultants and Nursing and Midwifery staff offset by increases across Support to Nursing staff and NHS Infrastructure staff groups.

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 premium agency and bank, in the short term it is likely that the Trust will require both.

Industrial action in April is expected to adversely impact on costs and 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	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Breakthrough Objective	Staffing Availability	Oracle	Melanie Whitfield	High
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	Stroke Team	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	Stroke Team	Peter Collins	High
Watch	Stroke & TIA: % CT'd within 1 hour	Stroke Team	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	Low
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 via Trust Data Warehouse	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 via Trust Data Warehouse	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:	3.1
Date of meeting:	04 May 2023		

Report tile:	Digital Strategy Programme Report April 2023			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Jonathan Burwell, Chief Information Officer			
Executive Sponsor: (presenting)	Naginder Dhanoa, Chief Digital Officer			

Recommendation:

Trust Board are asked to:

- Note the progress within the digital agenda during 2022/23
- Note the risk and mitigation on the digital plan for 2023/24

Executive Summary:

The purpose of this report is to provide an update on the progress made against the Trust's digital agenda during 2022/23. The Trust has recently refreshed its Digital Plan to be in line with the renewed Trust Strategy.

The report highlights good progress made against key programmes in particular the optimisation of Lorenzo with electronic prescribing and medicines administration (EPMA) beginning its rollout with a planned completion by September 2023, and implementation of a first phase of digitised nursing documentation. A key programme that is progressing is the procurement of a Shared Electronic Patient Record which is nearing completion of the Full Business Case for national approvals. This forms a key component to the Trust achieving the expectations around future digital maturity and is the main priority within the refreshed Digital Plan.

There have been some programmes delayed due to a mix of reprioritisation, supplier capacity and restrictions because of aging architecture, these are continued risks and mitigations are noted in the risk section below.

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	x
Other (please describe):	

Digital Strategy Progress Report April 2023

1. Introduction

1.1. The purpose of this report is to provide an update on the progress made against the Trust's digital agenda during 2022/23.

1.2. As part of the Trust Strategy's recent refresh, a new Digital Plan (nee strategy) was approved by Trust Board in November 2022 covering the same period as the Trust Strategy (2022/23 to 2026/27). The Digital Plan is seen as a key enabler to the priorities outlined within the Trust Strategy.

2. Progress on the Digital agenda

2.1. The Trust has made good progress in a range of areas in the Digital Strategy, albeit catching up on many delayed programmes due to the Covid pandemic. This has seen projects get reprioritised, new projects be added which support new ways of working and/or building on learning from the pandemic. Any new programme has gone through a prioritisation process aligned with Improving Together and where required, business cases for additional resource have been submitted (either through capital or revenue governance).

2.2. The Trust was able to leverage new national funding driven from post pandemic priorities to help procure replacement software/hardware. Much of this was procured in 2021/22 and rolled out during 2022/23.

2.3. A key priority over 2022/23 has been the availability of funding to support organisations in increasing their digital maturity with the aim of having an Electronic Patient Record (EPR) capable of supporting a digital maturity level of HIMSS Level 5. HIMSS is an internationally recognised scoring methodology focused on predominantly inpatient processes. The Trust is in the process of finalising their procurement of a new Shared EPR in conjunction with ICS Acute partners (Great Western Hospitals NHS Foundation Trust and Royal United Bath NHS Foundation Trust). This procurement and request for approval of the associated Full Business Case will go for national consideration in August 2023.

2.4. As part of the ICS multi year investment planning, an indicative 5 year digital investment plan has been developed which aligns with the Trust's new Digital Plan. The exact programme of future digital transformation will depend on a number of factors including the Trust's prioritisation of programmes and resources, the availability of sufficient funding and national NHS policy direction.

2.5. Progress against the digital agenda can be seen in the five priority themes (from the Digital Strategy 2019-2023) below. it is important to note that Improving Together and prioritisation might influence how some of these programmes are taken forward.

2.6. Alongside of the priorities below, digital literacy is a key component for successful digital transformation. The Trust has commenced and is in the process of embedding a new Digital Improvement Network, led by clinical digital leaders to help build a likeminded group of digital champions and digital superusers. Further work will continue to expand this in 2023/24 with the new Digital Plan having a particular focus on digital literacy activities for both our population and staff.

Journey to a Shared Care Record

Programme	Status and any outstanding work (where not mentioned in wider report)
Integrated Shared Care Record	Complete, initial implementation including Lorenzo patient context launch In Progress, phase 2 implementation of extended functionality including care planning and respect forms.
Shared EPR	In Progress, at Preferred Bidder Stage, expecting Full Business Case submission to NHS England in August 2023.
Electronic Discharge Summary upgrades	Complete, enabling among other things Pembroke nurse led discharging
Paperlite programme	Height and weight recording, Complete Centralisation of Allergy and Alerting, Complete ED optimisation, In Progress Nursing Clinical Charts, In Progress Electronic internal referrals, In Progress Electronic handovers, In Progress Electronic discharge summaries, In Progress *This programme is expected to stop to focus on the Shared EPR Programme from October 2023.*
Electronic Prescribing	In Progress, completion planned for September 2023.
Pathology LIMS replacement	In Progress, delayed due to complexity and supplier capacity. Completion now planned for March 2024.
Upgrade of Order Comms	Complete
Bed Management System	In Progress, an upgraded system will be relaunched in May 2023.
New Hospice IT System	In Progress, implementing solution in 2023/24

Wider systems for improving efficiency

Programme	Status and any outstanding work (where not mentioned in wider report)
Document management system upgrade	In Progress, deprioritised for six months due to other focus areas. Now expecting go live in August 2023
Virtual Consultation Refresh	Complete, initial implementation of core functionality In Progress, extension of additional functionality to enable patient portal functionalities (e.g. appointment rescheduling, digital correspondence)
Digital dictation	In Progress, expected to be completed by September 2023
RPA	In Progress, the programme has commenced in February 2023, having been deprioritised prior to this. The implementation will occur during 2023/24.

Medical eRostering	In Progress, programme commencing in 2023/24 after procurement of additional modules.
Implementation of radiology artificial intelligence (AI) software	Complete, two AI solutions implemented as pilots to test benefits realisation.
Virtual advice and guidance	Complete, rolled out
Endoscopy clinical system	In Progress, planned implementation in in May 2023.

Intelligent use of Information

Programme	**Status and any outstanding work (where not mentioned in wider report)**
Power BI Implementation and cloud	In Progress, expansion of Power BI has progressed well during 2022/23 with a roadmap for development in 2022/23. Business case being finalised for a move to Power BI in the cloud.
Data Warehouse replacement	Core build, Complete Full migration from old data warehouse in progress, planned for September 2023.

Digitally informed population

Programme	**Status and any outstanding work (where not mentioned in wider report)**
Intranet upgrade	Complete
Patient Portal/Personal Held Record development	In Progress, Cancer service patient portal pilot part rolled out with three other modalities planned for Q1 2023/24

Enabling Platforms

Programme	**Status and any outstanding work (where not mentioned in wider report)**
MDT virtual consultation equipment replacement	Complete
Over 30 upgrades of legacy applications to modern platforms	Complete
Mobile Device Management	Complete
GP access to results integration	Complete, extended GP access and community access to order comms
Cyber essentials plus compliance	Complete, maintaining DSPT (Cyber essentials equivalence) compliance however requirements are increasing.
Desk booking solution	Complete
Core infrastructure replacement	In Progress, planned to complete in December 2023
Implementation of a range of solutions to increase our cyber security	Complete, with further software based solutions being rolled out in 2023/24 in line with ICS peers

3. Risks

The main risks and mitigations for delivery of programmes for 2023/24 and the mitigating actions are as follows:

Risk	Mitigating Actions to be taken
Programme delays due to the speed of the core infrastructure.	Programme to replace aging infrastructure by December 2023, moving to a future proofed environment. Review of specific requirements for new projects to understand any actions possible to minimise the impact of the existing infrastructure, ensuring there is clear escalation on any expected delays to Digital Steering Group.
National funding does not materialise	For those programmes reliant on national funding, ensure routine engagement with NHS England, seeking assurance on the funding provision. Where funding is at risk, escalation through internal governance for decision on funding from internal means and/or stopping the programme(s).
Insufficient staff capacity and bandwidth to effectively engage with digital transformation	Ensure clear leadership/ownership is identified at the outset of each programme. Effective prioritisation of programmes aligned to Improving Together methodologies, helping to maintain a realistic level of transformation activities (both digital and non-digital). Escalation processes through divisional management teams to highlight where different approaches are required to better support staff to interact with digital transformation programmes.
Insufficient capacity within key third party suppliers, leading to potential delays.	Jointly agree programme plans with suppliers to ensure they are realistic. Ensure contracts are of a sufficient strength to hold third party suppliers to account for delivery within any agree timeframes. Strong governance to maintain oversight of programmes and emerging capacity/delivery risks, enabling the development of relevant mitigation plans wherever possible.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	6.1
Date of meeting:	4 May 2023		

Report tile:	NHS England Governance publications briefing			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

The Board to note the changes to the New Provider Licence and Code of Governance

Executive Summary:

NHS England have published 3 documents:

1. The new NHS Provider Licence – comes into force 1 April 2023.
2. Changes to the enforcement guidance setting out how NHSE intend to deal with breaches of the Provider Licence (consultation closed 9 December 22. Awaiting publication 2023/24.
3. New Code of Governance for Trusts and related governance documents - comes into force 1 April 2023.

New Provider Licence

The new Provider Licence has been issued and received by the Trust and has been updated to align to current statutory and policy requirements and was subject to a statutory consultation which closed on 9 December 2022. It provides oversight arrangements and serves as the legal mechanism for any formal regulatory intervention by NHSE. The aim is to support effective system working, enhance oversight of independent sector provision of key services and climate change. There have also been a number of technical amendments

3 new licence conditions:

1. Cooperation (with system partners)
2. Triple aim (aligned to triple aim and health inequalities expectations set out in Health & care Act 2022)
3. Digital Transformation (to reflect digital obligations and promote digital maturity).

2 re-framed conditions:

1. Integrated Care (positive obligation to encourage active participation in service integration)
2. Personalised Care & Patient Choice (requirement to support the implementation and delivery of personalised care)

1 condition removed:

1. Choice and Competition (to reflect shift from competition to collaboration).

Code of Governance

New code replaces the NHS FT Code of Governance last updated in 2014. Will now apply to all NHS Trusts not just FTs. The Code sets out a framework for the corporate governance of Trusts, reflecting developments in UK corporate governance and development of ICSs (compliments statutory and regulatory obligations).

Trusts must comply with the provisions of the code (reported in the Annual Report).

In general, the provisions of the Code are in the main unchanged. Updates reflect:

- its application to NHS trusts, following the extension of the NHS Provider licence to them
- changes to the UK Corporate Governance Code in 2018
- the legal establishment of integrated care systems (ICSs) under the Health and Care Act 2022
- the evolving NHS System Oversight Framework, under which trusts will be treated similarly regardless of their constitution as a trust or foundation trust.

Themes underlying the key changes are now included for the first time:

- Requirement for Boards of Directors to assess the Trust's contribution to the objectives of the ICP and ICB, and place-based partnerships as part of its assessment of performance
- The inclusion of the Board's role in assessing and monitoring the culture of the organisation including investing in, rewarding and promoting the wellbeing of the workforce. The previous code only mentions wellbeing in the context of the finances.
- New focus on EDI.
- For FTs – a greater involvement for NHSE in recruitment and appointment processes (focus on NEDs)

A number of related governance publications:

- Guidance on good governance and collaboration – in force
- Addendum to your statutory duties – reference guide for NHS FT Trust Governors – in force

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	X
Other (please describe):	

NHS
Salisbury
NHS Foundation Trust

NHS England Governance Publications Briefing

Fiona McNeight, Director of Intergrated Governance

Kylie Nye, Head of Corporate Governance

Context

NHS Salisbury NHS Foundation Trust

NHSE has published 3 documents:

1. The new NHS provider licence standard conditions (31 March 2023).
2. A consultation on changes to the enforcement guidance, setting out how NHSE intends to deal with breaches of the provider licence. This consultation also closes on 9 December.
3. A new code of governance for trusts, and related documents

1. NHS Provider Licence - Background

Salisbury NHS Foundation Trust

- First introduced in 2013 and held by all NHS foundation trusts, as well as independent sector providers unless exempt. Recent statutory changes will require NHS Trusts to be licenced from 1 April 23 (previously exempt).

- Updated to align to current statutory and policy requirements. Subjected to statutory consultation from 28 October to 9 December 22.

