Bundle Trust Board Public 10 March 2022

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX Certificates

January Staff SOX of the month -
February Staff SOX of the month -
January Patient Centred and Safe SOX -
February Patient Centred and Safe SOX -

1.2 10:10 - Staff Story

1.3 10:25 - Welcome and Apologies

1.4 Declaration of Interests

1.5 10:30 - Minutes of the previous meeting

Minutes attached from previous meeting held on 13th January 2022
For approval

1.5 Draft Public Board mins 13 Janaury 2022.docx

1.6 10:35 - Matters Arising and Action Log

1.6 Action Log Public Trust Board March 22.pdf

1.7 10:40 - Chairman's Business

Presented by Nick Marsden
For information

1.8 10:45 - Chief Executive Report

Presented by Stacey Hunter
For information

1.8a CEO Board Report - February for March Board.docx

1.8b Appendix 1 Spinal Injury Service Risks paper.docx

1.8c Appendix 2 - Letter to system - Ockenden One Year On_250122.pdf

1.8d Appendix 3 AHA Executive Group Slides.pptx

1.9 Register of Attendance

For information

1.9 Register of Attendance - Public Board 2021-22.docx

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Clinical Governance Committee - 22 February

Presented by Eiri Jones
For assurance

2.1 Escalation report - from February 2022 CGC to March Board 2022.docx

2.2 11:00 - Finance and Performance Committee - 22 February

Presented by Paul Miller
For assurance

2.2 Finance and Performance Committee escalation paper 22nd February 2022.docx

2.3 11:05 - People and Culture Committee - 24 February

Presented by Michael von Bertele
For assurance

2.3 MvB Escalation report - P&C Committee 24 Feb 22.docx

2.4 11:10 - Integrated Performance Report to include exception reports

Presented by Andy Hyett
For assurance

2.4a 100322 Trust Board cover sheet.docx

2.4b IPR March 2022 final TB.pdf

2.5 Trust Management Committee - 23 February - cancelled

3 PEOPLE AND CULTURE

3.1 11:15 - Health and Safety Annual Report (deferred from September 2021)

Presented by Melanie Whitfield
For assurance

3.1 Health and Safety Trust Board Annual Report 2020 -2021 GP & DC with Sept-Aug stats.docx

3.2 11:25 - Nursing Skill Mix

Presented by Judy Dyos
For assurance

3.2a Nurse Skill Mix cover sheet.docx

3.2b Nurse Skill review and update Feb 2022.docx

4 GOVERNANCE

4.1 11:35 - Trust Constitution

Presented by Fiona McNeight
For approval

4.1a Cover sheet - Constitution Feb 2022.docx

4.1b Constitution V 2.2 Draft Jan 2022.docx

5 Closing Business

5.1 11:40 - Agreement of Principle Actions and Items for Escalation

5.2 11:45 - Any Other Business

5.3 11:50 - Public Questions

5.4 Date next meeting

Next Public meeting 7th April 2022

6 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 13th January 2022, MS Teams Salisbury NHS Foundation Trust

Board Members:

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

In Attendance:

Esther Provins (EP)	Director of Improvement and Partnerships
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Helen Rynne (HR)	Patient Engagement Lead (item TB1 13/1/1/1.2)
Mark Wareham (MW)	Staff Side Union Representative (observer)
Ian Robinson (IR)	Head of Facilities & Sustainability Lead (item TB1 13/1/3.1)

ACTION

TB1 13/1/1 **OPENING BUSINESS**

TB1 13/1/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

- **AMU, Amesbury Suite, Redlynch Ward, Housekeeping Team, Catering Team & Portering Team** – Living Our Values, Patient-Centered & Safe
- **Bincy George, Ward Sister, Redlynch Ward** – SOX of the month
- **Jane Blaxley, Michaela Knowles, Karen Edwards, Charlie Eadle**, **Plastics Trauma Coordinators** – SOX of the month

NM noted the wide variety of nominations that he always receives and the great work underway during extremely challenging times. NM and the Board congratulated the members of staff who had received a SOX award.

TB1 13/1/1.2 **Patient Story**

HR joined the meeting to present the patient story which was told by a renal patient who had previously had a kidney transplant and was cared

for in several departments in the hospital.

The patient explained that she felt at points that the clinical staff in the Trust had very little knowledge of how to care for transplant patients and noted that the male doctors caring for her came across as arrogant and sometimes rude. The patient noted that they felt their intelligence was being questioned at times, even though they were offering the clinicians' advice about the best type of treatment for them. The patient noted that despite the communication issues during her stay, the nursing care was brilliant.

Discussion:
DB noted that from his experience as a GP it takes time for young and relatively inexperienced doctors to fully understand patient needs and aspirations and, as part of their ongoing training, they will gain that experience that helps to put their role into perspective. DB noted that medically, recipients of organ donors does not mean the patient is fully well and it is the beginning of a health condition that needs to be managed properly throughout that person's lifetime. DB felt that the Organ Donation group, of which he is a member, would benefit from hearing this story.

PC acknowledged that all staff would like to provide a good experience for all patients. For those who require specialist care it is important to work with teams to ensure they have the right knowledge for certain situations. It is reiterated that patients are a great source of information and young doctors at the beginning of their career can sometimes display arrogance as response to fear of admitting they do not know the correct information. Junior doctor's training should focus on helping medical staff understand that they are not infallible. Whilst the Trust has got better at this, there are improvements that can be made and this message also needs to be communicated to patients to manage expectations.

SH noted that the Trust did not get the balance right for this person and reiterated the need to have open and honest conversations and set mutual expectations with patients.

AH noted that if we are encouraging junior doctors to be open with patients and say they do require a second opinion, the Trust need to be mindful that this could increase complaints.

JD noted that doctors are not expected to know every nuance of managing all health issues and suggested that the patient experience team could look at how the Trust can improve the resources and guidance for patients in relation to this.

MvB noted that the patient had mentioned their weight as a factor for being treated differently. MvB noted that there is still unconscious bias and a view that obesity is always the patient's fault which is not the case and needs to be taught to staff.

NM thanked HR for bringing the story to the Board and to the patient for sharing their story. NM noted the contrast to the SOX awards where there were so many good examples of excellent patient care. NM felt

that this would be reflected in the Board meeting itself, where there would be areas of fantastic work and other areas which required improvement. HR left the meeting.

TB1 13/1/1.3 **Welcome and Apologies**

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

TB1 13/1//.4 **Declarations of Conflicts of Interest**

EJ noted that this was not a conflict of interest but reported that she had finished her NED role at Homerton University Hospital Foundation Trust and had recently commenced a new NED role at Dorset County Hospital.

TB1 13/1/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 9th December 2021.**

NM presented the minutes from 9th September. The minutes were agreed as a correct record of the meeting.

TB1 13/1/1.6 **Matters Arising and Action Log**

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

There were no further matters arising.

TB1 13/1/1.7 **Chairman's Business**

NM highlighted the following key points as part of her verbal report to the Board:

It is clear the Omicron variant of COVID-19 has moved things back in a number of areas and there have been a number of items released over the last few week in relation to reducing the burden, given the heightened pressure on NHS organisations.

The guidance released on 24th December 2021 with a number of important items that should be noted. The Trust will not return to financial normality on 1st April as this has now been deferred to 1st July. Additionally, the migration to Integrated Care Systems (ICS) will also be deferred to 1st July from 1st April.

As an organisation the Trust needs to focus on workforce for now and for the future and during 2022 and beyond this will be a primary focus as our people are critical to way we develop going forward. There is still a focus on COVID-19 but also on elective and emergency care and population health and in terms of support there will also be a digital focus.

What is clear is that 2022 is not going to be straightforward and it will be challenging.

TB1 13/1/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- SH referred to the most information that had been released from government in relation to vaccination as a condition of employment. Currently, the Trust is waiting for the policy describing how this process should be implemented and the Trust is doing its best to be open and communicate the guidance that has been received. Whilst this is not without controversy the Trust must stay out of the debate and ensure colleagues are supported and have access to the right information.
- From a south west perspective there has been a stabilisation of people with COVID who have required hospitalisation. However, there have been challenges across Bath and North East Somerset, Swindon and Wiltshire (BSW) as the other organisations have been experiencing high numbers of staff sickness which has led in some cases to an internal critical incident status.
- There have been some great successes in terms of recruitment to a number of clinical and non-clinical posts.
- SH extended her thanks to the executive team and all Trust colleagues for their continued efforts in such challenging circumstances.

Discussion:
TB asked if there has been any data on the impact of front line staff in the social care sector having to have the vaccination as a condition of employment. TB further asked if any analysis of why SFT had not experienced high numbers of Omicron and if this could potentially help for future planning.

SH explained that as part of some anecdotal feedback there had been loss in workforce in a social care setting. However, what was clear is that once notice letters were issued more people did come forward.

In terms of why cases of Omicron may not have peaked as much in Salisbury when compared to other locations, several observations have been made but the reasons are largely unknown but generally the population have been compliant in terms of observing social distancing measures alongside a high uptake in the vaccine.

EJ referred to the planning guidance which has been published and asked about delivery of the 10 priorities set out in the report. SH noted that in current circumstances the Trust will not achieve the level of progress on all 10 priorities. The Trust will observe and consider what action it can take to improve and deliver effective care for the population it serves. Inevitably, consideration will also be required in terms of resource.

The Board discussed the expectations over the next year and that staff will be experiencing ‘burn-out’ as a result of the last two years. PM noted that it will be difficult to measure what cannot be done due to staff being exhausted. SH noted the differential set of circumstances for staff as parts of the organisation, have a high vacancy factor which has caused those left to be extremely pressured in their roles. This has understandably caused staff to be tired and sometimes despondent.

However, there are other departments in the organisation who have not been able to fulfil their role as they would like due to some services taking priority and therefore it must be accepted that when priority setting for staff there will be differential support across the Trust.

JD referred to the letter received letter from the Royal College of Nursing about how nurses understand the support and responsibility the Trust takes during exceptional circumstances. The Trust has made a great effort to communicate with nurses who have been working tirelessly, e.g. JD and MW wrote to all nurses from a support perspective, sessions have been run in conjunction with the Nursing and Midwifery Council in relation to concerns and regular meetings have been held with the Band 7s from the wards.

MW also provided a list of support that has been ongoing for staff including; practical trainers delivering training on the wards, the introduction of Ward Buddies to volunteer where they can, annual leave is being supported and the communications team are continuing with positive, constructive and supportive messages every week.

AH noted that operationally the Trust currently had 88 'no right to reside' patients which continues to place additional pressure on wards and staff. Additionally, AH reminded the Board that in all clinical pathways there is a COVID clinical route and a non-COVID clinical route which also continues to be a constraint.

MVB noted that he found the planning guidance unhelpful and that the key focus should be workforce as without support for them none of the other work will be completed.