- Provides oversight arrangements and serves as the legal mechanism for any formal regulatory intervention by NHSE (SOF details the overall principles, responsibilities and key metrics for oversight)

NHS Provider Licence - Aims

Salisbury NHS Foundation Trust

- The new provider licence aims to:
  - Support effective system working
  - Enhance the oversight of key services provided by the independent sector
  - Address climate change
  - Make a number of technical amendments

Supporting System working

Salisbury NHS Foundation Trust

- **New cooperation condition (WS1)**
  - New licence condition outlining expectations to consistently cooperate with ICBs, LAs and other organisations that deliver NHS care when developing and delivering system plans, delivering NHS services, improving NHS services, delivering system financial plans and delivering system workforce plans.
  - Aligned with the revised duty on NHS bodies and local authorities to cooperate as set out in sections 72 and 82 of the NHS Act 2006 and with expectations around collaboration set out in the NHS Long Term Plan and the guidance on good governance and collaboration.

Supporting System working

Salisbury NHS Foundation Trust

- **New triple aim condition (WS2)**
  - To reflect the triple aim and health inequalities that mirrors the expectations set out in the Health & Care Act 2022, for providers to consider the triple aim and health inequalities in their work.
- **New digital transformation condition (WS3)**
  - To reflect digital obligations to enable system working and promote digital maturity and a separate amendment to the governance conditions (NHS2: Governance arrangements in the modified licence). These reflect expectations already set out in legislation and guidance (concerns this could be costly to comply)

Supporting System working

Salisbury NHS Foundation Trust

- **Integrated Care condition (current – IC1)**
  - Reframed as a positive obligation to encourage providers to actively participate in service integration to improve the quality of health care services, provide place-based integrated care, and reduce inequalities of access and outcomes.
- **Personalised Care & Patient choice condition (current - IC*2*)**
  - To require providers to support the implementation and delivery of personalised care by having regard for relevant guidance and legislation, offering people control to manage their own health and wellbeing.

Supporting System working

Salisbury NHS Foundation Trust

- **Removal of the Choice and Competition condition 2: Competition oversight**
  - Removed to reflect a shift in healthcare priorities from competition to collaboration and the removal of the former Monitor statutory functions relating to competition oversight, as the 2022 Act did not transfer enforcement authority to NHSE.

Enhancing the oversight of key services provided by the Independent Sector

Salisbury NHS Foundation Trust

- **Broadening the range of providers where continuity of services (CoS) conditions will apply**
  - Provisions included to expand NHSE's oversight beyond the narrow definition of commissioner requested services (CRS) to providers which deliver services considered hard to replace.
- **Expanding the scope of continuity of services conditions to include quality governance standards**
  - Provisions included to enhance risk mitigation and cooperation with NHSE in the event that an independent sector provider is experiencing serious quality issues which threaten service delivery. Mechanisms already exist to address quality concerns in NHS trusts and FTs.

Addressing climate change

Salisbury NHS Foundation Trust

- Provisions reflect the requirements set out in the 2022 Health and Care Act relating to the contribution of NHS trusts and foundation trusts to tackling climate change and delivering net zero carbon emissions. NHSE also proposes that the adherence to any NHSE guidance on tackling climate change is part of good corporate governance and aligns with the governance requirements in the 2022/23 NHS Standard Contract, requiring boards to nominate a board-level net zero lead and deliver a green plan.

Technical amendments

Salisbury NHS Foundation Trust

- **Shifting the focus of the costing conditions**
  - Changes modify the costing conditions and separate them from the other pricing conditions. This would reflect the wider role costing data plays in supporting integration and improvement as well as the pricing of NHS services.
- **Amending the pricing conditions to reflect changes to national policy**
  - Changes amend the pricing conditions to reflect changes to national policy and pricing legislation by referencing the national payment scheme and removing the condition related to local modifications.

Technical amendments

Salisbury NHS Foundation Trust

- **Applying conditions to NHS trusts and updating language to reflect the current statutory framework**
  - Refers to updating language, in order to reflect the current statutory framework, including the change of Monitor to NHSE as the regulatory body for the provider licence and inserting references to NHS trusts.
- **Removing obsolete conditions**
  - Proposal to removing conditions, such as those setting out the payment of fees to NHS England, which have never been used by NHSE and there is no intention to use them in the future.
- **Amending the Fit and Proper Persons condition**
  - Amendment in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and as per the statutory consultation conducted in 2021.

2. Enforcement guidance consultation – closed 9 Dec 22

Salisbury NHS Foundation Trust

- NHS England has updated its Enforcement guidance to reflect the Health and Care Act, 2022 and current practice. The revised guidance sets out NHS England's approach to enforcement of integrated care boards and providers.
- Applies to all ICBs and licensed providers in England where NHSE has determined that formal regulatory action is required, and explains the regulatory and statutory processes in the event of enforcement action as well as subsequent rights of appeal, where applicable. This includes:

  a) when NHS England may decide to take action, and what action it can take,

  b) how NHS England is likely to decide what kind of actions to take using its powers under the Act.

- NHS England has a statutory duty to consult on the proposed changes to the Enforcement guidance. The final version of the revised guidance will be issued during 2023/24

3. Code of Governance

Salisbury NHS Foundation Trust

- The new code replaces the NHS Foundation Trust Code of Governance, which was last updated in 2014. For the first time, the code will apply to all trusts from 1 April 2023.

- Sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems (compliments statutory and regulatory obligations)

- Trusts must comply with the provisions of the Code.

3. Code of Governance

Salisbury NHS Foundation Trust

Set out in five sections:

- Section A – Board Leadership and Purpose
- Section B – Division of responsibilities
- Section C – Composition, succession and evaluation
- Section D – Audit, Risk and Internal Control
- Section E – Remuneration

3. Code of Governance

Salisbury NHS Foundation Trust

Appendices

- Role of the Trust Secretary – significance of the role retained but appointment and removal now matter for whole Board (not just Chair and CEO)
- Council of governors and role of the nominated lead governor – contains the majority of provisions now. No legal change to roles and responsibilities. Focus on wider population and system collaboration and clarification on role in relation to approving significant transactions, mergers and acquisitions
- The Code and other Regulatory requirements – sets out how the Code disclosure requirements sit alongside other governance disclosures (e.g. AGS)

3. Code of Governance

Salisbury NHS Foundation Trust

- The majority of the code is familiar to FTs, and it makes clear where provisions are different depending on the constitution of the provider organisation (notably around the council of governors and board member recruitment, appointments, performance evaluation and remuneration).
- Compliance with the principles of the code, and with directors' duties and liabilities, in the context of system working is already producing some challenges for trust directors, notably around conflicts of interest and loyalty: these are not addressed in the code, nor in NHSE's current guidance on conflicts of interest. NHS Providers working with NHSE on this.

Code of Governance – related documents

Salisbury NHS Foundation Trust

- **Guidance on good governance and collaboration – in force**
  - New guidance seeking to clarify the expectations around collaboration on all provider trusts and to set out the governance characteristics that trusts should have in place to facilitate effective collaboration.
  - It links to the NHS Oversight Framework. The guidance includes a section explaining how NHSE will use this guidance in cases of non-compliance, noting that in the first instance integrated care board (ICB) leaders should seek informal resolution of issues locally, with NHSE intervention following if required, and in discussion with ICB leaders.

Code of Governance – related documents

Salisbury NHS Foundation Trust

- Describes five characteristics of governance arrangements to support effective collaboration, with key lines of enquiry (KLOEs) for each in the form of questions about providers' participation, engagement, dialogue, information-sharing and decision-making, among other things.

- The five characteristics expected of providers are:
  - developing and sustaining strong working relationships with partners
  - ensuring decisions are taken at the right level
  - setting out clear and system-minded rationale for decisions
  - establishing clear lines of accountability for decisions
  - ensuring delivery of improvements and decisions.

Code of Governance – related documents

Salisbury NHS Foundation Trust

- **Addendum to your statutory duties – reference guide for NHS foundation trust governors: System working and collaboration: role of foundation trust councils of governors – in force**

  - Supplements the existing guidance for governors and explains that governors' statutory duties have not changed: governors should not expect any material change to their day-today role. However, the context of system working and collaboration brings additional considerations for governors when undertaking their statutory duties.
  - Introduces the system working context

Code of Governance – related documents

Salisbury NHS Foundation Trust

- Goes into some detail on what representing the interests of the public means in the new context, emphasising that ‘the public’ should include the population of the local system of which the foundation trust is part.

- Focuses on the statutory duties of governors and additional considerations in relation to each: holding the NEDS to account for the performance of the board; representing the interests of members and public; and taking decisions on significant transactions.

- Suggests approaches to support better working between the board and council.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of meeting:	4th May 2023		

Report tile:	Corporate Governance Statement Self-Certifications FT4, G6, CoS7 (Continuation of Services) and Training for Governors			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices	Appendix 1 – Evidence to support response Appendix 2 Provider Licence Conditions			

Recommendation:

The Committee is asked to consider and approve the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and confirm the response, noting the risks and mitigations.

Executive Summary:

NHS Foundation Trusts are required to self-certify on an annual basis, as to whether they have:

- Effective systems to ensure compliance with the conditions of the NHS Provider Licence, NHS legislation and the duty to have regard to the NHS Constitution (Condition G6)
- Complied with governance arrangements (condition FT4)
- The required resources available if providing commissioner requested services (CRS) (condition CoS7
- Have provided Governors with the necessary training.

This paper provides the Board with assurance that the Trust fully meets the NHS Provider Licence conditions.

The statements and evidence have been reviewed and the Director of Integrated Governance proposes that the Trust Board responds with confirmed for all elements. The evidence to support the response is outlined in Appendix 1 of the paper.

Once returns have been agreed, the CEO and chair will sign. These are published on the Trust's website.

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	x
Other (please describe):	

‘		Evidence	Risks	Mitigating Actions
FT4 – Corporate Governance Statement				
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. **Proposed Response: Confirmed**	• Well-led Framework CQC inspection rated Trust as ‘Good’ • Annual Governance Statement • Head of Internal Audit Opinion • Board Assurance Framework • Board Committee annual effectiveness evaluation • Annual review of corporate objectives • Annual Director declaration of interests and Fit and Proper Persons • Compliance with the Code of Governance • External audit of the annual report and accounts • Quality Account • Internal and External Audit Reports • Constitution review and updated February 2023. • Board development programme • Policy management process • Board and Board Committee escalation reports • Governor observers on all Board and Board Committees • Contribution to ICS governance and risk management meetings	• Weaknesses in internal control identified through Internal Audit Programme for 2022/23 • Regulatory enforcement • Changing governance landscape aligned to the ICS	• The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management • established governance arrangements to strengthen assurance reporting to Board • Contribution to ICS governance and risk management meetings
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time **Proposed Response: Confirmed**	• Central management of incoming national and local correspondence to ensure effective oversight of required action and deliverables.	• Guidance is not identified or implemented in a timely manner	• Central log of all communications • Weekly update on correspondence received at Executive meeting

‘		Evidence	Risks	Mitigating Actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures. (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation. **Proposed Response: Confirmed**	• Integrated Governance Framework • Accountability Framework • Executive performance reviews • Divisional Governance Committees • Board and Committee annual effectiveness reviews • Scheme of Delegation and Standing Financial Instructions • Committee terms of reference annual review • Escalation reports from Board Committee Chairs to the Board • Annual review of Board and Committee work plans • Governor observers at all Board and Board Committees • Bi-weekly meetings with the Lead Governor and Chairman • Governance structure continually reviewed following a full review in March 2020. • Internal Audit reports • Electronic Board administration system (Ibabs)	• Revised governance structure is not fully embedded across the organisation.	• Annual review of Board and Board Committee effectiveness • Annual review of Board and Board Committee terms of reference.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee’s duty to operate efficiently, economically, and effectively. (b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations.	• Monthly Integrated Performance Report to Board • Annual Operating Plan and budget • Standing Financial Instructions and Scheme of Delegation • Head of Internal Audit Opinion • Annual Governance Statement • Internal Audit Programme and reports • External audit of the annual report and accounts	• The Trust’s internal control systems are not sufficiently robust to ensure compliance	• The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management

‘		Evidence	Risks	Mitigating Actions
	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions. (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making. (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence. (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements. **Proposed Response: Confirmed**	• Risk Management Strategy • Corporate and Divisional risk registers • Board Assurance Framework • Risk based Board and Committee work plans • Annual planning process • Electronic Board administration solution • Board Committee escalation reports • Finance and Performance Committee • Audit Committee		
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:	• Well-led Framework CQC inspection rated Trust as ‘Good’ • Board development programme • Executive Development Programme • Board effectiveness evaluation report	• Sustained deterioration in quality performance metrics	• Monthly monitoring of key quality performance metrics • Timely escalation of risk • Clear lines of accountability through the

‘		Evidence	Risks	Mitigating Actions
	(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided. (b) That the Board’s planning and decision-making processes take timely and appropriate account of quality-of-care considerations. (c) The collection of accurate, comprehensive, timely and up to date information on quality of care. (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care. (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and considers as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. **Proposed Response: Confirmed**	• Monthly quality and performance reports • Executive annual appraisals • Integrated Governance Framework • Customer care reports to Board • Clinical Governance Committee (CGC) • Clinical management Board • Freedom to Speak Up Guardian and Guardian of Safe Working reports to CGC. • Board safety walks • Executive ‘Back to the Floor’ initiative • Active engagement with Commissioners, local Health Scrutiny, Health and Well-being Boards and Healthwatch • Patient and staff stories to each Public Board meeting.		Chief Nursing and Chief Medical Officers
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to	• Workforce report • Nurse skill mix review bi-annually • Safer Nursing Care Tool and Care Hours Per Patient Day • Revalidation and appraisal processes • Executive Performance Reviews	• Availability of staff	• Focussed recruitment campaigns • Incentivised pay rates • Well-being offers for staff • Daily staffing meetings

‘		Evidence	Risks	Mitigating Actions
	ensure compliance with the conditions of its NHS provider licence. **Proposed Response: Confirmed**	• Board development programme with external facilitation • Externally facilitated Executive coaching • Annual Fit and Proper Person declaration process		• Divisional workforce plans • E-roster captures and collates staffing numbers and skill mix • Monitoring of bank and agency spend • Robust management of Industrial Action
General condition 6 – Systems for compliance with licence conditions				
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. **Proposed Response:** **Confirmed**- although the Trust is still subject to enforcement action where NHSI has found the Trust in breach of license conditions.	• Internal Audit and clinical audit work programmes • Data Security and Protection Toolkit compliance • Fit and Proper Person requirements included in all Director appointments and annual declaration • Board Assurance Framework • Integrated Governance Framework • Accountability Framework • CQC Registration • Risk Management Strategy • Annual submission of reference costs • Annual reference cost assurance report • Signed contracts with Commissioners based on national tariffs	N/A	N/A
Continuity of Services condition 7 – Availability of Resources				
1	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which	N/A	N/A	N/A

‘		Evidence	Risks	Mitigating Actions
	might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.			
or	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. **Proposed Response:** **Confirmed**	The financial plan for 2023/24 is challenging with a savings plan target of 5% c£15.3m, which is not without significant risk. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures and capacity. The Trust's planned deficit after savings will be largely mitigated by a financial risk share payment (22.4m) from within the system in 2023/24 which should protect cash reserves heading into 2024/25.	N/A	N/A
Training of Governors				
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. **Proposed Response:** **Confirmed**	• Induction and mandatory training Programme • Governor development days • Governor observers on all Board and Board Committees • Informal Governor and NED meetings • Attendance at external training events • Governor self-assessment to review training requirements.	N/A	N/A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Salisbury NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2022_23 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	**Risk**: Faiilure to adhere to accepted standards of corporate governance and/or best practice. **Mitigations:** Compliance with NHS Foundation Trust Code of Governance. Compliance evidenced to the Trust's Audit Committee via external and internal audits and counter fraud reviews. Compliance with Trust's Constitution including Register of Interests and Gifts and Hospitality Register reported annually to Trust Management Committee and Board. Director declaration's noted at each Board and Committee (standing agenda item) Governor elections are held in accordance with model election rules. Robust risk management processes, including Duty of Candour process. We have an active Freedom to Speak Up Guardian and ambassadors with regular reporting to the People and Culture Committee and Trust Board.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	**Risk**: Non-compliance with NHS Foundation Trust Code of Governance and other guidance guidance issues by the regulator. Guidence is not identified or implemented in a timely manner. **Mitigations:** A central log of all communications is kept with weekly updates on correspondence received at the Executive Director's meeting. Compliance with NHS Oversight Framework for 2021/22.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	**Risk:** Ineffective Board and Committee structures in place which are not reviewed and updated leading to duplication or omission of duties, unclear reporting lines. **Mitigations:** The Trust has a well established Board Committee structure, all chaired by Non-Executive Directors. The Terms of Reference are reviewed annually together with Committee effectiveness. Integrated Accountability and Governance Framework outlines the mechanisms in place to monitor and drive delivery of the Trust's strategic and operational plans	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	**Risks:** The Trust's internal control systems are not sufficiently robust to ensure compliance with all requirements. **Mitigations:** The systems and processes are regularly tested through the internal and external audit programmes. There is a robust approach to risk management. a) and d) Finance and Performance Committee meet 9 times per year and scrutinises fianncial and operational performance. b) Integrated Performance Report presented to Board, Board Committees and Trust Management Committee aligned to Trust corporate objectives. c) The Trust has a Clinical Governance Committee with oversight of Health Care Standards. Deep dives are undertaken where where quality performance requires further assurance. e) There are performance and escalation reports presented to Board and Board Committees. Board and Board Committee cycles of business are aligned to ensure flow of information. Board Assurance Framework (BAF) presented in full to all Board Committees and Board to triangulate risk against performance reporting. The BAF includes application of the Board-agreed risk appetite and tolerances with a clear focus on risks out with tolerance. f) Material risks to compliance addressed through Audit Committee and BAF. g) Operating plan development overseen by Finance and Performance Committee and Board. Standing Financial Instructions (SFIs) are reviewed annually by the CFO and Audit Committee. (h) Active monitoring of changes to legal landscape and up to date workplans for the Trust Board and Committees to include review of legal requirements.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	**Risk:** Lack of capability to provide effective organisational leadership on the quality of care provided. **Mitigations:** a) There are two clinically qualified non-executive director (NED) as well as a Chief Medical Officer and Chief Nurse. The NEDs bring a wide range of expertise, both financial, managerial and governance, and are collectively qualified to discharge their functions. There is a comprehensive annual Board Development programme. b) There is a detailed work plan that is regularly reviewed for the Trust Board. This plans ahead where possible on areas to review using evidence from the Integrated Performance Report, other performance reports and escalated risks. c), d) and e) Data quality ratings are applied within the IPR. Dedicated data quality teams pro-actively manage data quality within core systems, and provide appropriate training and guidance to service colleagues across the Trust. There is corporate leadership for data quality with the Chief Digital Officer (SIRO) holding responsibility for the quality of performance data which is reported monthly at the Trust Board and assurance committees. f) Robust Quality Governance structure, established to oversee quality of care provision and clear lines of escalation.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	**Risk:** Appointment of inexperienced board directors and senior staff and insufficient staff to comply with conditions of licence. **Mitigations:** All Executive and Non-Executive Director appointments are subject to relevant checks of qualification, professional registration (where required), references and induction arrangements. There is an annual appraisal process for executive directors and NEDs.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A N/A

OK

Worksheet "Training of governors"

Financial Year to which self-certification relates | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Stacey Hunter	**Name**	Ian Green
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A N/A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Salisbury NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | Please Respond

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed Please fill details in cell E22

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

1) Confirmed - However, the Trust is still subject to enforcement action where NHSI has found the Trust in breach of license conditions.

3b) The financial plan for 2023/24 is challenging with a savings plan target of 5% c£15.3m, which is not without significant risk. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures and capacity. The Trust's planned deficit after savings will be largely mitigated by a financial risk share payment (22.4m) from within the system in 2023/24 which should protect cash reserves heading into 2024/25.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Stacey Hunter	**Name**	Ian Green
Capacity	Chief Executive	**Capacity**	Chairman
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.3
Date of meeting:	4th May		

Report tile:	Integrated Governance and Accountability Framework 2023			
Status:	Information	Discussion	Assurance	Approval
	✓			✓
Approval Process: (where has this paper been reviewed and approved):	Approved at TMC 26th April			
Prepared by:	Lisa Thomas, Chief Operating Officer Fiona McNeight, Director of Integrated Governance Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices	Appendix 1 Board Committee Summary Appendix 2 Committee Structure Appendix 3 Board Committee Terms of Reference Appendix 4 Committee Effectiveness Template			

Recommendation:

The Board is asked to review and approve the revised Integrated Governance and Accountability Framework.

Executive Summary:

The Integrated Governance Framework and Accountability Framework reports historically came to the Trust Board on an annual basis for review and approval. As part of the Trust Improving Together Programme and a review of the operating framework at both Trust, Division and Specialty level and to align to the recently published NHS Oversight Framework, the Trust Accountability Framework, and Integrated Governance Framework ('the framework') have been merged to create one document.

The framework outlines the sufficient mechanisms in place to monitor and drive delivery of the Trust's strategic and operational plans, considering the requirement to comply and adopt best practice from the NHS Oversight Framework, Provider Licence, Trust's constitution, NHS Standard Contract, NHS Code of Governance, and the Care Quality Commission. The framework also takes into the account the Trust's involvement as part of the BSW Integrated Care system and new collaborative arrangements at system level.

As this document sets out the expectations of the Trust as a whole and as individual divisions, it is important for members of the Board and the wider Trust to review and adhere to the framework. This ensures consistency for the Trust in its approach to managing and delivering its plans, and that sufficient escalation triggers are in place and the Board is routinely sighted on and involved in the mitigation of key risks.

Once approved at Trust Board the document will be published on the Trust's website.

Salisbury NHS Foundation Trust

To note: Remuneration Committee and Charitable Funds Committee ToR are due to be revised in June 2023.

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	x
Other (please describe):	

DRAFT

Accountability and Integrated Governance Framework

March 2023

Version	V 1
Author	Fiona McNeight, Director of Integrated Governance Lisa Thomas, Chief Operating Officer

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Appendix 1 - Board Committees Summary
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1. Background

1.1. As part of the Trust Improving Together Programme and review of the operating framework at both Trust, Division and Specialty level and to align to the recently published NHS Oversight Framework, the Trust Accountability Framework, and Integrated Governance Framework ('the framework') have been merged to create one document.

2. Purpose

2.1. The purpose of the Accountability and Integrated Governance Framework is to ensure that Salisbury NHS Foundation Trust has sufficient mechanisms in place to monitor and drive delivery of the Trust's strategic and operational plans during 2022 and beyond. This framework takes account of the Trust's requirement to comply and adopt best practice from the following:

- NHS Oversight Framework (27 June 2022)
- Trust Provider Licence
- Trust Constitution
- NHS Standard Contract
- NHS Code of Governance
- Care Quality Commission

2.2. The framework also takes account of the establishment of the BSW Integrated Care System on 1 July 2022, and new collaborative arrangements at system level. The framework aims to outline proportionate and effective oversight arrangements of Trust-led care within this system.

2.3. The Framework sets out the expectations of the Trust as a whole and as individual divisions. It provides a framework for how the Trust will monitor and manage its own performance within defined governance parameters. In order to achieve its ambitions, the Trust must ensure consistency in its approach to managing and delivering its plans, and that sufficient escalation triggers are in place and the Board is routinely sighted on and involved in the mitigation of key risks.

3. NHS oversight

3.1. This framework will ensure that as an organisation we are pro-active in providing assurance to our regulators. There are five accountability themes which align to the national themes set out in the NHS Oversight Framework.

Theme	Aim
Quality of care, access, and outcomes	To continuously improve care quality, helping to create the safest, highest quality health and care service

Finance and use of resources	For the Trust to balance its finances and improve its productivity
Preventing ill-health and reducing inequalities	To support prevention programmes to help people to stay healthy and support more accurate assessment of health inequalities and unmet needs of the local population
People	To be a responsive and flexible employer and address current workforce pressures
Leadership and capability	To build leadership and improvement capability to deliver sustainable services
Local Strategic priorities	The Trust is part of the ICB and the planning process. The ICB strategy is being refreshed in line with the national timelines.

4. NHS England Monitoring

4.1. NHS England use information to identify where providers are triggering a potential concern in one or more of the five themes (which indicates they are not in segment 1 and may benefit from support) and judgement, based on consistent principles, to determine whether or not they are in breach of licence and, if so, whether the issues are serious or very serious/complex.

4.2. To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support, all ICBs and Trusts are allocated to one of four segments:

Segment	Description of support needs
1. Maximum autonomy (consistently performing across the 5 oversight themes)	No actual support needs identified across the 5 themes Systems empowered to direct improvement resources
2. Targeted support	Support needed to address specific identified issues
3. Mandated support	Significant support needs against one or more oversight themes
4. Special measures/Mandated intensive Support	Intensive support required to address very serious/complex issues manifesting as critical quality and/or financial concerns

5. Governance

5.1. Integrated Governance is how the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to support the delivery of our vision to "provide an outstanding experience for our patients, their families and the people who work for and with us" by an organisation that is well managed, cost effective and has a skilled and motivated workforce.

5.2. Salisbury NHS Foundation Trust is committed to operating by the principles of good governance. This framework sets out to describe the system of integrated governance used within the Trust with reference to the provision of quality services.

6. Strategic Priorities

6.1. The Trust's strategic priorities are set out in its 2022-26 strategy. Underpinning delivery of these objectives, there is a business planning process. The strategic aims are:

6.2. In 2022, the Trust launched the Improving Together Programme, which is one of the four strategic priorities that underpin the delivery of the updated Trust Strategy. These priorities, supported by annual breakthrough objectives, will be focusing and guiding how we work within our hospital and as part of an Integrated Care System (ICS).