TB1 13/1/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 13/1/2.1 **Clinical Governance Committee (CGC) 21st December**

EJ presented the report, providing a summary of escalation points from the meeting held on 21st December. EJ asked for the report to be taken as read and highlighted the key points:

- The Committee had a discussion regarding Stroke Services and were assured by PC that the Trust is not an outlier from a mortality perspective. This raised a discussion about ensuring the Committee does not just focus on one service and this is reflected in the annual work plan.
- The whistleblowing reports were explored in detail and it was agreed that when you triangulated with the five steps to safety internal audit there is further work to do on this. Assurance was provided that the executives are managing this.
- Patient experience remains positive but again, there are areas to address which the relevant clinical leads are working on.

Discussion:
SH thanked EJ for the report and noted the positive discussions regarding the proportionality of services reviewed.

TB1 13/1/2.2 **Finance and Performance Committee (F&P) 21st December**

PM provided a summary of escalation points from the Finance and Performance Committee held on 21st December. PM asked for the report to be taken as read but highlighted the key points:

- The Committee received a detailed and helpful paper from Lynne Abbott, Associate Director of Finance – contract and income, on productivity. This work was commended and the Committee encouraged further benchmarking analysis.
- The Committee noted the Emergency Planning Assurance Report and formally congratulated AH and the team for the excellent work undertaken.

The report was noted.

TB1 13/1/2.3 **Trust Management Committee (TMC) 22nd December**

SH presented her report which provided a summary of escalation points from the Trust Management Committee (TMC) held on 22nd December. SH asked for the report to be taken as ready an noted that:

- A number of items in the report were picked up in the Board Committee escalation reports.
- The Committee received two business cases; Lead Cancer Nurse Business Case and Associate Director of HR Operations Business Case. These were both considered and approved.

The report was noted.

TB1 13/1/2.4 **Audit Committee – 16th December**

PK provided a summary of escalation points from the Audit Committee held on 16th December.

- The Committee received three internal audit reports of which each had elements that were concerning.
- Management has documented plans to remediate all of the issues but concern was expressed by the Committee as to the timescale for completion given the pressures in the Trust currently.
- Positively the Committee noted that work had been undertaken in pharmacy to respond to the governance issues regarding medicines reconciliation.

Discussion
SH referred to the WHO checklist and noted that this is a safety issue and the approach and attitude of some staff is unacceptable. The Trust must adhere to this standard.

PC acknowledged that this relies on a multidisciplinary team to provide this and the Trust need to support staff to drive this improvement and address some of cultural issues in the department. An action plan will go to CGC in February.

TB1 13/1/2.5 **Charitable Funds Committee (CFC) – 16th December**

NM provided a summary of escalation points from the Charitable Funds Committee held on 16th December 2021. NM took the report as read and highlighted the key points:

- NM noted that the charitable funds investment governance processes introduced over the last 18 months has proven to be rigorous and allows CFC to look at the more strategic side of charitable funds.

Discussion:
PK noted that he was content with governance arrangements but gently reminded colleagues that whilst this Committee undertakes the business the Board retain their responsibility as Trustees. PK asked if the Trustees could have a session just to remind everyone of the principles being applied so the Trustees could endorse the position.

NM agreed and noted that he will bring this back to the Board in three months' time when the financial strategy for the charity was fully developed. SH suggested that the Trustee's will need to consider the hospice as there are some strategic conversations to have. NM noted that he would an overall charity paper with a focus on Stars Appeal.
ACTION: NM **NM**

TB1 13/1/2.6 **Integrated Performance Report (IPR) (M8)**

LT presented the Integrated Performance Report and noted that this report provided a summary of November 2021 performance. LT noted that a lot of the current operational challenges facing the Trust had already been discussed but highlighted the following key points were noted:

- The Trust continues to operate under significant pressure with Length of Stay increasing, bed occupancy increasing and escalation bed days exceeding 2000. This has affected flow throughout the organisation and the average number of patients in the Trust with no criteria to reside is at 77.
- Workforce metrics reflect the pressure in the organisation with sickness absence remaining higher than the Trust target and mandatory training and appraisal rates declining.
- Theatre performance is moving in the right direction and there is now 11 more substantive staff in theatres which will enable an increase in elective flow.

Discussion:
AH noted that in terms of long term solutions to help improve and streamline processes on wards, investment in the Trust's digital maturity in terms of systems and data would have a significant impact. AH explained that the introduction of IT systems such as Electronic Prescribing (EPMA) would help to streamline discharge practices and enable better care for patients and a better experience for staff. NM and

AH discussed the current data challenges and AH noted that some of systems are multiple entry and with a depleted workforce this adds additional pressure. SH noted that this is a very live conversation and is also being driven by the level of data we now have to provide. It was noted that F&P Committee would receive future reports on the Trust's digital maturity.

TB referred to the number of patients with no criteria to reside and noted this issue being exacerbated by the staffing issues across the system and more widely the funding in social care. TB asked if the Trust had looked at alternative patient pathways, i.e. is there a cohort of patients with no criteria to reside who could be treated in a nursing care environment by the Trust's staff. SH noted that the Trust need to work alongside Wiltshire Council as there is a risk of undermining the market even further. The Trust will be working with its partners, including Wiltshire Council to see what can be done in the mid to long term. SH also acknowledged that currently the provision of domiciliary care is more concerning due to the workforce gaps in that sector. SH explained that from a funding perspective the NHS position is that the additional funding for discharge will not be extended beyond the end of March. SH noted that SFT and the wider ICS need to move on from the non-recurrent nature of work which has dominated the last few years and focus on how to improve and sustain health care for the population it serves.

EJ asked how many escalation beds were open and how are staffing ratios varying in relation to safety. AH explained that there are 55 escalation beds open and that in relation to staffing the Trust has been reporting 'Red' for the last 4 months. JD explained that staffing is reviewed three times a day to ensure it is managed appropriately and noted that two registered nurses to a 24 bed ward is categorised as 'Red'. AH explained that if staffing were to deplete any further the Trust have provisions in place to stand up a 'Deployment Cell'.

SH noted that there were a few errors in the IPR and asked for the report to be checked prior to publication for future meetings.

TB1 13/1/3 **FINANCIAL AND OPEATIONAL GOVERNANCE**

TB1 13/1/3.1 **The Green Plan**

IR joined the meeting to present the Green Plan which had been supported at the F&P Committee in December. AH noted that the Board were being asked to approve the Trust's Green Plan prior to submission and highlighted the tremendous amount of work IR and the team had put into this plan.

IR explained that this is a requirement of all NHS organisations and sets out a framework for how we will reduce the impact of climate change, embrace green learning and innovation and support the NHS to deliver a carbon net zero healthcare system by 2045. IR noted that there is a lot of work to do and the actions that need to be taken are described within the report. IR noted that progress on this will require investment, time and dedication from all staff.

Discussion
NM thanked IR for providing an excellent plan and acknowledged the hard work that had gone into this document.

TB asked if Salisbury City Council have similar plans to move towards carbon net zero as it would be useful to link with them in relation to transport and increasing awareness to the public. IR explained that the ICS have formed a group; including local authority and education to approach this situation and that the ICS have set a more challenging target. There are a number of unknowns currently relating to government policy, innovation and the effect of suppliers to the NHS. This progress will be interlined with all partners and work towards a carbon net zero position will be done as a regional group rather than just within the NHS.

EP explained that there are a group of really motivated colleagues who have developed an eco-council and are championing this agenda. EP noted that this group of staff would be very interested in supporting management teams to progress this work.

EJ reflected that the challenge with this work, like a number of key initiatives, will be how deliverable it is. However, this is vital work and as part of the Trust and the wider NHS we do need to lead by example in terms of prioritising the move towards becoming greener.

PM applauded the ambitions set out in the Trust's Green Plan and noted that health care is a physical business and this plan will result in changes to clinical pathways and services that will have to be designed and implemented to make this a reality. Virtual clinics is a step towards this but generally what hospitals do is physical work and therefore PM asked how the Trust is linking the emerging clinical strategy to this agenda. PC agreed that there are a lot of infrastructural costs associated and that the model of care does need to be addressed as does the public's approach to transport into hospitals etc.

IR explained that the action plan developed only relates to 3 years of 18 year journey and this is very much an evolving picture and a live document. IR referred back to the unknowns and noted that currently the Trust does not understand the full scope of carbon emissions of the organisation as this has never been measured. The Trust will get a better picture as in early 2022/23 NHSE/I will be collecting this data at an organisational level.

IR referred to clinical pathways and noted that there is a clinical fellowship scheme to support delivery of net zero health care. Some of this will be beyond the organisation but there will be support. IR noted that if the Trust and wider NHS is going to be busier in the next few years as projected, carbon emissions will increase but there are proposed changes to procurement processes in that any contract of £5m or above the supplier will have to show zero carbon footprint for those services. What is expected is that the NHS carbon footprint will increase throughout this decade before the effect of the the changes are realised. IR clarified that the organisation itself won't get to net zero but the NHS will, as it will offset the carbon emissions.

Decision:
The Board approved the Green Plan. The Board noted that the governance route for the Green Plan is through TMC with an escalation report coming to Board.

IR left the meeting.

TB1 13/1/4 **QUALITY AND RISK**

TB1 13/1/4.1 **Q2 Patient Experience Report**

JD presented the report which provided a report of activity for Q2 2021/22 in relation to complaints and the opportunities for learning and service improvement. The following key points were noted:

- In the reporting period there were 110,000 episodes of care with 54 complaints and 52 compliments reported.
- The general key themes remain the same with attitude of medical staff, unsatisfactory treatment and further complications being the top three.
- 98% respondents of the Friends and Family Test had a good or very good experience.
- The results of the urgent and emergency care 2020 survey and adult inpatient survey have been published by the CQC. JD reported that the Trust's scores in ED were average and SFT were not outliers in terms of performance so the focus should be on how we aim to achieve outstanding care going forward. In the inpatient survey the Trust scored declined in one area but overall scored on the positive side of average.
- JD was pleased to report that the Trust had recruited two new people to the patient experience team, a head of patient experience and a patient experience lead, both of whom would be starting their roles in the next few months.

Discussion
SH observed that in terms of negative comments a number related to the infrastructure and estate. SH noted that the Trust was not yet at a point where the decision is to stop using certain parts of the estate and noted that there was some work to do to manage patient's expectations in relation to this and how they are supported during their stay.

LT reiterated that the Trust does not have enough funding to fix the estates issues, invest in digital maturity and replace medical equipment. There will be something that has to give and it was noted that issues in relation to capital funding would be picked up at the F&P Committee at the end of January. LT further explained that how the Trust spends charitable funds will be part of that debate.

DB noted the positive trend in seeing the percentage of responses sent within the agreed timeframe increase. DB noted that in comparison to other organisations, complaints relating to communication are common but explained that he did not generally see complaints relating to doctor attitude as a theme. PC explained that whilst this is one of the key themes it should be noted the very small number of episodes this refers

to. Additionally, when deep dives have been undertaken in the past it has been found that this category is quite broad and further context is required. However, PC explained that the Trust monitor's complaints about individuals and if issues are highlighted then these are acted upon. JD agreed that that these do relate to small numbers and the Trust should be reassured that it consistently receives lower levels of complaints than other organisations.

PM referred to SH's challenge regarding suboptimal locations and noted that the Board will need to get into this detail to establish where services should be located and if this is aligned to capital funding.