7. Scope of the Framework for Integrated Governance

7.1. Corporate Governance

7.1.1. The term is used in the NHS to mean the system by which an organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet the necessary standards of accountability, probity and openness. Corporate governance, led by the Trust Board, is about achieving objectives, providing quality services and delivering value for money.

7.1.2. The Constitution sets out the workings of the Foundation Trust – the membership, Council and Board. Appendices to the Constitution include formal procedures for the conduct of meetings and membership elections.

7.1.3. As a Foundation Trust, the organisation is asked to certify annually that it is compliant with the NHS Provider license conditions. The Trust completes an annual self-certification that confirms eligibility to hold an NHS Provider licence and submits this to NHS Improvement/England.

7.2. ***Financial Governance***

7.2.1. Financial governance will be the responsibility of the Board supported by the Audit Committee, (governance, risk management and internal control, internal audit; external audit, other assurance functions, counter fraud, financial reporting and raising concerns) and the Finance & Performance Committee (financial strategy and policies, effective and efficient use of resources, appraise annual budgets, cost improvement plans, financial issue management, performance reporting and management).

7.3. ***Standing Orders and Standing Financial Instructions***

7.3.1. The Trust Standing Orders and Standing Financial Instructions provide the regulatory framework for the financial conduct of the Trust. This includes guidance on delegation limits and procurement rules.

7.4. ***Clinical Governance***

7.4.1. This is a responsibility of the Trust Board, supported by the Clinical Governance Committee for continuously improving the quality of the services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

7.4.2. Clinical governance is the mechanism for understanding and learning, to promote the components that facilitate the delivery of quality care: candour, learning, questioning, a just culture, and excellent leadership for clinicians and services directly involved with patient care.

7.5. ***Demonstrating Quality***

7.5.1. The Integrated Governance Framework will provide evidence to the Trust Board through demonstrating its compliance with the quality and safety standards relevant to an NHS provider organisation. This will include Quality Accounts, Data Security and Protection Toolkit, CQC standards and the Trust's performance monitoring framework.

7.6. ***Continuous Quality Improvement***

7.6.1. Trust Board are responsible for ensuring that a continuous quality improvement approach is adopted and embedded throughout the organisation. This should be evidenced at all levels across the organisation. This approach should be evident

at Trust Board and all Board Committees and at Executive Committees.

7.6.2. The Improving Together Programme is focused on continuous improvement and is supported by the development of a coaching culture. This programme will support staff in undertaking tasks that really add value and empower them to make process changes at a local level. The approach is intended to ensure that everyone has the time, space, and responsibility to be curious about processes, consider how priorities can be achieved and have freedom to test new ways of working. As part of this programme all Trust colleagues will be invited to a modular training programme, which will be rolled out in a phased approach.

7.7. **Risk Management Strategy & Board Assurance Framework**

7.7.1. The Risk Management Strategy and Board Assurance Framework enable the Trust to manage risk at all levels in the organisation.

7.7.2. The key objectives of the risk framework are to:

- Ensure that the Board Assurance Framework is a dynamic Board assurance tool, underpinned by the Corporate and Divisional Risk Registers
- Clearly evidence the control and management of risk to achieve the Trust's strategic aims and objectives.
- Provide assurance that the Trust has an appropriate Assurance Framework in place and adheres to guidance on the Annual Governance Statement.
- Ensure that principal risks to meeting corporate objectives are identified and mitigated to an acceptable level.

7.7.3. The Board will be responsible for the Board Assurance framework, but the Audit Committee will undertake scrutiny and review of the process, to provide assurance to the Board, supported by the three assuring committees: Clinical Governance Committee, Finance & Performance Committee, People and Culture Committee together with the Trust Management Committee.

7.7.4. The Board Assurance Framework is reported to the Trust Board quarterly with a detailed review undertaken in advance by the assurance committees.

8. **The Role of the Trust Board**

8.1. Comprising executive and non-executive directors, the Trust Board will work actively to promote and demonstrate the values and behaviours which underpin integrated governance.

8.2. It will ensure a balanced focus on all aspects of its business. Further to this:

- The Integrated Governance Framework ensures the Board and its committees are structured effectively and properly constituted.
- The Board will ensure it promotes a culture where patients are at the centre; staff learn from experience; and the Trust engages with patients, the public

and partners to develop services in the future.

- Board business cycles will be clearly set out with actions implemented.
- The Board will ensure codes of conduct are upheld and the public service values of accountability, probity and openness in the conduct of business are maintained.
- Board members will receive appropriate induction and ongoing training and development to ensure they can undertake their responsibilities effectively and appropriately.

9. Charitable Trustees

9.1. The Trust Board is the corporate trustee of the Salisbury District Hospital Charitable Fund, known as the STARS appeal. Members of the Board meet quarterly as the Charitable Funds Committee to oversee the work of the charity, decide how charitable money should be used to support the hospital, manage its investments and the reporting requirements to the Charity Commission. The Terms of Reference can be found in Appendix 3.

10. Annual Governance Statement

10.1. The Annual Governance Statement (AGS) is produced and signed off by the Accounting Officer having regard to the model template and following discussion at the Audit Committee and comment from the auditors on the effectiveness of the Trust's internal controls. This is supported by the Board Assurance Framework and the underpinning Trust risk management arrangements.

10.2. Any significant weaknesses identified in the Trust's internal control mechanisms are highlighted in the AGS, together with the actions necessary to address the issues reported on.

11. Internal performance Framework

11.1. The internal governance framework has two main overarching aims and is the underpinning structure to enable:

- Supporting continuous improvement to deliver the Trust's Vision.
- The Trust to show accountability for its performance from Board all the way through to clinical specialities/wards (quality/finance/performance and workforce).

11.2. The measurement of performance is directly linked to achieving the Trust strategy (2022-26), to ensure we plan and embed new ways of working alongside achieving tangible progress for our ambitions and aims.

The main strands of performance reporting within SFT are:

Information flow

- Integrated performance reports
- Vision, breakthrough, driver and watch metrics,
- Performance dashboards
- Divisional reporting pack
- Specialty scorecards
- Risk register/corporate risk register/BAF

Accountability

- Trust Board meetings
- Board subcommittee meetings
- Executive led performance review meetings (EPR)
- Divisional management/ governance
- Specialty review meetings

12. **Board of Directors**

The Board of Directors has overall responsibility for the implementation of the Integrated Governance Framework. The Board is required to ensure that the Trust remains at all times compliant with Monitor's Provider License and has regard to the NHS Constitution.

12.1. Accountability

Level 1: SFT Trust Board		
Committee	**Membership**	**Principal Reporting Documents**
Trust Board	All directors	Corporate Strategy. Other principal strategies – e.g. People, Quality, I.T, & Estates. Budget & Capital Programme Annual reports on Health & safety, Information Governance, Risk Management. Performance Reports – quality, workforce, operations, finance. Board Committee supporting information. Customer Care and Legal Reports.
Board Committees	Non-Executive Directors, CEO Lead Executives	Presentation on key performance information, including detailed information and actions on any key business targets currently being failed. Scrutiny of the Trust's commercial holdings. Scrutiny and assurance regarding risks and adequacy of actions. Escalation actions from Divisional Performance Reviews (by exception).

12.2. Information

12.2.1. The Trust's Integrated Performance Report (IPR), using a balanced scorecard approach, provides a summary of the core critical indicators for SFT. The reporting focuses on the key metrics aligned to the areas prioritised for improvement in year (breakthrough objectives and Driver metrics), monitoring progress of improvement. The report also contains "Watch" metrics, those metrics aligned to the statutory and contractual reporting requirements to ensure Board oversight and focus.

12.2.2. The IPR is issued to the Board of Directors monthly, highlighting key areas of success or concern and actions being taken to address the issues. Performance is also visually displayed in the form of tables and charts which show historic performance and trends via the use of SPC.

12.3. Committees of the Board

12.3.1. There are several board assurance committees. An outline of each committee responsibilities and core functions are set out in Appendix 1 and the overall Trust Committee Assurance Map in Appendix 2.

- Audit Committee
- Clinical Governance Committee
- Finance & Performance Committee
- People and Culture Committee
- Renumeration and Nomination committee

12.3.2. The individual Board Committees received the IPR and BAF relevant to the committee topic alongside a programme of more regular deep dives with additional information for assurance.

12.3.3. All committee terms of reference can be found in appendix 3.

12.3.4. Each committee will undertake an annual review of their performance against the terms of reference. The template can be found in Appendix 4.

13. Divisional Reporting

13.1. Accountability

13.1.1. The Divisional Performance Reporting process is focused on monitoring operational performance, finance, quality, and workforce metrics aligned to the Trust breakthrough objectives.

13.1.2. The objective of the Divisional Performance Reviews is to review the performance of each Division in relation to an agreed suite of key metrics, ensuring both compliance and continual improvement. The reviews will also provide a forum for Divisions to discuss issues and challenges facing services with Executive Directors

and agree solutions in partnership as well as an opportunity to share and celebrate success and good practice.

13.1.3. There will be a clear and consistent schedule of Divisional Performance Reviews agreed at the start of each new financial year.

Level 2: Review of Divisional Management		
Committee	**Membership**	**Principal Reporting Documents**
Executive Performance Review Meetings	Lead Executives Divisional Management Team HR and Finance Business Partners	Detailed performance dashboard for Division Division commentary Risk Registers Other issues by exception

14. ***Information***

The key information follows a similar format to the Board report, it contains performance, workforce, finance, and quality improvement targets disaggregated to Divisional level. The reporting packs focus on the breakthrough and driver metrics aligning the delivery of the Trust strategy with key in year improvement targets. The purpose is to provide an insight into the contribution of individual divisions to performance of the business-critical indicators, as well as furnishing the divisions with performance data more specific to their area of activity through watch metrics.

15. **Divisional Management**

15.1. ***Accountability***

The Divisional management teams have Divisional Management committees with a wider group of staff (finance, business intelligence and Workforce Business partners) to ensure oversight of all the specialities the Division covers. There are two key monthly meetings to ensure robust governance is in place, the Divisional management Team meeting, and the Divisional clinical governance meeting. Key risks are taken from the specialty reporting and discussed in both forums to mitigate risk to delivery/performance or quality impacts.

15.2. ***Information***

The Divisions have access to Power BI with a range of dashboards to support quality/performance/finance and workforce metrics (specialty/divisional/specific resource metrics e.g., Theatres/outpatients). These are used to underpin performance at specialty level.

Committee	**Membership**	**Principal Reporting Documents**
Divisional Management Committees	Divisional Management Committee,	Divisional performance dashboard Individual dashboards, locally held performance information, and divisional risk register.

	HR and Finance Business Partners	
Divisional Governance Committees		Team/specialty goals and measures Improvement as set out in the Trust's Quality/performance/finance and workforce objectives

15.3. ***Specialty Reporting***

Level 4: Specialty / Service Line		
Committee	**Membership**	**Principal Reporting Documents**
Specialty and department review process	Divisional Management Committee, HR and Finance Business Partners, Specialty Director, Service Lead and Senior Sister	Specialty-level performance dashboard Individual dashboards, locally held performance information, Risk assessment and mitigation

15.4. **Escalation**

There are a range of scenario's where additional support may be required in response to performance not matching expected levels or particular issues that require greater oversight. These could range from non-delivery of key quality, performance, and finance metrics at Divisional level, to team or individual workforce issues which require greater focus and support. There are a range of interventions that may be deployed at any one time to address remedial issues, these include:

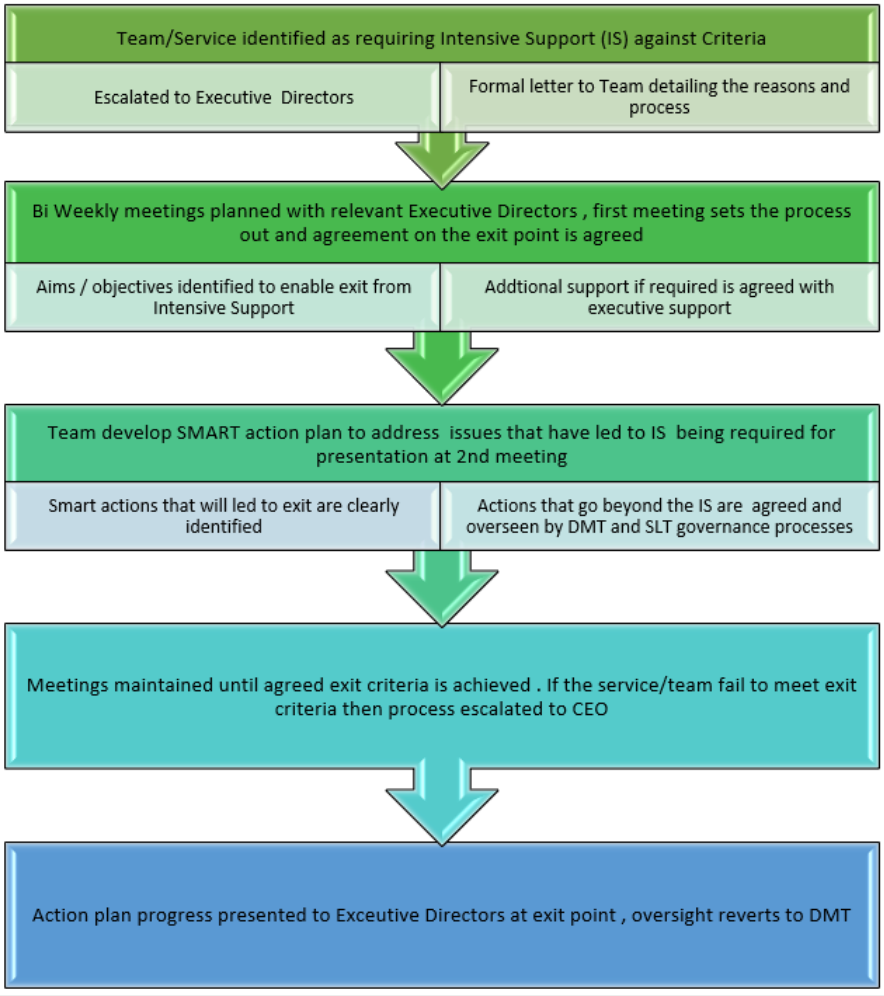
Stage	Intervention
Enhanced diagnostic	• Ensure root cause analysis addressed • Remedial action plans in place • Utilisation of improving together tools (Go See, Improvement Huddles, A3 thinking)
Enhanced Oversight	• Increased reporting • Consideration of external/peer review • Comprehensive action plans with clear metrics for improvement.
Intensive Support	• Bespoke mandated support • Executive oversight •
	• Meeting with CEO regularly • Capacity and Capability review

Stage	Intervention
CEO escalation	• Identification of any longer term structural and strategic issues which must be addressed.

15.4.1. The decision to escalate a division may be made on the basis of significant underperformance against multiple metrics; however, it may also be as a result of just one core area of underperformance which presents a significant risk to the overall delivery of the Trust's plan. The decision to escalate will be taken by the Trust's Executive Directors at the Executive Performance Review meetings

15.5. **Intensive Support**

Intensive Support is a process that can be implemented for one or more reasons where there is concern or indication that care within a ward/department may have fallen below acceptable standards. These may include a cluster of incidents e.g., pressure ulcers, falls, SIIs. HCAIs, failure to submit/pass infection prevention audits, increased volume/severity of complaints, increased staff sickness/vacancy levels.



15.5.1. The focus of the meetings is to ensure actions are being taken promptly, required improvements are being made and that the actions prioritise the key areas of concern. The meetings will also enable the Executives to identify and action any additional support or help required, to ensure standards can be improved and sustained. At any stage of escalation, all parties will agree the criteria that must be met for the Division to exit any mandated support. Specific arrangements will need to be agreed in each situation to ensure appropriate governance and oversight.

16. **Corporate Departments**

This will be reviewed once content of EPR agreed.

Additional information to support the Governance process is provided in the attached appendices.

17. **Public Accountability**

17.1. **Council of Governors**

The Council of Governors comprises Public, Staff and Appointed governors and has a number of responsibilities to hold the Trust Board to account through the Non-Executive Directors, to appoint and remunerate the non-Executives, to appoint the Trust's auditor (in conjunction with the Audit Committee). It has an essential role in representing the views of the Foundation Trust membership to the Trust Board.

18. Collaborative Working and Partnerships

The Trust is part of the Bath & Northeast Somerset, Swindon, and Wiltshire Integrated Care System (BSW ICS). This allows partners to take collective responsibility for the health and wellbeing of the population across the region. The agencies that comprise the partnership are working to address five priorities:

- Create locality-based integrated teams supporting primary care
- Shift the focus of care from treatment to prevention and proactive care
- We will develop an efficient infrastructure to support new care models
- Establish a flexible and collaborative approach to workforce
- Enable better collaboration between acute providers

18.1. Statutory component parts of an ICS are an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). The ICB is a statutory NHS body that bring partner organisations together in a new collaborative way with common purpose; and will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place. The Trust Board receives a monthly update on system working through the Chief executive report, outlining the activities at system level in BSW and the impact and involvement of the Trust.

18.2. As part of the move towards more collaborative working the Trust is also part of the Acute Hospital Alliance (AHA) with Great Western Hospital and Royal United Hospitals (RUH) Bath NHS Foundation Trusts. The AHA is focused on improving clinical services and closing the gaps in relation to health and care inequalities and finance to benefit the population of BSW. The local place-based Wiltshire Integrated Care Alliance is also a clear focus for the executive team and clinical leaders.

Version control

Document Title	**Integrated Governance and Accountability Framework 2022/23**			
Date Issued/Approved:	TBC 4th May 2023			
Date Valid From:	May 2023			
Date Valid To:	April 2024			
Division / Department responsible (author/owner):	Chief Operating Officer			
Executive Director responsible for Policy:	Chief Operating Officer			
Date revised:	March 2023			
Approval route (names of committees)/consultation:	Chief Operating Officer in consultation with Trust Board			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	x	Intranet Only	
Related Documents	Listed Appendices			

Version Control Table

Date	Version No.	Summary of Changes	Changes made by (name and job title)
18/03/22	**V1**	**Draft document – joint Integrated Governance and Accountability Framework**	**Lisa Thomas, Chief Operating Officer** **Fiona McNeight, Director of Integrated Governance** **Kylie Nye, Head of Corporate Governance**

Appendix 1: Board Committees

BOARD COMMITTEES

The Board's purpose is to govern effectively and in doing so build patient, public and stakeholder confidence that sustained, quality services are delivered. Several meetings and processes support the Board in its role.

Level 1: Assurance Committees of the Board

Audit Committee

The Audit Committee's terms of reference detail its role in providing assurance by independently and objectively monitoring and reviewing the Trust's processes of integrated governance, risk management, assurance, and internal control and, where appropriate, to require the Executive to instigate actions necessary to mitigate gaps.

The Committee fulfils its governance and accounting responsibilities by consideration of the integrity, completeness and clarity of annual accounts and the risks and controls around its management.

The Committee adopts a risk-based approach, but this does not, however, preclude the Committee from investigating, any specific matter relevant to their purpose.

Principal functions:

To oversee the governance and management of risk and internal control including the provision of the following:

- Governance
- Risk Management
- Internal Audit
- External Audit
- Other Assurance Functions
- Counter Fraud
- Financial Reporting
- Raising Concerns

Clinical Governance Committee

The Clinical Governance Committee's terms of reference detail its responsibility in delivering clinical governance and the quality agenda i.e. patient safety, clinical effectiveness and patient experience.

The Committee reviews the Quality Account and agrees priorities for the forthcoming year and monitoring of the current year.

The Committee provides assurance to the Board, through ensuring the supporting processes

are embedded and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties.

Principal functions:

To provide assurance to the Board on:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Service Improvement and Change Management
- Continuous Quality Improvement

Finance & Performance Committee

The Finance & Performance Committee provides assurance to the Board that the finance and performance of the Trust is meeting its targets and proposes mitigating strategies as required. It will do this through continual review of financial, risk and performance issues. The Committee has delegated powers to scrutinise, on behalf of the Board, all high-level operational matters and finance related matters, providing assurance regarding reported results and compliance with NHS Improvement requirements.

Principal functions:
To provide assurance on and scrutinise high level operational and finance related matters, providing assurance to the Board regarding reported results and compliance with NHSI requirements and in particular:

- Financial strategy, policy, management, and reporting
- Management and reporting Performance
- Monitoring Cost Improvement Programmes
- Operational performance

People and Culture Committee

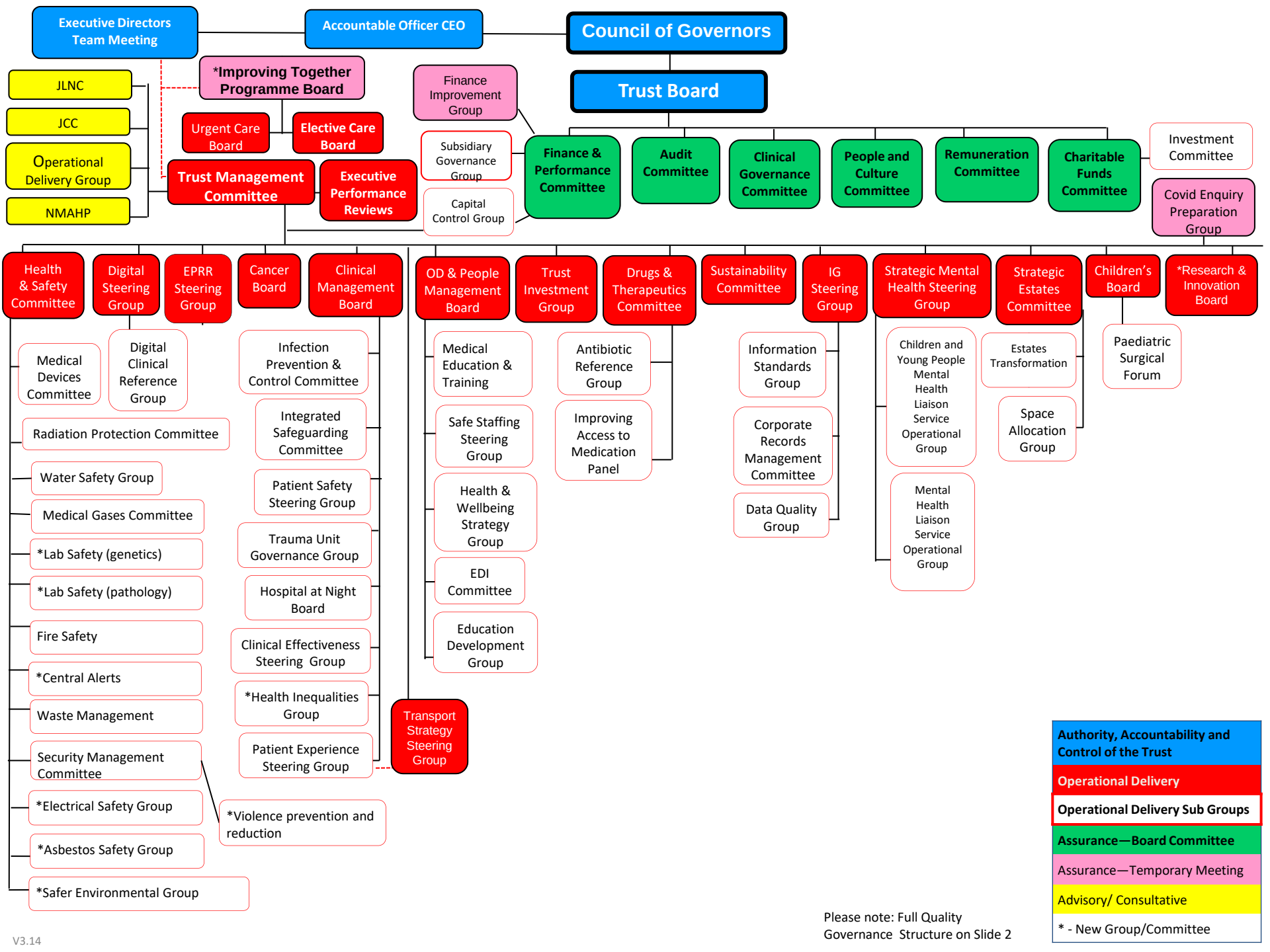
The People and Culture Committee has responsibility for the delivery and assurance of the People Strategy. In addition, it has responsibility for:

- ensuring the mechanisms are in place to support the development of compassionate and inclusive leadership capacity and capability within the Trust
- the development and design of the workforce, to ensure that the Trust has productive staff, with the skills, competencies, and information to meet the required contractual obligations
- the mechanisms of improving how the Trust engages with its workforce so that they are motivated to do the best they can for the organisation and for the communities the Trust serves.
- That Organisational Development and Change Management are deployed well to maximise the opportunities of improvement and shape the Trust culture
- Continuous Quality Improvement methodology is readily made available, the skills reinforced and this way of working actively promoted

Principal functions:

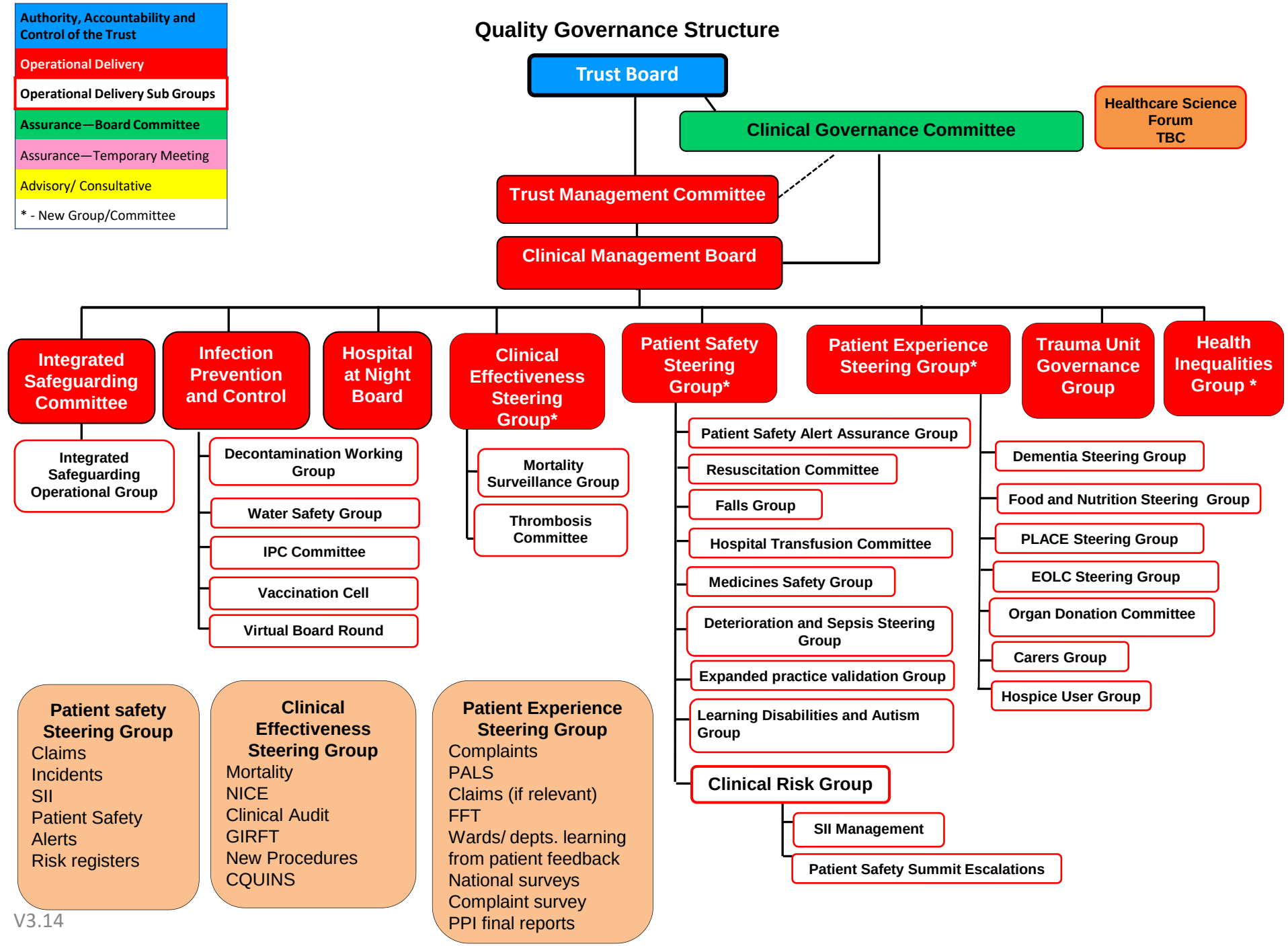
To provide assurance on:

- Workforce Effectiveness Programme
- HR Strategy
- Scrutiny of Workforce Performance
- Organisational Development
- Policies and Procedures
- Key workforce KPIs
- Compliance with employment legislation
- Educational and professional development
- Recruitment and retention
- Staff engagement
- Change Management
- Occupational therapy and counselling services
- Service Improvement and Change Management



Please note: Full Quality Governance Structure on Slide 2

V3.14


Authority, Accountability and Control of the Trust
Operational Delivery
Operational Delivery Sub Groups
Assurance—Board Committee
Assurance—Temporary Meeting
Advisory/ Consultative
* - New Group/Committee
Quality Governance Structure
Trust Board
Clinical Governance Committee
Healthcare Science Forum TBC
Trust Management Committee
Clinical Management Board
Integrated Safeguarding Committee
Integrated Safeguarding Operational Group
Infection Prevention and Control
Decontamination Working Group
Water Safety Group
IPC Committee
Vaccination Cell
Virtual Board Round
Hospital at Night Board
Clinical Effectiveness Steering Group*
Mortality Surveillance Group
Thrombosis Committee
Patient Safety Steering Group*
Patient Safety Alert Assurance Group
Resuscitation Committee
Falls Group
Hospital Transfusion Committee
Medicines Safety Group
Deterioration and Sepsis Steering Group
Expanded practice validation Group
Learning Disabilities and Autism Group
Clinical Risk Group
SII Management
Patient Safety Summit Escalations
Patient Experience Steering Group*
Dementia Steering Group
Food and Nutrition Steering Group
PLACE Steering Group
EOLC Steering Group
Organ Donation Committee
Carers Group
Hospice User Group
Trauma Unit Governance Group
Health Inequalities Group *
Patient safety Steering Group
Claims
Incidents
SII
Patient Safety Alerts
Risk registers
Clinical Effectiveness Steering Group
Mortality
NICE
Clinical Audit
GIRFT
New Procedures
CQUINS
Patient Experience Steering Group
Complaints
PALS
Claims (if relevant)
FFT
Wards/ depts. learning from patient feedback
National surveys
Complaint survey
PPI final reports
V3.14

Charitable Funds Committee Terms of Reference

The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), operating under the working name of Stars Appeal, and is responsible for the management of funds it holds on trust.

In line with the registration to the charity commission the Board of Directors of Salisbury NHS Foundation Trust collective is the Corporate Trustee. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately.

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
August 2018	1	Approved version	Approved by the Trust Board of Directors	
March 2019	2	Minor	Added role of secretary to the Committee	Director of Corporate Governance
December 2020	2.1	Minor	Membership and Administration	Investment Planning and Policy Manager
March 2022	2.2	Minor	Review of TOR addition of Head of PALS to attend.	Executive Services Manager

Date Adopted	1st January 2021/ Approved at Board 7th April 2021 tbc
Review Frequency	Annual
Terms of Reference Drafting	Investment Planning and Policy Manager
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1. Purpose

The Committee is established to provide the Board of Directors with assurance on the appropriate management and use of charitable funds it holds on trust.

2. The committee is established to:

2.1. Ensuring the stewardship and effective management of funds which have been donated, bequeathed and given to Salisbury District Hospital Charitable Fund for charitable fund purposes.

2.2. Determining an investment strategy and arrangements for the investment of funds which are no immediately required for use.

2.3. Coordinating the provision of assurance to the Board of Directors, acting as trustee of the funds, that the funds are accounted for, deployed and invested in line with legal and statutory requirements.

2.4. Considering and approving the annual accounts for charitable funds for submission to the Board of Directors, acting as trustee of the funds.

3. Authority

3.1. The Board of Directors, acting as the Trustee for the Salisbury Hospital Charitable Fund Charity, hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds Committee (the Committee). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3.2. The Committee is a standing committee of the Board of Directors (the Board).

3.3. The Committee is authorised to:

- Perform any of the activities within its terms of reference;
- To approve or ratify as appropriate those policies and procedures for which it has responsibility (including SFI and SO's).
- Obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- Consider and make recommendations to the Board of Directors any and all items of which they should be aware to fulfil their responsibility as corporate trustee.
- Approve use of charitable funds in line with the SFI's.

4. Membership and Attendance

Membership

4.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Non-Executive Directors
- Executive Directors, of which one is the Chief Finance Officer (lead Executive)

4.2. A Non-Executive Director shall be appointed as Chair of the Committee. In the absence of the Chair, a Non-Executive Committee member will perform this role

4.3. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

4.4. Three voting members of the Board of Directors (at least one Executive Director and one Non-Executive Director). A nominated Deputy for the Chief Finance Officer must be in attendance if the Chief Finance Officer is absent.

Attendance (non-voting members)

4.5. Meetings of the Committee shall be attended by:

- Senior Responsible Officer for the Charity
- Financial Controller or Financial Accountant
- Director of Integrated Governance
- Representative from the Fundraising Team
- Staff representation – in the form of representatives from the Charity Ambassador board
- Community representation – in the form of the Chairman for the Fundraising Committee which is external to the Trust
- Head of Patient Advice and Liaison Service (PALS) Department

Attendance by Other Trustees

4.6. Any member of the Board of Directors (Trustee) can attend.

4.7. Note: All Board of Directors will be sent copies of the agenda for each meeting and may attend the meeting should they wish to do so.

5. Roles and Responsibilities

5.1. The duties of the Committee can be categorised as follows:

Assurance

5.2. Manage the affairs of the Salisbury District Hospital Charitable Fund within the terms of its declaration of trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations.

5.3. Scrutinise requests for the use of charitable funds to ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.

5.4. Review the Charitable Funds annual accounts and comment/ recommend approval to the Trustee as appropriate.

5.5. Ensure that the NHS Foundation Trust's Constitution, Standing Financial Instructions and the Scheme of Reservation and Delegation are appropriately interpreted for charitable funds.

5.6. Receive and discuss all audit reports on charitable funds and recommend action to the Trustee.

Investments

5.7. Recommend an investment advisor to the Trustees following appropriate tendering procedures and regularly monitor and review their performance.

5.8. Ensure that the investment policy for Charitable Funds set by the Trustees is implemented and that sufficient funds are kept readily available to meet planned requirements.

5.9. Review the performance of investments on a regular basis with the external investment advisors to ensure the optimum return from surplus funds.

Fundraising

5.10. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commissioner guidance and legislation.

5.11. Ensure the sources of income and the terms on which donations are received are acceptable to the Trustee.

5.12. Ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law.

5.13. Ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments

5.14. Ensure effective communication regarding whistle blowing relating to fundraising, donations or subsequent use of funds.

6. Conduct of Business

Administration

6.1. The Chief Finance Officer is a member of the committee and has corporate responsibility for:

6.2. Liaising with the chair on all aspects of the work of the committee, including providing advice.

6.3. Ensuring the committee acts in accordance with standing orders and scheme of reservation and delegation.

6.4. The Executive Services Manager will act as the role of secretary to the Committee.

Frequency

6.5. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

6.6. Meetings will be held no less than four times per year, with additional meetings where necessary.

Notice of meetings

6.7. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than three working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

6.8. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

6.9. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

6.10. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

6.11. The Committee will report annually to the Board of Directors on the performance of its duties as reflected within its Terms of Reference.

6.12. Any items of specific concern or which require the Board of Directors approval will be subject to a separate report.

7. Review

7.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

7.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

NHS
Salisbury
NHS Foundation Trust

Remuneration, Nominations and Appointments Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
September 2019	1	New ToR		Director of Corporate Governance
November 2020	1.1	Minor	Updates to membership and attendance sections and minor formatting	Director of Corporate Governance
March 2022	1.2	Minor		Head of Corporate Governance

Date Adopted	7th April
Review Frequency	Annual
Terms of Reference Drafting	Head of Corporate Governance
Review and Approval	Approved 7th April 2022
Adoption and ratification	Trust Board

1. Purpose

1.1. To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

2. Authority

2.1. The Remuneration, Nominations and Appointments Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

2.2. The committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the committee.

2.3. The committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Membership and Attendance

Membership

3.1. The membership of the Committee shall consist of:

- The Trust Chair
- The other Non-Executive Directors
- When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act). When appointing or removing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act (that is, the Chairman, Chief Executive and the Non-Executive Directors).

3.2. The Trust Chair shall chair the Committee.

Attendance

3.3. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair. At the invitation of the Committee, meetings shall normally be attended by the Director of OD and People.

3.4. Any non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Quorum

3.5. The quorum necessary for the transaction of business shall be the Chair of the Committee and three other Non-Executive Directors

Secretary

3.6. The Director of Corporate Governance shall be secretary to the Committee.

4. Duties

4.1. Appointments

The Committee will:

4.1.1. Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Nomination Committee of the Council of Governors, as applicable, with regard to any changes. The Constitution sets out the requirements of the Board composition.

4.1.2. Consider and make plans for succession planning for the Chief Executive and other Executive Directors considering the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

4.1.3. Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.1.4. Be responsible for identifying and appointing Executive Director candidates to fill posts within its remit as and when they arise.

4.1.5. When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the appointment. In identifying suitable candidates, the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.1.6. Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

4.1.7. Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.1.8. Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

4.2 Remuneration

The Committee will:

4.2.1. Establish and keep under review a remuneration policy in respect of Executive Board Directors.

4.2.2. Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

4.2.3. In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's Executive Directors, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses;
- Compensation payments.

4.2.4. In adhering to all relevant laws, regulations and trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

4.2.5. Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify them.