EJ explained that she had not worked in a single organisation that did not have medical staff attitude as an issue. EJ noted the difficulties and no quick solution, particularly when someone is not satisfied with their care as, even if it is clinically right, this can still result in formal complaint.

JD noted that it was always useful to challenge ourselves but explained it is also important to summarise that this report reflects positively on patient experience within the Trust.

TB1 13/1/4.2 **Q2 Learning from Deaths Report**

PC presented the report which provided the Board with assurance that the Trust is learning from deaths and making improvements as a result. The following key points were noted:

- Overall the Trust remained within expected levels of mortality.
- There were 16 structured judgement reviews requested by the medical examiner system in Q2. The main theme for Q2 related to falls and this is a key focus for the Improving Together work

Discussion

SH thanked Ben Browne, Head of Clinical Effectiveness, for a well written report. EJ noted that the effectiveness work in organisation has improved and there is now a quarterly focus on effectiveness coming to CGC. FMc noted that the three key steering groups, clinical effectiveness, patient safety and patient experience have supported that quality initiative.

TB referred to the deaths of those people who had a learning disability or serious mental illness and asked if there was any particular learning from those cases or areas of concern. PC explained that the team review all deaths and a lot of the learning from these cases is led through the Learning Disability Team and there are currently no concerns in terms of gaps in care for those patients. What is acknowledged is the work to reduce healthcare inequalities has to focus on learning disability and patients with mental health illness but there are currently no concerning themes arising in the Trust.

TB1 13/1/4.3 **Director of Infection Prevention and Control Report**

JD presented the report which provided assurance to the Board of the performance against Infection, Prevention and Control (IPC) requirements for April 2021 – Sept 2021. JD noted the following key points.

- IPC is moving faster in terms of expectations in guidance. There is guidance expected this week in relation to new isolation periods COVID positive or close contacts.
- JD commended the hard work of the housekeeping team. Cleaning sessions have significantly increased and that is one of many reasons why housekeeping won team of the year at the Trust Staff Awards.
- JD summarised the various challenges in the reporting period relating to Colostrum Difficile, the staffing challenges in relation to an Antimicrobial Pharmacist and the efforts to maintain testing and controls of the Trust's water to manage legionella. JD summarised the actions and progress against these challenges.
- Staff compliance in relation to PPE has declined as has the number of patients wearing facemasks. This was over a period where standards of PPE had reduced in the community; however the emergence of the Omicron variant has now increased PPE compliance.
- The Trust struggles to meet the standards for ventilation and the ventilation group is considering the use of air-scrubbers. The Trust has asked for guidance from NHSE/I to ensure this approach is worth investment.

Discussion:
PM noted that the ventilation issue is an important one and whilst he is assured that it is on the executive's radar he asked that the DIPC report include a small section explaining the Trust's position. **ACTION: JD** **JD**

SH thanked JD for the incredible job she has undertaken as DIPC during the pandemic and noted that her efforts had been helpful to the organisation and wider system.

EJ referred to the KLoE action plan in the report and asked for further clarity on points 1.20 and 1.21 which related to the risk assessment for ventilation and were flagging red. JD explained that this related to documenting the risk so it is available for people to see.

RA highlighted the Trust's ambitions for carbon net zero and the conflicting approach to IPC, which now more than ever means that there are single use items due to COVID-19.

TB1 13/1/5 **PEOPLE AND CULTURE**

TB1 13/1/5.1 **Health and Safety Annual Report**

This item was deferred from September 2021 to March 2022.

TB1 13/1/5.2 **Education and Development Annual Report**

PC left the meeting.

MW presented the report which had been written by J Scrase prior to her leaving the Trust. MW noted that the team have done extraordinarily well and maintained a safe and resilient approach to activity that needed to be completed in year.

MW noted that further work is required to ensure staff feel well trained and to maintain and improve the skills requirement of the workforce. This is whilst also taking into consideration the impact on space to undertake training and staffing issues across the Trust

Discussion:
RA asked if the Trust's staff have the right training and right skill set and is there a skills analysis for current and new roles. RA also asked how this fits into future proofing and also upskilling. SH noted that there is room for improvement in terms of upskilling and referred to the development and planned launch of the BSW Academy which is an exciting opportunity to develop networks further and share learning.

PM asked if the Training Needs Analysis (TNA) is signed off at TMC proactively or is it a retrospective look that is submitted. SH noted that the TNA does not come to TMC but what has been acknowledged is that the current TNA is skills orientated and is not strategic.

MVB noted that this had been discussed at People and Culture Committee and what it did describe was the wide scope of training the Trust do undertake. MVB noted that training is a quality initiative and the Trust need to understand skills and knowledge required to then inform the sort of learning required and how this will be delivered.

TB1 13/1/5.3 **Nursing Skill Mix**

It was noted that this item was deferred to March 2022.

TB1 13/1/5.4 **Equality and Diversity Annual Report**

MW presented the report which provided assurance to the Board

- Equality agenda the evidence is sobering – these provides factual data and clear about a number of dimensions and does not make positive reading.
- Has been a challenging year for some colleagues. Equality of pay, access to promotion and having work modified appropriately. AN audit from PWC was helpful and Rex has taken forward and have provided additional support of Ricky. Board development session before Christmas.
- Lays out a clear position and positive interventions are required

Discussion:
SH what our intentions are re networks. MW have spoken with Rex and Ricky – proposal to bring to execs first and then Board.

NM agreed with Melanie's summary and reiterated

TB1 13/1/5.5 **Medical Education Performance Report**

This item has been deferred to March 2022 Board.

TB1 13/1//6 **GOVERNANCE**

TB1 13/1/6.1 **Emergency Preparedness Annual Report and Compliance Statement**

AH presented the report which asked the Board to support the ongoing work required to fulfil our EPRR duties and responsibilities.

Discussion:
SH noted the excellent work that AH had the team had accomplished.

The report was noted.

TB1 13/1/6.2 **Register of Seals**

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

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

The report was noted.

TB1 13/1/6.4 **Annual Review of the Constitution**

FMc presented the constitution which had been reviewed as part of the annual process and noted that no significant changes have been made.

Decision:
The Board approved the Constitution and noted it would be submitted to the Council of Governors in February for final ratification.

TB1 13/1/7 **CLOSING BUSINESS**

TB1 13/1/7.1 **Agreement of Principle Actions and Items for Escalation**

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

- The Board received the Green Plan and approved this vital piece of work.
- The Board noted the continuing operational pressure and the challenges this presents throughout the Trust.
- The health and wellbeing of staff continues to be a key focus for the Board.
- The great effort from the education department was noted in the Education and Development Annual Report.

TB1 13/1/7.2 **Any Other Business**

No other business.

TB1 13/1/7.3 **Public Questions**

There were no public questions.

TB1 13/1/7.4 **Date of Next Public Meeting**

Thursday 20th March 2022, Board Room, Salisbury NHS Foundation Trust

TB1 13/1//8 **RESOLUTION**

TB1 13/1/8.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

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Master Action Log
Open Actions

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB Public 13/01/2.5 - Charitable Funds Trategy	07/04/2022	Nick Marsden, NM	PK asked if the Trustees could have a session just to remind everyone of the principles being applied so the Trustees could endorse the position. NM agreed and noted that he will bring this back to the Board in three months' time when the financial strategy for the charity was fully developed	Apr-22	N	4
Trust Board Public	Sasha Grandfield	TB1 13/1/4.3 - DIPC report/ Ventilation	07/07/2022	Judy Dyos, JD	PM noted that the ventilation issue is an important one and whilst he is assured that it is on the executive's radar he asked that the DIPC report include a small section explaining the Trust's position.	Jul-22	N	4

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	10 March 2022		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Stacey Hunter, Chief Executive Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):	Appendix 1 – Spinal Injury Service Risk Paper Appendix 2 – Ockenden One Year on Letter Appendix 3 – AHA Executive Slides			

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

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the last public board meeting on the 13th January 2022. Key points to note: • The hospital is still extremely busy, with activity and admissions remaining higher than that we would expect at this time of year. • The health and well-being of our people remains our key priority. As activity and the availability of staff is a challenge, we need to maintain our focus on the resilience of our colleagues. • Performance remains stable across all areas given the context. Elective recovery has been sustained overall despite the pressure on the surgical bed base due to a sustained increase in the number of people in the hospital with no criteria to reside. • We continue to play a key role in the delivery of the vaccination programme for BSW and we are delivering new antiviral medication to those identified as vulnerable and most likely to benefit.

- The number of hospitalisations for COVID is static; however the number of outbreaks in the hospitals has increased as COVID measures in the community have been removed.
- There is ongoing work to develop and agree the governance arrangement for the new Integrated Care Board and place based joint committee. I and Executive colleagues are supporting this activity. Sue Harriman the new Designate CEO commenced in February 2022 and the Chairman and I have had an initial opportunity to meet with her.
- The Acute Hospital Alliance's newly formed committee in common has had its inaugural meeting and is refreshing the work to determine the vision and ambition for AHA.
- Our 'Improving Together' programme has been formally launched. The programme will support us to continue to deliver outstanding care by improving our systems, processes and improving the way we all work together. This is a long-term programme that will be reaching every member of staff over the next few years.

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

1. Our Population

1.1 Operational Context

The hospital continues to be under increased pressure. Staff are worked incredibly hard to respond with adjustments being made to facilitate better patient flow and discharge despite which at the time of writing this report there are over 100 people in the hospital who are ready for discharge but cannot leave as the necessary care they need isn't available. This is creating additional pressure particularly for our nursing and medical teams who are supporting an average of an additional 60 escalation beds each day managing this.
There is a significant challenge in respect of maintaining appropriate staffing ratios which our clinical and operational leaders are doing their best to respond too as per our escalation frameworks.

We have consistently been at our highest level of escalation (OPEL 4) with the system declaring OPEL 4 for 10 days February.
This is impacting the flow within our hospital as well as across the system and resulted in an increased number of delays in ambulance handovers and some long waits for a bed for people who need a hospital admission. I would like to apologise to those people who have endured long waits in an ambulance and or in our Emergency Department.

As part of maintaining the urgent and emergency care service we have had to open our in extremis capacity in the Spinal Gym. This alongside an increased number of people with a delayed discharge is having a significant adverse impact on the delivery of the spinal injury service.

I have escalated this to the BSW Gold Incident response group and asked for further and specific support to address this. Please see appendix one for further details. I can provide a verbal update on the position to the Board when we meet on the 10th March 2022.

1.2 Elective Recovery

Despite the pressures detailed above our teams are making consistent progress with elective recovery. The focus for the end of March is on overall activity levels to minimise the risks of growth in the overall numbers of people on a waiting list and focusing on ensuring we are able to offer appointments for everyone who has waited 104 weeks. There is good progress on this which is detailed in the IPR which is thanks to a significant amount of oversight and focus from our clinical and operational teams.

Our progress to date on cancer and diagnostics is continued and whilst there are some fluctuations on a week-by-week basis the overall recovery of these services relative to the position of other providers in the ICS and region is positive.