4.2.6. Be sensitive to pay and employment conditions elsewhere in the Trust.

4.2.7. Monitor and assess the output of the evaluation of the performance of individual Executive Directors and consider this output when reviewing changes to remuneration levels.

4.2.8. Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

5. Conduct of Business

Administration

5.1 The Director of Corporate Governance shall be Secretary to the Committee.

Frequency

5.2 The Committee will be held bi-annually and at such other times as the Chair of the Committee shall require.

Notice of meetings

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting,

Reporting

5.4 Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

6 Review

6.1 These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

People and Culture Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
May 2020	3		Annual Revision	Corporate Governance Manager
March 2021	3.1	Minor	Annual Revision	Corporate Governance Manager
January 2022	3.2	Minor	Annual Revision	PA to Chief People Officer
Jan 2023	3.3	Minor	Annual Revision	Head of Corporate Governance
Apr 23	3.4	Minor	Annual Revision agreed at P&CC	Deputy Chief People Officer

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Head of Corporate Governance
Review and Approval	People and Culture Committee
Adoption and ratification	Trust Board

1. Purpose and Function

1.1 The purpose of the Committee is to ensure that the Trust has a workforce strategy in place that recognises the importance of all the people who work within the Trust, and that will enable it to recruit and retain enough people with the necessary skills, training, and motivation to deliver its clinical and other objectives. Specifically:

- That the Trust has a clear understanding of its strategic workforce needs and plans are in place to deliver these.
- That the Trust has a comprehensive long-term people plan with supporting specialist strategies and an ability to regularly review the positive impact on our people services
- That the Board receive assurance that all legislative and regulatory requirements relating to the workforce are met.
- That workforce risks are understood by the Board and that appropriate mitigating actions have been identified and are being implemented.

1.2 To achieve this, the Committee shall:

- Support the development and monitoring of a workforce strategy, particularly our progress against our vision metrics (Increasing staff engagement; Reducing turnover and increasing retention; and Being a Fair and Equitable Employer).
- Champion workforce issues through the inclusion and promotion of the non-Executive independent roles such as the Freedom to Speak up Champion and Wellbeing Guardian ensuring adequate oversight of all workforce areas by the Board.

1.3 The Committee shall discharge this function on behalf of the Board of Directors by:

- Monitoring key workforce metrics to ensure that the expected standards are being delivered particularly against our key people indicators.
- Receiving reports to not only provide assurance around compliance with legislation and regulations but to demonstrate our commitment and progress as a leading employer in the community.
- Considering and challenging workforce plans and improvement plans on behalf of the Board to continue to improve our people practises across an increasingly diverse and professional workforce.

2. Authority

2.1 The Board of Directors hereby resolves to establish a Committee of the Board to be known as the People and Culture Committee (the Committee).

2.2 The Committee is a standing committee of the Board of Directors (the Board).

2.3 The Committee is a Non-Executive Committee and has no Executive powers.

3. Membership and Attendance

Membership

3.1 The Committee shall be appointed by the Board of Directors and shall consist of:

- Three Non-Executive Directors
- Chief People Officer (Lead Executive)

- Chief Medical Officer
- Chief Nursing Officer

3.2 A Non-Executive Director shall be appointed as Chair of the Committee.

3.3 The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the Chair.

3.4 Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5 Quorum shall be at least half the members being present, including at least two Non-Executive Director members or nominated deputy.

3.6 Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7 Meetings of the Committee shall normally be attended by the members listed in item 3.1 and others by invitation. This list is not exhaustive but regular attendees include:

- Chair.
- Chief Executive Officer.
- Deputy Chief People Officer.
- Associate Director Communications Engagement and Community Relations.
- Guardian of Safe working.
- Freedom to Speak Up Guardian.

3.8 The Director of Integrated Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

3.9 Executive and Non-Executive Directors can attend any Board Committee to exercise their functions.

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1 Oversee progress on the development and delivery of workforce, Organisational Development and cultural change strategies, taking into account relevant best practice and ensuring alignment with the Trust's strategic priorities and objectives.

4.2 Review and provide assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance. The detail of this review will be upwardly reported to the Board to provide oversight.

4.3 Oversight of the delivery of the HR operating plan and associated policy management.

4.4 Maintaining oversight of the business of the Organisational Development and People Management Board and associated sub-structure. Escalation reports will come to the People and Culture Committee summarising the themes and providing assurance on operational decisions affecting workforce performance, organisational change and the implementation of initiatives.

4.5 Oversight of the development and delivery of the People Strategy and the people aspect of the Clinical Strategy.

4.6 Monitor effectiveness of compliance with local and National staff surveys and the implementation of action plans to deliver against identified areas of concern.

4.7 Receipt and review of the Workforce Report prior to submission to Trust Board as part of the Integrated Performance Report. This includes a review of the Trust's workforce performance indicators to provide assurance that mitigating actions are in place where appropriate.

4.8 Oversee the implementation of Internal Audit recommendations as directed by the Audit Committee.

4.9 To receive and review quarterly and annual reports of the Guardian of Safe Working on the Board's behalf with a particular focus on the indications of a healthy speak up culture and the encouragement of sharing learnings.

4.10 To receive and review Safe Staffing reports to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the needs of patients and service users.

4.11 Maintaining oversight of the Trust's employment related equality, diversity and inclusion agenda. Champion the Trusts position as an equitable employer encouraging and maintaining progress against both our strategic commitment and public sector duties.

5. Conduct of Business

Administration

5.1 The EA to the Chief People Officer shall be Secretary to the Committee.

5.2 The Committee shall be supported administratively by the EA to the Chief People Officer whose duties in this respect will include:

- Agreement of agendas with Chair and attendees and collation of papers.
- Taking the minutes.
- Keeping a record of actions, matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues/areas.
- Provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

5.3 The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.4 Meetings will be held at least nine times per year, with additional meetings where necessary.

Notice of meetings

5.5 An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.6 In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.7 Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.8 The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board through use of the Board Escalation Report template. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.9 The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

5.10 The Committee will receive, for oversight and information, the escalation report of the following committees:

- Organisational Development and People Management Board.
- H and S quarterly report.
- Bi-annual Safe Staffing Report.

6. Review

6.1 These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2 As part of this assessment, the Committee shall consider whether it receives adequate and appropriate support in fulfilment of its role and whether its current workload is manageable.

6.3 These terms of reference were approved by the People and Culture Committee with amendments on and ratified by the Board of Directors on **{Insert date}.**

Audit Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
March 2020	2.1	Minor	Annual Revision	Director of Corporate Governance
March 2021	2.2	Nil changes	Annual Revision	Director of Corporate Governance
Dec 2021	2.3	Nil changes	Annual Revision	Director of Integrated Governance
Dec 2022	2.4	Minor change	Annual Revision – title change	Director of Integrated Governance

Date Adopted	TBC
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	Audit Committee
Adoption and ratification of changes	Board of Directors

1) Purpose and function

The purpose and function of the Committee is to:

1.1. Monitor the integrity of the financial statements of the Trust, any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them

1.2. Assist the Board of Directors with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management, and where appropriate, facilitate and support through its independence, the attainment of effective processes

1.3. Review the effectiveness of the Trust's internal audit and external audit function; and in discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards.

1.4. Report to the Board as to how it is discharging its responsibilities as a Committee

2) Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee.

2.2. The Committee is a standing committee of the Board of Directors (the Board).

2.3. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and any such employee will be directed to co-operate with any request made by the Committee.

2.4. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise. Should the projected cost of any such external advice exceed £50k, consent of the CEO and Director of Finance should be sought in advance of engagement.

2.5. A Non-Executive Committee of the Trust Board of Directors has no executive powers, other than those specifically delegated in these Terms of Reference

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of four Non-Executive Directors, with at least one of whom shall have recent and relevant financial experience.

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.

3.3. The Chairman of the Board of Directors shall not be a member of the Committee.

3.4. The Chair of the Committee shall not be the Senior Independent Director of the Board of Directors.

Quorum

3.5. The quorum necessary for the transaction of business shall be two members of the Committee

3.6. In the absence of the Chair of the Committee, the Secretary will invite one of the other Committee members to chair the meeting.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- The Chief Executive
- The Chief Finance Officer, or a nominated Deputy
- Representatives from the External (Appointed) Auditors, Internal Auditors and Counter Fraud advisors
- The Director of Integrated Governance, or nominated deputy, will act as Secretary to the Committee and will therefore attend all meetings
- Financial Controller
- Others by invitation – this may include executive sponsors in the case of audit reports
- Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1 Financial reporting

The Committee shall:

a) Ensure the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain
b) Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement, focusing in particular on:
    - Any changes in accounting policies and practices
    - Major judgmental areas
    - Value for Money considerations
    - Significant adjustments arising from the audit
    - The going concern basis
    - Compliance with accounting standards
    - Major risks to the Trust
c) Review the consistency of, and changes to, accounting policies both on a year-on-year basis and across the Trust.
d) Review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements)
e) Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of both the Trust Executive and the External Auditor
f) Review the clarity of disclosure in the Trust's financial reports and the context within which statements are made
g) The Committee Chair shall report formally to the Board on its proceedings after each meeting on all escalation matters
h) The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

4.2 Governance, Risk Management and Internal Control

The Committee shall:

a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives
b) Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit

statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board

c) Review the Trust's processes to establish and maintain an effective Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements
d) Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security as required by the NHS Counter Fraud Authority
e) Receive assurance from Internal Audit, External Audit, Directors and managers, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.3 Internal Audit and Counter Fraud

The Committee shall:

a) Ensure that there is an effective Internal Audit function that meets the aspirations of the Trust's Executive, *Government Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors
b) Consider and approve the Internal Audit Strategy and annual plan recommended by the Chief Finance Officer and ensure there are adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management or other restrictions
c) Review promptly all reports on the Trust from the Internal and External Auditors, review and monitor the Executive Management's responsiveness to the findings and recommendations of reports, and ensure coordination between Internal and External Auditors to assist the Executive to optimise use of audit resource
d) Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee
e) Conduct a review of the Executive's use of internal audit and counter fraud consultancy resources, including an assessment of the effectiveness of these services.

4.4 External Audit

The Committee shall:

a) In conjunction with the Chief Finance Officer, consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor
b) Work with the Chief Finance Officer and the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors
c) Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts
d) Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted
e) Review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work

f) Meet the external auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audit
g) Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, and the impact on the audit fee
h) Review all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

4.5 Other Board Assurance Functions

a) The Committee will initiate investigations or reviews of any matters within its scope of authority in response to any indicators or matters of concern arising at the Committee or raised elsewhere and referred to the Committee.
b) The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators and professional bodies with responsibility for the performance of staff or functions
c) The Committee shall review the work of other Committees within the organization, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Clinical Governance Committee and the Finance and Performance Committee. In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will satisfy itself on the assurance that can be gained from the clinical audit function.

5). Reporting and Accountability

a) The Committee Chair shall report formally to the Trust Board of Directors through the template escalation report, and make recommendations the Committee deems appropriate on any area within its remit where action or improvement is needed
b) The Committee shall report to the Trust Board annually on its work in support of the Annual Governance Statement and Accounts
c) The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement as it deems appropriate
d) The Chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances
e) Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee shall write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation
f) The Committee shall produce a statement to be included in the Trust's Annual Report which describes how the Committee has fulfilled its terms of reference and discharged its responsibilities throughout the previous year
g) The Committee shall review its own terms of reference annually.

6) Conduct of Business

Administration

a) The Director of Integrated Governance shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

b) The Committee shall be supported administratively by the Director of Integrated Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- minute the proceedings of all Committee meetings, and draft minutes of Committee meetings shall be made available promptly to all members of the Committee
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

Enabling the development and training of Committee members

c) The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

d) Meetings will be held at least quarterly, an additional meeting to review the draft annual report and accounts, with additional meetings where necessary.

Notice of meetings

e) An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

f) In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Approved on {insert date} at Trust Board

NHS
Salisbury
NHS Foundation Trust

Finance & Performance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
Nov 2019	3	Minor	Added delegated authority limits	Corporate Governance Manager
May 2020	4	Minor	Annual Review	Corporate Governance Manager
March 2021	4.1	Minor	Annual Review	Corporate Governance Manager
March 2022	4.2	Minor	Annual Review	Head of Corporate Governance
Feb 2023	4.3	Minor	Annual Review	Head of Corporate Governance

Date Adopted	
Review Frequency	**Annual**
Terms of Reference Drafting	**Director of Integrated Governance**
Review and Approval	**Finance & Performance Committee**
Adoption and ratification	**Trust Board**

1. Purpose

1.1. The Committee is established to provide the Board of Directors with assurance on the trust's financial and operational performance. The Committee also supports the Board's strategic direction and stewardship of the Trust's finances, investments, and sustainability.