1.3 Maternity Services

The leadership triumvirate in Women's and Newborn continue to progress their plans to respond to both Ockenden and their most recent CQC inspection. The detail of this is going via the Clinical Governance Group with the focus for them being maintaining the improvements they have secured, continuing to recruit to midwifery vacancies and embedded the improvements with front line staff.

TMC has seen an early version of some detailed work re how the team may be able to respond to the requirements set out by NHSE/I for continuity of carer which are particularly challenging in smaller, rural teams. This work will need to result in a business case as there will be significant investment in additional staff to meet the requirements. This will be shared with the Board in due course.

I have recently received a letter re Ockenden 1 year on which is shared at appendix 2

1.4 Financial sustainability

The early weeks of 2022 have seen considerable demand for emergency pathway beds, this has in turn led increases in the number of our own workforce working additional hours as well as the utilisation of the temporary workforce available to us. Although this comes at a significant financial cost it had been anticipated as part of our preparations for winter, and as such we remain confident of delivering on delivering the required financially balanced outturn.

Preparations to 2022/23 are well underway, with plans to deliver on the collective ambition to reduce waiting lists and modernise patient pathways being developed. Early indications suggest the financial challenge will be significant, both within the Trust and across the wider NHS, so a focus on the recovery of pre-Covid levels of productivity will be key.

The Chief Finance Officer will provide a detailed update on the planning for 22/23 for the Board in our private session.

1.5 Quality, Experience and Use of Resource

Our teams continue to do a brilliant job delivering services for our local population. The Board will be aware this is reported via the IPR for many things and specific areas of work detailed via our Board sub-committees on behalf of the Board. Rather than be repetitive the other material areas to note can be found in the IPR and Board sub-committee escalation reports.

2.0 Our People

2.1 COVID-19 vaccination

The Trust spent time planning for the introduction of vaccination as a condition of deployment (VCOD). After a huge team effort over 96% of staff demonstrated proof of double COVID vaccination with only a very small number declining to be vaccinated.
My thanks to our colleagues in OD and People who had to deploy significant resource and time to the preparation for VCOD.

The Board will be aware the government is currently consulting whether or not to progress with this current legal requirement. The statutory consultation period has ceased and at the time of writing this report we await the outcome. I will advise the Board at our meeting of any changes to this.

2.2 Workforce

Throughout January, staff availability has been a significant challenge as we continue to experience significant operational pressures / staff isolation / season illness and holidays toward the end of the year. This also impacts on our development of the workforce by limiting time available for routine training and an ongoing decline in formal completion of appraisals. Line managers continue to check in on the wellbeing of their teams and we are to pilot a more formal and supported approach in the weeks ahead.

2.3 Actions taken during the period to support colleagues include:

- Our Occupational Health Service (OHS) was restructured to provide a dedicated COVID Track and Trace team, and our Pre employment management referral triage and first line ill health investigations have been temporarily outsourced while we rebuild the OHS team with new hires and re-examine our wellbeing offer to our staff. This action is likely to take 4-6 months to complete.
- While absence and staff availability continue to be a concern, our OD&P team is analysing root causes with a view to optimising staff availability through better control over absence planning, more proactive long term sick management and analysing data to target proactive wellbeing initiatives. This work is likely to continue beyond our winter plan.
- The work being led by our colleagues in OD delivering education and training to develop more consistent leadership capacity and capabilities is making good progress. This is aligned to the work in Improving Together and fulfilling the NHS People Promise over the next 3 years.
- The Board will want to join me in thanking our volunteers and members of staff from our corporate and support services who have a number of times over this last 6 weeks responded to asks to go and assist in our wards. This has been on occasions when the hospital has been exceptionally busy and staffing in our ward areas extremely tight.

I am very grateful to everyone who has been able to offer some help, it makes a big difference to patients and our ward staff and underlines our fantastic team Salisbury Spirit.

2.4 Improving Together Launch

February saw the launch of our Improving Together programme, which will support us to continue to deliver outstanding care by improving the systems and processes that we use, and the way we work together. The programme is based on learning from other Trusts that have embedded a culture of continuous quality improvement, and the evidenced link between continuous quality improvement leading to better care for our patients and improved job satisfaction for our colleagues.

The programme aims to:

- Enable every colleague to understand the Trust strategy and be clear on what their role is,
- Clarify priorities, and stop doing the things that don't add value
- Empower everyone to lead improvements in their own area
- Create an environment where everyone feels valued and deliver their best.

At the beginning of February our divisional management teams started their 5-month training and coaching programme, with four front line teams due to start their training in March.

This is a long-term programme that will be reaching every member of staff over the next few years.

2.5 Cathedral service

On 22nd March the Trust and Salisbury Cathedral are holding a special Evensong service to reflect on the past 2 years. All NHS staff, carers and the community are invited to attend what should be a very special event with music, poetry and new readings. I am grateful to Dave Roberts and our chaplains who have supported us to work with the Cathedral planning and delivering what I am sure will be a great event.

2.6 COVID reflections for colleagues

I am pleased to report that the innovative poetry project at the Trust now published as a collection *My Name is Mercy* has been getting rave reviews and is available at the League of Friends shop. And secondly that the Stars Appeal fundraiser Walk for Wards is back – it is great to have some level of normality returning.

2.7 Five Star Food Hygiene Award

I know the Board would like to know that following a recent Environmental Health Inspection of our food premises, we achieved a 5-star rating. I am sure the Board would join me in congratulating everyone involved in this tremendous achievement.

3.0 Our Partnerships

3.1 BSW Acute Hospital Alliance

Our work with our secondary care partners in the BSW Acute Hospital Alliance continues to make positive progress. The Board will be familiar with the key programmes and I have included the last detailed update that went to the AHA executive group at appendix 3 for further

information. This gives a high-level summary position of the work and the early thinking in respect of the vision for the newly formed AHA committee in common which is made up of the 3 Chairs and the 3 CEOs.

As you will see from the highlight reports many of our leaders from SFT are involved in AHA activities which will continue to play a key role in our overall sustainability and transformation of services.

Going forward we are working on producing a consistent AHA report for the 3 Boards.

3.2 BSW ICS partnership

BSW executive and partnership groups have taken place over the last 2 weeks. I and the Chairman currently provide representation from our Board into these forums. The activities are multiple and broad in their nature spanning the following areas:

- Transformation work streams for :
- Ageing Well
- Mental Health
- Elective Care
- Urgent Care and Flow
- Digital
- ICS estates
- Maternity
- Learning Disability and Autism

The partnership board received updates from all the programmes and information of current work to determine what will be the ICS priorities for 22/23.

The Board will want to note that as part of the work for urgent care there is a critical piece of work re out of hospital capacity for 22/23 progressing. This is important to us as it relates to both hospital admission avoidance and discharge both of which we need to see a significant improvement in to secure our elective recovery for next year. I am concerned as over the course of the last year we have benefitted from £15m of hospital discharge programme funding as part of the NHS's wider support package to the pandemic which come to an end in March 2022.

3.3 BSW Care Model

The BSW Partnership Board received a report from the public engagement work on Shaping a Healthier Future which is the ICS's strategy for a redesigned care model to support local communities. I enclose the report at appendix 4 for Board members awareness.
We are due to spend some time in a future Board development session about our role in the new ICS landscape and the Board may want to receive an update as part of this session on the emerging BSW Care Model which this engagement report relates too.

3.4 Wiltshire Place Based Integrated Care Alliance

I continue to play an active role in the leadership of the above. The current priority for the leadership alliance is on agreeing the future arrangements for placed based leadership and governance across BSW ICS. The DOH released a recent white paper on the 9th February on health and social care integration. The paper sets out some of the ways place based health and care systems will draw upon resources and skills across the NHS and local government to better meet the needs of communities reduce waiting lists and help level up health care across the country.

It is essential we ensure our local place based arrangements in Wiltshire are designed and implemented in a way that enables these priorities. I have had an initial joint discussion with the ICS Designate CEO and the CEO of Wiltshire Council and will continue to influence this via the Wiltshire ICA in preparation for changes in July 2022.
I will share any material discussions and agreements with the Board.

3.5 Joint work with Wiltshire Council

I am in discussion with the CEO of council re the challenges we are experiencing in the supply of domiciliary and home care for our local communities which is giving rise to a significant increase in the number of people unable to be discharged from our hospital. The council have a statutory responsibility for commissioning these services as well as having developed a new in-house service this year in an effort to increase supply.

It is clear that there is more to be done and our day to day operational tactical responses are not sufficient to make significant improvements. Board members are aware of the ongoing impacts of this in the hospital and will know we need to secure a stepped change into 22/23.

The council CEO is receptive to exploring how we can work together on a strategic response to this and I and the Chief Finance Officer will progress this in the coming weeks. There are a number of different examples of this emerging across the country including acute hospitals setting up their own domiciliary care agencies. I am keen wherever feasible that we do something in partnership with the local authority and will report back to the Board in due course.

SFT Spinal Injury Services- Risks impacting service provision

This high level risk assessment has been considered due to a significant increase in the inter provider waiter times for people with spinal cord injury to get access to the provision. The average number of people waiting to come into the Spinal Unit from other hospitals is 4-6 at one time with a waiting time of 1-2 weeks. The current number of people waiting is 22 the longest waiter goes back to November and several of these people have waited since December. The usual run rate is to admit x 2 people a week into the unit to manage the demand and keep the waits at an acceptable level.
The specialist commissioners have flagged their increased concern in the failure to meet the service specifications and have stated they consider there is now a much greater risk of harm to those waiting. They have asked for a plan to address the situation which reopens the service and returns the volume of people waiting for admission and the length of individual waits to an acceptable level.

The root causes:

1) Increased numbers of people with NCTR resulting in all available surge and super surge capacity being utilised on a consistent basis since November. This includes patients with NCTR in the spinal unit.
2) Use of a spinal injury gym as in extremis non clinical capacity to support day to day flow as all other Trust alternatives exhausted.
3) Outbreak of COVID in the Spinal Injury Unit.

The potential increased risks to those individuals not able to access this specialist care waiting in the referring hospitals includes:

- Suboptimal bowel and bladder care with increased risks of long terms physiological consequences and avoidable complications for e.g. bladder injury , renal stones
- Significant risks of developing pressure damage due to sub optimal turning and placement in non-specialist settings (this is equipment and skills related)
- Risk of missing the optimal window for rehabilitation for people with life changing injuries – physical, psychological and emotional impacts
- Increased risks of reduced cardiovascular fitness, muscle weakness and bone density due to deconditioning
- Increased risk of long term mental health impacts due lack of appropriate and specialist psychological support
- Lack of access to the gym for those patients on the unit is impacting the quantity and quality of rehabilitation offered and has stopped the area being used to support routine rapid assessments for spinal injury patients who are referred as an outpatient for this purpose.
- From an organisational perspective there is a reputational risk as we are not able to meet the fundamental requirements of the service.

The ask from SFT to BSW Gold is:

1) System awareness of acknowledgement of the issues detailed
2) Further support to reduce the numbers of people with NCTR in the hospital to be able to use all 39 beds for Spinal Injury patients and to stop using the Spinal Gym as in extremis non-clinical capacity

Stacey Hunter

CEO SFT

23/2/2022

To: NHS Trust and Foundation Trust Chief Executives

cc. Trust Chairs and Directors of Nursing
ICS, CCG, LMS Leaders,
Regional Directors,
Regional Chief Nurses,
Regional Chief Midwives,
and Regional Obstetricians

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

25 January 2022

Dear colleagues,

Ockenden review of maternity services – one year on

Thank you for all your efforts in response to the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust published in December 2020, and for your continued focus on the Immediate and Essential Actions (IEAs) despite the sustained pressure on your services throughout the pandemic. As well as ensuring progress continues, we need to prepare for the publication of further reports into maternity services during 2022.

The national response to the Ockenden report included a £95.6M investment into maternity services across England including funding for:

- 1200 additional midwifery roles,
- 100 wte equivalent consultant obstetricians,
- backfill for MDT training
- International recruitment programme for midwives
- Support to the recruitment and retention of maternity support workers

In our letter of 14 December 2020, we asked you to use the Assurance Assessment Tool, which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report, to support a discussion at your trust public Board. One year on, we are asking that you again discuss progress at your public Board before the end of March 2022.

We expect the discussion to cover:

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance,
- Maternity services workforce plans,

Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore you should ensure progress is shared and discussed with your LMS and ICS. Progress must also be reported to your regional maternity team by 15 April 2022.

As you will no doubt agree, women and families using our maternity services deserve the best of NHS care. We recognise the huge efforts being made across the system and thank you for your continued commitment and support in driving the improvements required.

Yours faithfully

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer, England
NHS England and NHS Improvement

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

BSW Acute Hospital Alliance Executive Meeting

25th February 2022

BI/ AW/ NC

Draft Programme Executive Agenda for 25th February

Agenda Item	Title	Resource	Owner	Time
1	**Welcome, Introductions & Apologies [PC - DM, MW, AL]** - Declarations of interest - Terms of Reference *[Action: Appoint Deputies]*	Paper to note	CCB	5 mins
2	**Minutes/ Actions/ Decisions/ Risks** - Actions - Risks - Programme & Project Prioritisation Approach *[Action: Appoint lead]*	Slides 3-5	CCB & BI	5 mins
3	**CIC Ambition and Core Projects List [17th February]** - Programme Executive & leads role/ next steps	Slides 6-9	CCB, & KM, SH, BI	5 mins
4	**AHA Corporate Stream** - **EPR** (OBC, Procurement, FBC) - **Finance** (SFIs); **Procurement** (to be added); AHA **Capital Priorities** - Estates Collaboration Opportunities [No report in February] - Legal workstream - HR / People Workstream - Robotic Process Automation	Slides 10-20	BM, DK, SW, LW - Na - BI BI/ AW CT	30 mins
5	**AHA Clinical Stream** - Clinical Strategy (Narrative, Summit, Resource) - Dermatology - Ophthalmology	Slides 21-29	JW/BM	20 mins
6	**AHA Programme Resource**	Slide 30-32	BI	5 mins
7	**AHA Communications**	Slide 33	BI/TE	5 mins
8	**AOB**		All	5 mins
9	**Next meeting: 25th March 2022**			

2.0 AHA Programme Executive Actions Log

Ref	Date	Meeting/Project	Action	Responsible	Completion Date	Progress/update	Status
CIC1	30.07.21	Programme Board	Recruit Clinical Transformation leads: Share JD with GWH team.	BM	07.08.21	NB. generic person spec had been created. UP to 4 PAs Recruitment completed in SFT and GWH; underway in RUH – interview early March.	Ongoing
CIC3	17.12.21	Committees in Common	MOU to be circulated for signature	BI	17.02.22	Complete. MOU signed by three CEOs.	CIC/ Exec
CIC4	17.12.21	Committees in Common	Decision. Nomination of SRO as BSW ICB Partner Member proposed. [NB formal		17.02.22	Formal nomination timeline to be confirmed by ICS team. Delayed owing to legislative timetable; likely to be required in April.	CIC/ Exec
CIC5	17.12.21	Committees in Common	Separate Programme Executive and CIC business fully. Agree Format of Papers including reports to CIC	BI.CCB.LC	10.02.22	To discuss and agree.	CIC
CIC 6	17.12.21	Prog Exec	Ophthalmology programme. Programme Executive to support leads to overcome blockages and provider oversight going forward	CCB	28.02.22	Funding for CUES secured. PA for clinical lead confirmed. Clinical pathway work progressing.	Programme Executive
CIC 7	17.12.21	Prog Exec	Ophthalmology programme. Matt Wakefield to contact KM and JW re GWH engagement	MW	28.02.22	Update tbc	Programme Executive
CIC 8	17.12.21	Prog Exec	Clinical Strategy. Action 1: Core project team to ensure tertiary relationships form part of the Clinical Strategy development. Action 2: Ensure Clinical Strategy connects/is grounded in BSW Care Model work.	BI, GU	28.02.22	Action 1: Underway – reflected in latest draft Action 2: Care Model to be considered by BSW Partnership on 25th February. Team will continue to reflect in AHA Clinical strategy work.	Programme Executive
CIC 9	17.12.21	Prog Exec	RPA. GWH team to proceed with further development of PID and business case and establish team. Project to be managed by Programme Executive.	CT.	28.02.22	Team created. On 28.02 Programme Executive agenda.	Programme Executive

AHA Risk Register

AHA Programme risks to be refreshed for the next Executive meeting planned for 25th March, informed by project SROs.

Risk / Issue Ref	Workstream	Risk / Issue	Date risk entered on register	Owner	Likelihood	Impact	Risk score	Target score	Treatment	Updates	Historic Risk Score
AHA R1	PMO	Resource (People): there is a risk of not having sufficient core team resource to assist in the development of the collaboration programme. Not having the sufficient resource would mean not being able to participate in the full range of discussions and projects that are required to develop collaboration.	17/11/2021	Ben Irvine	3	3	9	3	Additional PM resource in AW and NC. GU assisting with the development of the clinical strategy. Recruitment underway for a Programme manager.		Oct: 9 Nov: Dec: Jan:
AHA R2	PMO	Resource: there is a risk of not being able to access the required subject matter experts to contribute effectively to the development of the transformation programmes. This would lead to a lack of buy in with key stakeholders and essential clinical and non-clinical expertise and input.	06/09/2021	Ben Irvine	3	4	12	8	Raising the difficulty of organising meetings at the programme board. Clinical transformation leads recruitment taking place. Defining roles and responsibilities across the ICS.		Oct: 12 Nov: Dec: Jan:
AHA R3	PMO	Communication: there is a risk of a negative perception of the AHA collaboration due to the programme being viewed as exclusionary towards organisations which aren't acute trusts. This may limit the engagement in AHA activities thus limiting the impact of programmes and projects.	17/11/2021	Ben Irvine/Comms Lead	3	4	12	4	Communication strategy in place which is being implemented. Sharing the programme plan to show the link between projects and long term development opportunities. Develop meetings with communications leads to build the links across the ICS.		Oct: 12 Nov: Dec: Jan:
AHA R4	Corporate	EPR: This register does not include the full list of EPR risk which are stored separately on an EPR Risk Register. On completion of the new K drive structure a link can be added here.		David Kwo			0				Oct: Nov: Dec: Jan:
AHA R5	PMO	Operations: there is a risk that other system priorities, including winter operational priorities, may take greater precedence stakeholders instead of the AHA programme. This would result in a delay of programme delivery.	08/11/2021	Workstream leads	3	3	9	6	Programme plan, building a view of the priorities that can be communicated to the wider audience. Highlighting benefits of ICS development.		Oct: 9 Nov: Dec: Jan:
AHA R6	PMO	Resource (funding): there is a risk of a lack of investment due to low revenue and capital. This will mean a shortfall stopping	17/11/2021	Finance Directors			0		Clear process to accessing funds.		Oct: 9 Nov: Dec:

Risks in AHA & BSW

1. ***Capacity: Balance between short-medium & long-term priorities***
2. ***Leadership Transition in BSW. Transition of CCG*** and establishment of new ICS leadership team creates destabilising effect.
3. **Access to EPR Funding.** CIC support will be required over next 12 months.
4. **Shared understanding of priorities**. CIC & Exec to confirm and communicate effectively.

AHA Programme Prioritisation Matrix Scorecard [*To be used in 2022-23 once new working pattern established*]

Programme must balance project worklist and resource availability.

Periodic review of prioritisation to take place at Executive Meeting. Process akin to those used internally in 3 Trusts.

Next step: Lead required to support, provide challenge. Nomination/s sought.

		Strategy	Resource usage	Risks	Benefits realisation	Finance	Schedule	Comments
	Current Strategic Priorities	Raw Scores						Actions and Decisions
1	Top Projects to discuss	0	0	0	0	0	0	
2	Top Projects to discuss	0	0	0	0	0	0	
3	Top Projects to discuss	0	0	0	0	0	0	
4	Top Projects to discuss	0	0	0	0	0	0	
5	Top Projects to discuss	0	0	0	0	0	0	
Outcome of Assessment								
Raw Score Total		0	0	0	0	0	0	0
Average Raw Score								
Weighted Score								
Investment Ranking								

3. Committees in Common: Strategic View

Readout from 18th February Meeting

3. Strategic View. Acute Alliance CIC Discussion Summary

1. **Part One. Defining our Ambition**
    1. What & Why. Equity, Sustainability, Improvement. Role in BSW.

2. **Part Two: How we will achieve that Ambition - Our Core Projects**
    1. Five core areas would be most enabling, i.e where CIC might have strategic and collective impact.

        1. **Transparent financial base line** across AHA parties. Demonstrable improvement in our individual and collective Model Hospital and other benchmarking scores demonstrating improved efficiency/productivity and sustainability.
        2. Transparent **staff modelling across AHA** parties - System approach to staffing will help address risk.
        3. Delivery of a **secondary care clinical strategy for BSW**
        4. **Capital**. Delivery of a **single capital strategy**
        5. Delivery of the **Single EPR role out** and effective integration with partners.

        1. NB **list is not to the exclusion of other work**, but rather would be the *focus of CIC interest* for the next period.
        2. Efficiency and productivity information from **benchmarking** should inform the AHA's work.
        3. The need for consistency of interpretation and assumptions regarding this list was raised. This would be addressed in the CIC away day.
        4. CIC noted importance of supporting Boards with common approach on the role of collaboration and ICS.

1. **Part three: How we use our time in CIC**
    1. Away day being planned; Aim to define strategy, approach and focus.