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Finance & Performance Committee (the Committee).
2.2. The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
2.3. The Committee may take any legal or other professional advice with regard to the financial performance of the Trust as necessary.
2.4. The Committee is authorised by the Board to review, monitor, and where appropriate, investigate any financial matter within its terms of reference, and seek such information as it requires facilitating this activity.

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Three non-Executive Directors
- Chief Finance Officer (Lead executive)
- Chief Executive
- Chief Operating Officer
- Chief People Officer

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.
3.3. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.
3.4. Each member may nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members.
3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- Core members defined in para 3.1 above
- Deputy Chief Finance Officer Other directors and other staff by invitation
- Governor observer(s)

The Director of Integrated Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance. Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4. Roles and responsibilities

4.1. The aim of the Finance and Performance committee is to provide an objective view of the financial and operational performance, and financial strategy of the Trust, together with an understanding of the risks and assumptions within the Trust plans and projections.

4.2. The Committee will routinely consider four key reports in detail:

- The monthly performance reports
- The monthly finance report, (including forecast outturn report quarterly)
- The monthly contracting monitoring report
- The monthly cost savings report

4.3. The duties of the committee can be categorised as follows:

4.3.1. **Reporting**

- To oversee the ongoing development of the Integrated Performance Report.
- To seek assurance that the measures incorporated in the Board report meet the requirements of external stakeholders.
- To seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support operational management of the organisation.
- Monitor the effectiveness of the Trust's financial and operational performance reporting systems to provide assurance to the Board of continued compliance through its annual reporting, reporting by exception where required. Where the Committee cannot gain assurance of compliance, they must satisfy themselves of the reasons and impact of non- compliance, the actions necessary to achieve compliance the timescales to remedy the situation. The matter is then escalated to the Board.
- To review in detail via a deep dive any major performance variation, to obtain assurance on behalf of the Board as to the effectiveness of corrective actions and associated governance arrangements.
- To consider changes to the Trust reporting requirements under any new regulatory arrangements.

4.3.2. **Financial and Operational performance management**

- To undertake high-level, exception-based monitoring of the delivery of operational and financial performance to ensure that the Trust is operating in line with its annual business plan objectives and, where not, satisfy itself that appropriate action is being taken by Executive Directors.
- To take an overview of the Trust's performance against financial and performance objectives as aligned to the Improving Together programme, ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

- Review forecast performance against operational targets and improvement trajectories, escalating issues of non-delivery to the Board, and monitoring against achievement of any national funding (e.g., Provider sustainability funding).

- Monitor identification of schemes within the Cost Improvement Programme and overall forecast delivery, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

- Review operational performance in relation to information technology, information governance, data quality and estates and facilities.

4.3.3. **Income and Contracts management**

- Review the Trust contracting approach with key commissioners

- Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.

- Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.

- Consider material opportunities to grow new commercial income streams and market share of existing services.

4.3.4. **Annual Trust planning cycle**

- To consider the Trust's medium and long-term financial strategy, in relation to both revenue and capital.

- To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of divisional business plans, including workforce plans, aligned to the Trust's vision metrics, strategic initiatives, and breakthrough objectives as part of Improving Together.

- Consider proposals for Commercial and Business Development activities in accordance with Standing Financial instructions.
    - The Finance and Performance Committee has delegated authority to approve revenue business cases from **£250k - £750k**.
    - The Committee has delegated authority to approve capital business cases from **£500k - £750k.**

- Review the annual CIP plans to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable.

- Receive benchmarking and other information (for example from GIRFT and Model Hospital) to assess Trust productivity and ensure targeting or efficiency programmes.

- Review the Trust procurement strategy, systems, and arrangements for obtaining best value. Monitor progress against the NHS standards of Procurement within the Trust.

- To consider the implications of wider changes in NHS policy and governance within the committee's remit including (but not limited to) the development of Integrated Care Boards (ICB), NHSE regulatory oversight and developments of provider collaboratives including BSW Acute Alliance.

4.3.5. **Capital management**

- Review the strategic five-year capital programme and the annual capital budgets and recommend as appropriate to the Board of Directors.

- To consider the financial proposals for investment in the estate and technology to ensure alignment with Trust strategy.

- Approve capital business cases in accordance with the Trust's Detailed Scheme of Delegation (DSoD).

4.3.6. **Treasury management**

- To review the cash position of the Trust and the related treasury management policies of the Trust.

- Review Trust finance applications including loan applications.

4.3.7. **Risk Management**

- The Committee shall ensure the Trust has robust financial and operational risk management systems and processes in place.

- To regularly review the Board Assurance Framework (BAF) and risk profile in accordance with the agreed risk appetite and risk tolerance levels.

4.3.8. **Subsidiary Governance**

- The Committee will receive and review regular updates on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company (known as a related company/entity).

- The Committee will ensure the Trust has a clear strategy for the use and development of subsidiary and related companies/entities.

- To maintain a clear view of the subsidiary level risk profile and the operational, reputational, and financial exposure across the group profile.

- Ensuring the Trust has a clear governance framework and structure for oversight of any related company/entity.

4.3.9 **Digital**

- To review the Digital Strategy and gain assurance on the Trust's digital programmes of work, to scrutinise delivery and achievement of key milestones.

- Receive regular Senior Information Risk Owner (SIRO) reports to have oversight of areas of improved compliance and areas of concern with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

- To have oversight on progress of the Trust's annual Data Security and Protection Toolkit (DPST) submission.

- To gain assurance on the progress and effectiveness of the Trust's cyber security activities.

4.3.10 Other

- To review any matters referred to this committee by the Board of Directors.

- To make arrangements as necessary to ensure that all Board members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.

- To notify the Audit Committee of any statutory reporting concerns or system weaknesses identified.

5. Conduct of Business

Administration

5.1. The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:
- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas.

Frequency

5.2. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.3. Meetings will be held at least nine times per year, with additional meetings stood up where agreed triggers have deemed it appropriate to do so.

Notice of meetings

5.4. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.5. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.6. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board via an escalation report. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.8. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2. As part of this assessment, the Committee shall consider whether it receives adequate and appropriate support in fulfilment of its role and whether its current workload is manageable.

6.3. These terms of reference were reviewed and approved by Trust Board on {insert date}

Salisbury NHS Foundation Trust

Clinical Governance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
March 2019	2	Major	All sections revised	Director of Corporate Governance
May 2020	3	Minor	Annual review	Corporate Governance Manager
March 2021	3.1	Minor	Annual Review	Corporate Governance Manager
March 2022	3.2	Minor	Annual Review	Director of Integrated Governance – updates made by PA
March 2023 & April 2023	3.3	Minor addition of health inequalities oversight	Annual Review	Director of Integrated Governance

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	CGC
Adoption and ratification	Trust Board

1. Purpose

1.1. The Committee has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board and the Chief Executive that high quality care is provided to patients throughout the Trust.

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Clinical Governance Committee (the Committee).

2.2. The Committee is a standing committee of the Board of Directors (the Board).

2.3. A non-executive Committee of the Trust Board of Directors has no executive powers, other than those specifically delegated in these Terms of Reference

2.4. The Committee is authorized to monitor, scrutinize and where appropriate, investigate any quality activity considered to be within its terms of reference

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Three Non-Executive Directors
- Chief Medical Officer, Chief Nursing Officer (joint Lead executive)
- Chief Operating Officer

3.2. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.3. A Non-Executive Director shall be appointed as Chair of the Committee.

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members or nominated deputy.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- Any nominated deputy attending in place of a designated Committee member.
- Other Non-Executive Directors and Executive Directors are invited to contact the Chairman in advance if they wish to attend a CGC meeting.
- The PA to the Chief Nursing Officer and Chief Medical Officer will act as Secretary to the Committee.
- Governor observer(s)

- The Director of Integrated Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.
- Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1. The function of the Committee is to ensure:

4.1.1. That the Board establishes and maintains compliance with health care standards including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission and statutory regulators of health care professionals (including NHS Improvement).

4.1.2. Provision of assurance that high quality care is provided to patients throughout the Trust, actively engaging with patients, staff and other key stakeholders as appropriate.

4.1.3. There is clear accountability for quality of care throughout the Trust including but not restricted to, systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate

4.1.4. Support for the Trust's objective to strive for continuous quality improvement and outcomes, through the Care and Innovation objectives.

4.1.5. Consideration of the clinical risks to the Trust's ability to achieve high quality care and continuous quality improvement through review of the Care and Innovation sections of the Board Assurance Framework

4.1.6. To consider the implications of wider changes in NHS policy and governance within the committee's remit including (but not limited to) the development of Integrated Care Boards (ICB), NHSE regulatory oversight and developments of provider collaboratives including BSW Acute Alliance.

4.1.7.

4.2. The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

4.2.1. Development and Review

- Agree the annual quality plan (quality account priorities) and monitor progress**.**
- Extend the Boards monitoring and scrutiny of the standards of quality, compliance and performance of Trust services
- Make recommendations to the Board on opportunities for improvement in the quality of services
- Support and encourage quality improvement where opportunities are identified
- Working in conjunction with the Audit Committee, People and Committee and Finance and Performance Committee, cross-referencing data and ensuring alignment of the Board assurances derived from the activities of each committee
- Review the Trust's Annual Quality Report and Account prior to submission to the Trust's Board of Directors for approval
- Monitor the status of the Trust's quality objectives as set out in the Annual Plan
- Review the Integrated Performance Report Quality and Care section prior to inclusion in the Board Integrated Performance Report Consider

relevant regional and national benchmarking statistics when assessing the performance of the Trust

- Receive Quality Impact Assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience, and patient safety
- Provide oversight of relevant Internal Audit recommendations as directed by the Audit Committee
- Understanding inequalities in access to health or outcomes for individuals within our population and devising strategies to tackle inequalities when where they exist.

4.2.2. Review of Trust activity in assigned area

Patient Safety:

- Agree the annual safety priorities and monitor progress.
- Ensure risks to patients are minimised through application of a comprehensive risk management system in accordance with the risk management strategy. Identify areas of significant risk, set priorities and agree actions using the Assurance Framework and Corporate Risk Register process.
- Monitor and review the clinical risks in the Assurance Framework and corporate risk register as per the risk management strategy and policy.
- Assure that there are processes in place that safeguard adults and children within the trust and review the annual safeguarding adult and children's reports prior to submission to Trust Board
- Receive and review bi-annual reports from the Director of Infection Prevention and Control

Clinical Effectiveness / Clinical Outcomes:

- Ensure that care is based on evidence of best practice and national guidance.
- Assure the implementation of all new procedures and technologies according to Trust policies
- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.
- Review the Annual Clinical Audit plan and receive a bi-annual report on progress with the plan.

Patient Experience:

Assure that the Trust has reliable, real time, up to date information about what it is like to be a patient experiencing care in this hospital, to identify areas for improvement and ensure that these improvements are made. This will be provided through a comprehensive patient engagement programme. This will be achieved through:

- Review of the patient experience quarterly report
- Agree the annual patient experience/engagement plan and monitor progress.
- Receipt of reports regarding patient experience and engagement and review the results and outcomes of local and national patient surveys

Learning:

- Commitment to strengthen learning across the organization aligned with continuous improvement and improve patient safety, experience and outcomes.

- Ensure the Trust is outward looking and incorporates learning and recommendations from external bodies into practice with mechanisms to monitor their delivery.
- Request reports to monitor against action plans arising from Serious Incidents, complaints and Never Events to ensure Trust-wide learning.

4.2.3. Policy monitoring and review

Ensure the research programme and governance framework is implemented and monitored.

5. Conduct of Business

Administration

5.1. The Committee shall be supported administratively by the PA to the Chief Nursing Officer and Chief Medical Officer whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

The Committee chair will provide an escalation report to the Board of Directors following each meeting, in the public session where possible; agreed with the Committee Chair.

Frequency

5.2. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.3. Meetings will be held 12 times per year, with additional meetings where necessary.

Notice of meetings

5.4. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.5. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.6. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner through the Board escalation report template.

5.8. Reporting arrangements into the Committee from Sub-Committees

5.9. The Clinical Management Board will continue to report to the Trust Management Committee, and its Escalation Report (Minutes) will be submitted to the Clinical Governance Committee for assurance.

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

6.3. These terms of reference were approved by the Clinical Governance Committee with amendments on Tuesday 28th March 2023 and these terms of reference will be reviewed and approved by Trust Board on 6th April 2023.

NHS
Salisbury
NHS Foundation Trust

Report to:		Agenda item:	
Date of meeting:			

Report tile:	**Annual Review of {Insert} Committee 2022-2023**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:				
Executive Sponsor: (presenting)				

Recommendation:

Executive Summary:

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	x
Other (please describe):	

Annual Review of {INSERT}

1. Introduction

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2. Work undertaken in {insert year}

3. Committee membership attendance at {INSERT} Committee meetings

Member	Designation	Meetings attended (based on membership tenure)

4. Work Plan for {INSERT FINANCIAL YEAR}

5. Terms of Reference

5. Conclusion