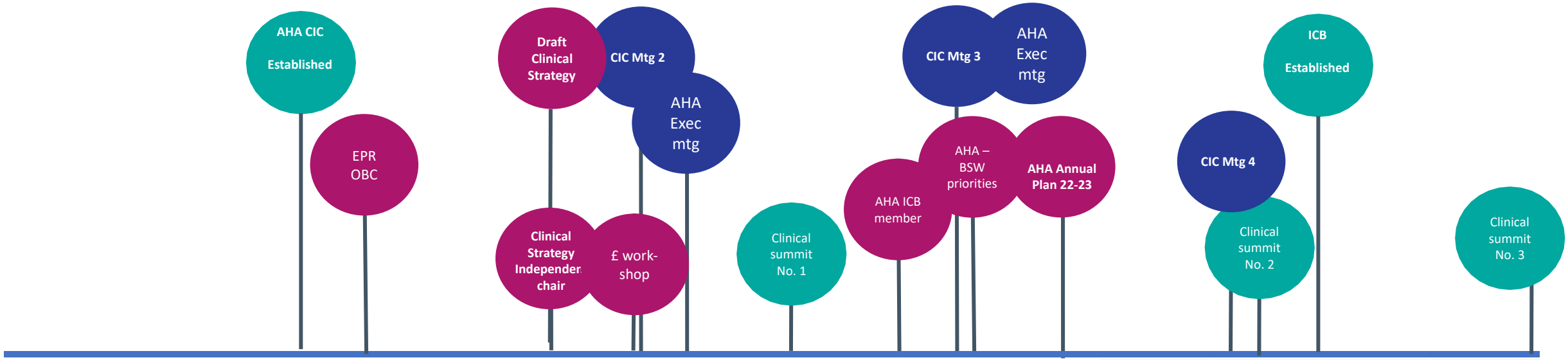
3.1 AHA in BSW - Programme Next Steps

1. Programme Executive meets monthly – focus on delivery**. Short-term focus by Execs on defining art-of-possible and suggested assumptions in relation to Five Core Projects**; these would be key inputs for CIC discussions.
2. CIC defines **strategy for AHA** (Mid-April). Away day planned c 8th April.
3. Executive functional group meetings. [largely in place already/ emerging…to support]
4. **Define detail of relationship between AHA and BSW** – including agreed areas of focus and reporting arrangements. (end April)
5. Programme Executive **refresh programme for 2022-2023-2024** – detail lead provider planning and assumptions. (March - April)
6. Assume continued strong **connection with BSW Planning Round** through planning and strategy teams [continue to March/ April for 2022-23; same approach for BSW ICS 5-year strategy.
7. **Assume Trusts work jointly** through Elective Care Board **on Elective Recovery**

- Milestones:
- Key meetings:
- Key events:

- Completed:
- On schedule:
- Behind schedule:

AHA Collaboration Programme at a Glance [*to complete detail with Executive leads – March - April*]



- CIC chair and SRO confirmed
- ICB Board membership engagement with AHA

- First AHA CIC
- Agree AHA ICB Board Partner Member nomination process
- *Approve Clinical Strategy development plan*
- *Approve EPR OBC*

- CIC Away Day
- Establish AHA Programme Executive team
- Scoping of 2022-23 programme
- Clinical Summit; Clinical Stocktake
- *Approve RPA PID*
- *Region Approve EPR OBC*

- ICB Board members Confirmed
- ***Detailed AHA Annual Plan drafted and approved***
- ***Approve AHA Clinical Strategy***

- National team approval of EPR OBC [April]

- **ICB Launch**
- **ICP establishment – date TBC**

4. Corporate Workstream

- Corporate Workstream Summary
  - EPR (OBC, Procurement, FBC)
  - Finance (SFIs), Procurement and AHA Capital Priorities [*report pending*]
  - Estates Collaboration Opportunities [*report pending*]
  - Legal Workstream
  - HR/People Workstream
  - Robotic Process Automation Workstream

Corporate Workstream Summary

Phase 1: Discovery, Initiation & mobilisation

Phase 2: Work in Progress

Phase 3: Closure, Evaluation & Analysis

G1 Queue

G2 Feasibility

G3 Analysis

G4 Redesign

G5 Implementation and success

G6 Continuous improvement

Corporate Workstreams

- BI
- Library
- Estates and Facilities
- People
- RPA
- Legal
- EPR
- QI (GWH)
- QI (SFT)
- QI (RUH)
- Procurement
- Finance (multiple projects)

EPR Highlight Report

EPR Programme - February 2022 | Lead: David Kwo, Bernie Marden | Gateway: 2/3 | Overall Status

Summary: The EPR programme is the development of an integrated Electronic Patient Record system across the AHA. The EPR Programme is on track with central approval of the Outline Business Case (OBC).

Key Achievements

· OBC: The OBC was approved by SW Region on 21 Feb and has now been referred to the national NHSE/I and DHSC team for the Second Stage Review.
· Procurement: Workshops with Trust leads are being scheduled to raise awareness of, and engagement in, the next stage of EPR procurement.
· Governance: The Clinical Design Authority, co-chaired by Peter Collins and Jon Westbrook, held its inaugural meeting on 17.02.22. The Non-Clinical Design Authority chair has been appointed (E Provins).

Pending Decisions:

· Procurement: At the end of March, the EPR Programme Board and AHA Programme Executive will select the market engagement approach for the procurement.
· Budget: At the end of March, the EPR Programme Board and AHA Programme Executive will review the EPR Programme's budget request for next financial year 2022-2023.

Dependencies:

· The Programme key dependencies are: (1) Central approval of the OBC by November 2022; (b) Trust Board approvals of the FBC by November 2022; and (c) Securing additional capital funding by November 2022.

Breakthrough Objectives:

· N/A

Benefits Realisation:

· EPR benefits are not expected to begin to be realised until after EPR go-lives in 2024 and 2025.

Top Risks:

Risk No	Risk Owner	Risk Heading	Risk Description	Original Risk	Current Risk	Mitigation/Approach
R002	D. Kwo	Insufficient central funding available to support programme	The programme is dependant on receiving (a) Unified Tech Fund EPR and other EPR related funding from NHSX; and (b) additional capital funds for the BSW ICS during 2023-26.	15	15	(a) Work closely with regional and national NHSI/ teams to ensure OBC and FBC are fit for purpose. (b) CEOs/Chairs lobby central agencies and local politicians to ensure BSW attracts more capital.

Project Progress

Progress Against Plan

Milestones	Due Date	Comments
OBC Review	21/02/2022	OBC due to be approved by SW Region - completed: 1
Procurement	23/02/2022	Tender documentation due to be approved - on hold pending procurement workshops: -
CDA Launch	17/02/2022	Clinical Design Authority inaugural meeting scheduled - completed: 1
Budget	21/02/2022	EPR Programme Budget Statement and Out-Turn for 2021-2022 due - completed: 1
Risk Log	21/02/2022	Risk Log update due - completed: 1
FBC Plan	21/02/2022	First draft plan for FBC development due - completed: 1

EPR – Further slides to be added – D Kwo

Finance Slides – Further slides to be added – Simon Wade

Procurement Highlight Report

Procurement - February

Leads: Rob Webb | Gateway: Implementation and Success (S5) | Overall Status

The Procurement programme of work is focused on the closer integration of procurement teams in the AHA to drive improvement of efficiency and delivery of services.

Key Achievements :

. Successful delivery of 2021-22 programme. [£2.7m]

- Focus now on building programme for 2022-23 – see next slide. [£4.5m]

· Created new relevant groups, establishment of three core workstreams (Management of Expiring Products and Waste, Catalogue and Contract Management and Management of substitutions, alternative products and new item requests).

· Agreed standardised processes for requests across the three trusts, this process has been mapped out and shared across the procurement.

Pending decisions:

· Approval of year end position and plan for 2022-23.

Dependencies:

·Dependencies to be confirmed. Note Covid impact.

Breakthrough Objectives:

· Breakthrough objectives to be defined.

Benefits Realisation:

· Benefits realisation – see next slide for details of delivery.

Top Risks

Risk No	Risk Owner	Risk Heading	Risk Description	Impact	Rating	Mitigation/Approach
R001	Procurement	Sourcing	40% vacancy in sourcing and contracts teams (12 in total)	TBC	Red	A recruitment exercise is currently taking place to address this risk
R002	Procurement	Sourcing	Supply issues, TIF, Capital, work is taking priority.	TBC	Amber	

Project Progress

Progress against Plan

Milestones	Date completed	Comments
2021-22 delivery	Q4 21-22	Over-delivery – refer next slide.
Single Team in place	Q3 21-22	Single team in place. Site-by-site issues being identified and worked through

* a more detailed submission will be shared at the March meeting

Legal Highlight Report

Legal - February | Leads: TBC | Gateway: **Feasibility (G2)** | Overall Status

The legal programme has been created in response to resilience concerns raised around Legal Services in 2021. The project team is scoping the potential areas for collaboration. Opportunities have been identified for Clinical Legal Services to explore cross department development, Other potential areas of collaboration, as significant users of external legal support, include Estates, Commercial and HR.

Key Achievements:

· Workshops have identified six themes for developing the possible scope of work: 1. Complimentary skillsets, 2. In-house approach; reduce external expenditure, 3. Resilience, 4. Legal Services provided at scale, 5. Purchasing outsourced skills at scale, 6. Learning from GIRFT and NHS Resolution.

· Trusts have completed a National benchmarking exercise on Legal Services and reviewed the key findings at the last group workshop. Areas for further discussion include Healthcare law, Commercial, Employment and Estates. There are opportunities to review external expenditure and how this could be structured in the future to offer AHA Trusts better value for money for legal services - particularly in Commercial, Contractual requirements and Employment legal advice.

- In the healthcare law area, potential collaboration will be explored in training, mock inquests and sharing best practice.

· The benchmarking exercise and workshops have highlighted the potential for a business case for investment in internal resources, particularly in the area of employment law. We intend to develop this and discuss with the wider group engagement group.

Pending Decisions:

· Confirmation of scope / priorities for healthcare law team and HR, estates and procurement teams.

·

Dependencies:

· Expanding the project group to include HR, estates and procurement to understand current utilisation of external legal services.

Breakthrough Objectives:

· Resilience and financial benefits will be defined once the scope has been confirmed.

Benefits Realisation:

· To be defined once the scope has been confirmed.

Top Risks: (No risks currently, when the programme of work is outlined, risks will be added)

Project Progress

Progress against Plan

Milestones	Date completed	Comments
Workshop One	24/11/2022	
Workshop Two	16/12/2022	
National Benchmarking	28/01/2022	
Workshop Three	01/02/2022	

Robotic Process Automation Highlight Report

Robotic Process Automation - February Lead: Peter Coutts / Claire Thompson Gateway: Feasibility **(G2)** Overall Status

AHA RPA is a project developing the opportunity for Robot process automation roll out across the three Acutes. The platform is in place at GWH, this is looking at the potential opportunity to expand on this and spread benefits to RUH and SFT.

Key Achievements:

· Over the last 18 months there have been a number of key achievements for GWH regarding Robotic Process Automation. The trust has mainly focussed on Outpatient automation (bookings and referral management) but also supports Finance and Pharmacy. A Project Implementation Document has been communicated with the aspiration of creating a centre of excellence and implementing a hub and spoke model to support RPA rollout across the AHA. To date the PID has been reviewed and a steering group formed. TIF monies have been secured and will be utilised to seed RPA in SFT and RUH. The first of these meetings took place on February 7th.

Pending Decisions:

· There are no pending decisions for the AHA. Each Trust is currently formulating business cases to identify funding options for the RPA teams.

Dependencies:

· IT support for integration within each Domain.
· Recruitment processes within Acutes to resource locally.
· HR/Recruitment

Breakthrough Objectives:

· No breakthrough objectives have been defined at this time.

Benefits Realisation:

· The benefits realisation could be developed around the experiences learnt from the GWH project, as well as priorities defined by RUH and SFT. Benefits realised at GWH include efficiency benefits in Outpatients processes, with Admin bookings being automated saving 9.79 WTE of admin time to Nov 21.

Top Risks

Risk No	Risk Owner	Risk Heading	Risk Description	Impact	Rating	Mitigation/Approach

Project Progress

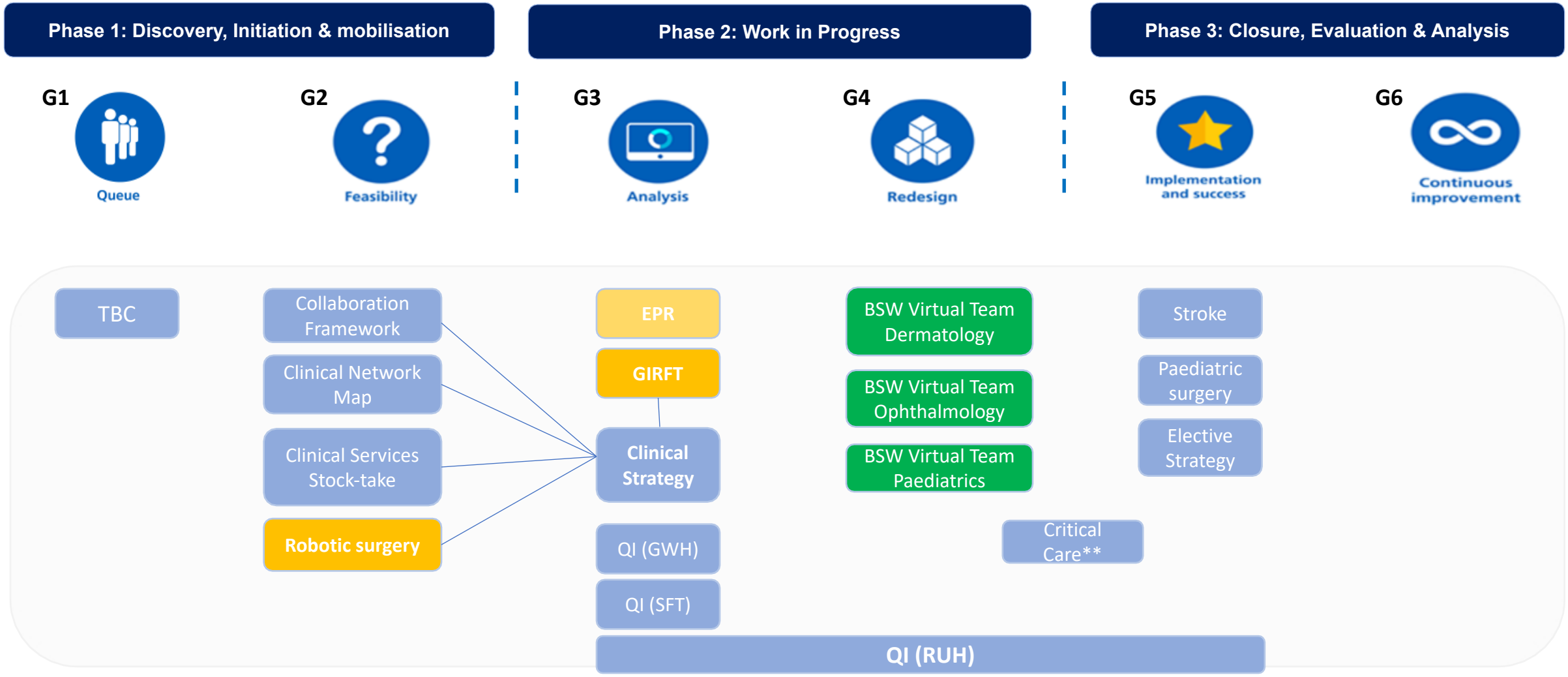
Progress against Plan

Milestones	Date completed	Comments
Establish AHA steering Group	07/02/20222	AHA membership to be identified, meetings fortnightly during early establishment
Approve PID	Feb/ March 2022	PID due for approval
Procure platforms		
Establish spoke teams		
Establish working Group		

5. Clinical Workstream

- Clinical Workstream Summary
  - Clinical Strategy Development
  - Dermatology Workstream
  - Ophthalmology Workstream

3.3.1 Clinical Workstream Summary



**NB Critical Care Mutual Aid Arrangements agreed 2020-21; COOs/ MDs standing up again.

Clinical Strategy Highlight Report

Clinical Strategy - February

Leads: Medical Directors, PC, BM, JW
Prg Mgr: Geoff Underwood

Gateway: G3 (Analysis)

Overall Status

Developing the first Clinical Strategy to drive the work of the BSW Acute Hospital Alliance.

Key Achievements:

· AHA Clinical Strategy drafted and going through a process of updates in discussion with Medical Directors and the AHA Working Group.
· Date for first AHA Clinical Summit confirmed - 18th March 2022.
· We have identified an external clinical adviser, have been through an informal appointment process and are now seeking to formalise an arrangement to secure that external guidance/support for the AHA work.
· We have launched a high level clinical stocktake of acute services in BSW. Data gathering will be completed in early March, to inform the Summit on 18th March.

Pending Decisions:

· None for this reporting period

Dependencies:

· We have mapped a dependency to the development of the BSW Health and Care Model and have used the model as the basis for the AHA Clinical Strategy.

Breakthrough Objectives:

Benefits Realisation:

· Defining the benefits of this work will be part of the discussion at the Summit on 18th March.
· Actions following the Summit are likely to include benefits definition and baselining.

Top Risks

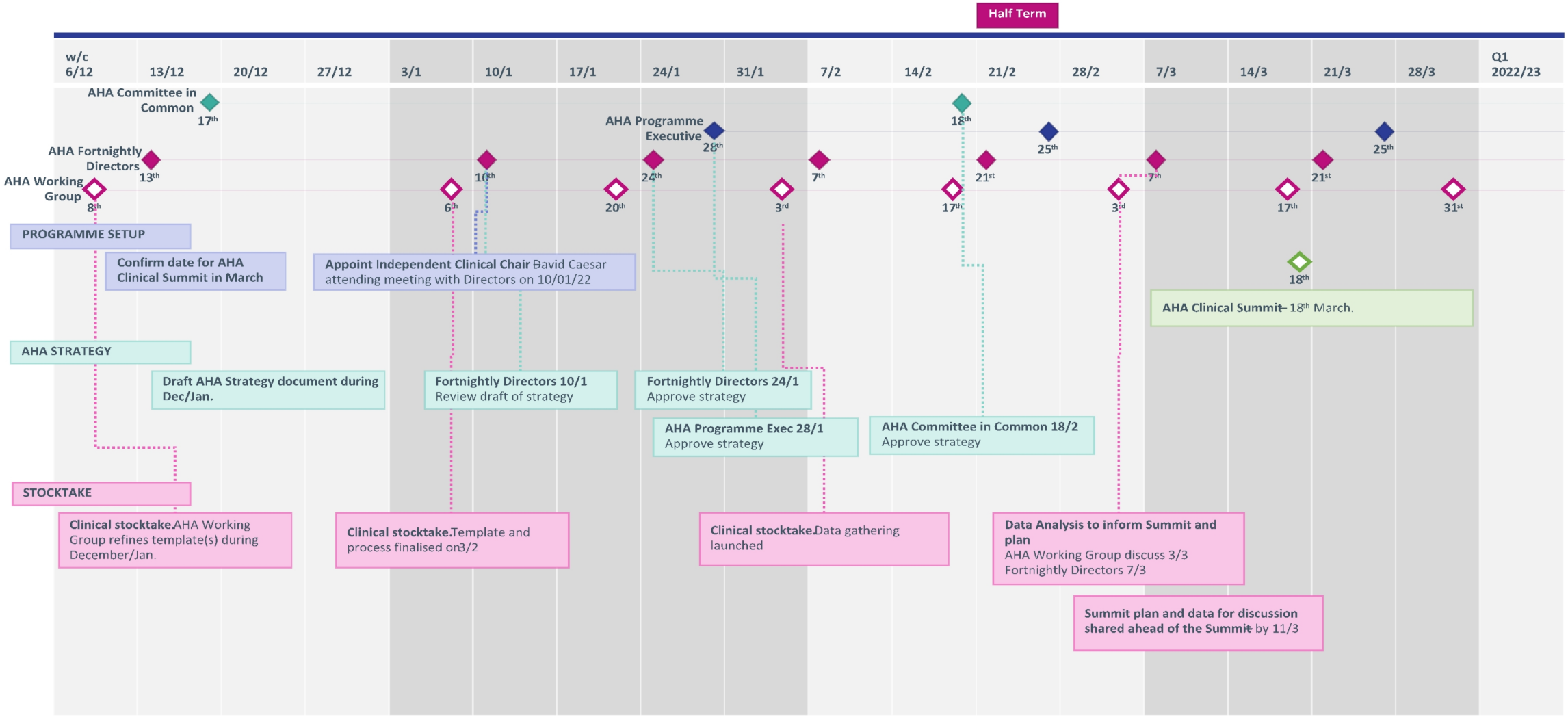
Risk No	Risk Owner	Risk Heading	Risk Description	Impact	Rating	Mitigation/Approach
1	Ben Irvine	Lack of senior ownership	There is a risk that executives and senior leaders do not develop strong ownership of this work and do not drive and support the work among other priorities.	Work may be delayed or not completed	12	- Fortnightly meetings with Medical Directors and AHA Working Group - Good engagement at AHA Committee In Common - Summit events intended to develop and strengthen ownership - AHA work aligned with Care Model and other priorities so as to compliment rather than compete with other work
2	Ben Irvine	Lack of clinical/management capacity to deliver	There is a risk that clinicians and managers may not have enough capacity to engage with this work and deliver it.	Work may be delayed or not completed	12	- Regular discussion at AHA Working Group on timing of work, requirements of busy clinicians/managers - to ensure that project work is as realistic and deliverable as possible. - Support from senior leaders e.g. MDs helps to prioritise this work
3	Ben Irvine	Lack of project management resource	There is a risk that the AHA programme lacks sufficient project management resource to drive it forward.	Work may be delayed or not completed	8	- Support currently provided by SCW CSU. Support is available on an ongoing basis.

Clinical Strategy

- Draft developed with AHA Working Group and Medical Directors
- Built around the BSW Health and Care Model – which broadens scope to include projects with the wider BSW system over time
- External clinical adviser identified and has engaged with Medical Directors and strategy development already
- Immediate focus: clinical stocktake to inform Summit on 18/3

- *MD's approaching as purely clinically-driven exercise.*

Clinical Strategy Plan



Dermatology Highlight Report (1/2)

Dermatology- February

Leads: Jon Westbrook,
Prg Mgr: Andy Jennings

Gateway: **Redesign (G4)**

Overall Status

The Dermatology project is focused on improving the delivery and efficiency of services in BSW and addressing the covid-19 backlog. This includes a focus on telederm advice and guidance.

Key Achievements:

· B&NES high risk BCC service procurement underway - Contract Award Recommendation Report considered by At Scale Commissioning Committee 17 Feb – recommendation to approve contact award to CCG Governing Body 17th March.
· Telederm mutual aid RUH for Salisbury - has been in place since November '21
· Transition to cinapsis - completed, Nov '21
· Ongoing GP education events - telederm and lesion recognition - 21/22 programme completed, 22/23 dates agreed

Pending Decisions:

· Confirm whether dermatology remains an AHA priority workstream; there are no significant outstanding actions.

Dependencies:

· Clinical strategy work. Opportunity to spread approach adopted by Dermatology virtual team.

Breakthrough Objectives:

· Reduced RTT / improved 18ww performance / reduction in long waiters - achievement impacted by Covid
· Address backlog that has occurred due to covid 19 - achievement impacted by workforce pressures and budget constraints (the latter preventing additional work going to local independent sector)
· Improved 2ww performance - impacted by Covid and workforce pressures
· Patients referred to right place first time - improved due to telederm Advice & Guidance
· Care closer to home - improved due to telederm Advice & Guidance

Benefits Realisation:

· Continued high level of telederm requests resulting in “no referral required”/higher proportion of those referred, found to have skin cancer
· Mutual aid RUH/SFT requirement - live
· Transition to Cinapsis appears to have been a success; working on improving uptake in Salisbury, Swindon, areas
· Some issues with volume of 2ww derm and ability of trusts to see/treat within cancer timescales; being addressed locally, and subject of Cancer Alliance focus
· Volume of derm 2ww treated, has now returned to, and exceeds, pre-covid levels (Mar 20-Sep 21 v pre-covid baseline)
· GIRFT recommendations have been reviewed to ensure completion, and learning has been shared between trusts

Dermatology Highlight Report (2/2)

Dermatology- February

Leads: Jon Westbrook,
Prg Mgr: Andy Jennings

Gateway: **Redesign (G4)**

Overall Status

Top Risks

Risk No	Risk Owner	Risk Heading	Risk Description	Impact	Rating	Mitigation / Approach
1	?	Capacity/funding	There is a risk that, continued pressure in dermatology cannot be addressed, due to absence of any agreement to provide additional funding (which would enable increased use of available local independent sector capacity)	Action to address current and ongoing pressures is not possible = it will not be possible to recover performance impact = patients will have to continue to wait longer than might otherwise be the case	Likelihood = 5 Impact = 2 Total = 10	Either - accept the risk will (continue to) be realised and therefore this will be an ongoing issue, or a decision is needed on making additional funding available, to pay for additional activity to take place in the independent sector

Project Progress

Progress against Plan

Milestones	Target Date	RAG
1. Establish workstream	Aug-20	Complete
2. Co-design strategy, finalise implementation plan and detailed milestones, metrics	Jan-21	Complete
3. Telederm roll-out completed	Apr-21	Complete
4. B&NES high risk BCC service tendered	Jul-21	On track
5. Implementation complete	By Mar 22	Ongoing

Ophthalmology Highlight Report (1/2)

Ophthalmology - February

Leads: Peter Collins, Matt Wakefield (Clinical), Lauraine Jones (Managerial)

Gateway: **Redesign (G4)**

Overall Status

The Ophthalmology project is focused on improving the delivery and efficiency of eye services and developing a long term strategy for services and pathways.

Key Achievements

· **Community Urgent Eyecare Service: T**he At Scale Commissioning Committee agreed via quorate for CUES to continue for 12mths using ERF to support the development of eyecare hubs. Application for a Tender Waiver has been agreed with final ratification by the ASCC on 17thJan.
· **Eyecare Hubs:** Planning Document for hub development underway including site locations, sub-specialities (glaucoma, Cataract), diagnostic equipment, staff resource and projected activity numbers.
· **Eye Service Strategy:** The strategy & trend/data analysis to complete by end of march
· **Improve Cataract Conversion Rates:** The pilot project to collect patient decision outcome data has been pushed back to mid February due to the staff redeployment (Covid) RMS (data collection) and cataract providers (data providers).
· **BSW cataract 'follow up' RCOpth and BCO interim guidance:** 'The local post op discharge pathway does not include commissioned post op data return to providers as per NHSE guidance. The pathway will continue whilst solutions are sought to this issue**.**
· **5 year digital road map** - Following Network discussion Jon Burwell has submitted a National Funding bid for Ophthalmic image sharing across the network, eERS and diagnostic hub hardware.
· **Clinical Lead:** Funding approved for lead role

Pending decisions:

Dependencies:

Breakthrough objectives:

Benefits Realisation:

· Clinicians work together to understand similarities and differences to improve clinical delivery / engagement continues
· Identifying the population need in relation to Eye services / informing strategy work
· Develop systems approach to manage backlog of referrals
· Address any differences highlighted by GIRFT with an aim of reducing long waits (with Cataracts as a priority area) / detailed work in progress
· Agree priorities in relation to the Eyewise work / detailed work TBA
· Agree and deliver a long term vision (strategy) for BSW Ophthalmology services and pathways moving forward inclusive of community services and an agreed way to work with the independent sector / engagement event July 21

Ophthalmology Highlight Report (2/2)

Ophthalmology - February

Leads: Peter Collins, Matt Wakefield (Clinical), Lauraine Jones (Managerial)

Gateway: **Redesign (G4)**

Overall Status

Top Risks

Risk No	Risk Owner	Risk Heading	Risk Description	Impact	Rating	Mitigation/Approach
1		Monies Identification	Monies to be identified for provision/possible procurement of eyecare hubs from April 23.			
2		Cataract Monies Movement	We will need to manage the movement of monies to support shifting Cataract follow-ups from the acute providers into community Optometry (including PIFU) to ensure collection of NOD data			

Progress against Plan

Milestones	Target Date	RAG
BSW Eye Care Strategic Plan & Development of Ophthalmology Data and Trend Analysis (Needs Assessment)	Mar-22	In Progress
Improve Cataract Conversion Rates - 2nd phase results	Dec-21	Overdue
BSW workplan agreed to address NHSE Eye Care Planning Implementation Guidance 2021-22	Mar-22	In Progress
Proposal submitted outlining provision of Community Urgent Eye Services to reduce hospital outpatient appointments	Dec-21	Completed
Develop Operational Level T&F Groups to feed into BSW Eyecare Network Group	Mar-22	In Progress

Register of Attendance – Public Board 2021/22

	8 April	6 May	8 July	9 September	4 November	13 January 2022	10 March 2022	attendance rate
Nick Marsden	✓	✓	✓	✓	✓	✓		6/6
Tania Baker	✓	✓	x	✓	✓	✓		5/6
Michael von Bertele	✓	✓	✓	✓	✓	✓		6/6
Paul Kemp	✓	✓	✓	✓	✓	✓		6/6
Paul Miller	✓	✓	✓	✓	✓	✓		6/6
Stacey Hunter	✓	✓	✓	✓	✓	✓		6/6
Lisa Thomas	✓	✓	✓	✓	✓	✓		6/6
Andy Hyett	✓	✓	✓	✓	✓	✓		6/6
Judy Dyos	✓	✓	✓	✓	✓	✓		6/6
Susan Young	✓	✓	✓					3/3
Melanie Whitfield				✓	✓	✓		3/3
Eiri Jones	✓	✓	✓	✓	✓	✓		6/6
Rakhee Aggarwal	✓	✓	✓	x	x	✓		4/6
David Buckle	✓	✓	✓	✓	✓	✓		6/6
Peter Collins	✓	x	✓	x	✓	✓		4/6

Governor Observer							
John Mangan	✓	✓					
Lucinda Herklotts			✓	✓	✓	x	

Attended - ✓

Apologies – X

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	10th March 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	22nd February 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation
Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 22nd February 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - Two deep dives were presented to the committee:
    - The first was a presentation on the review of the second phase of Covid deaths (14th June 2020 – 31st August 2021). Good assurance was provided that outcomes had improved from the first phase and that learning from the first phase review had been embedded into practice. Assurance was also provided in relation to patient and / or family involvement. Clinical teams remain focussed on further improvement with a detailed work programme in relation to recognising deterioration.
    - The second was in relation to falls and the plans for improvement as one of the breakthrough objectives in Improving Together. It was acknowledged that falls are the highest harm event (as it is nationally). The new Falls Coordinator was welcomed to the meeting and presented the detailed work that has been undertaken to understand the reasons behind this harm event. Recognising that some falls are unavoidable, areas for improvement are receiving focus. The committee asked for confirmation that the actions planned will help reduce the harms from falls. The committee will receive regular updates in relation to this.
  - The expected presentation from the spinal service had to be deferred again and the Executives were asked to ensure that this was resolved. The Chief Executive updated the committee on the escalation risk in relation to spinal services which reinforced the committees request for assurance in relation to the service.
  - Information was provided that despite clear infection prevention and control (IP&C) practices, due to the highly contagious nature of the current variant, 6 outbreaks had occurred. Daily assessments were being undertaken and positive

feedback had been received from the Clinical Commissioning Group (CCG) and Public Health England (PHE) in relation to actions to mitigate.

- A presentation was received from the Digital senior team (CIO, CCIO and CNIO) outlining how the clinical services are being supported to embrace and embed digital improvements. This was welcomed by the committee. A key risk was the ability to release time for staff to engage with the digital agenda. This information has been shared with the Chair of the People and Culture committee.
- Whilst there were no extraordinary concerns in the discussion on the IPR, concerns continue about the safety risks due to the inability to discharge in a timely way. Of particular concern is the inability to move a number of individuals who meet the no right to reside criteria to a more appropriate setting.
- Assurance was provided that the Trust continued to be licensed under the Human Tissue Authority (HTA) to undertake stem cell work and post-mortem examinations. The inspection was reported to be supportive with assistance provided in how to improve and address the required actions in relation to the more detailed standards now in place. One area for improvement related to the standard operating procedures. As this resonated with the LocSiPP and NatSiPP improvements required and discussed in the previous month's meeting, a detailed timeline would be requested from the CMO for the clinical SOP work.
- The research report was noted, once again acknowledging the excellent work being done by the Trust. The committee congratulated one of the team on achieving her PhD.
- Regular reports were received in relation to Patient Experience, Safeguarding Children and Adults. It was noted that improvements were required in relation to response times for complaints. Positively it was noted that the Trust has strong leadership in relation to safeguarding practices with a recognition star being given to an individual who had persisted in raising an issue. One area of concern related to lack of engagement with the Trust by other interagency partners. The Chief Executive offered to discuss this at system level.

In summary, a key theme in today's meeting was the impact of delay in discharge resulting in potential or actual harm.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	10 March 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	22nd February 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non-Executive Director			
Board Sponsor (presenting):	Paul Miller, Non-Executive Director			

Recommendation
To note key aspects of the Finance and Performance (F&P) Committee meeting held on the 22nd February 2022

Items for Escalation to Board
(1) Contract recommendation report – Insourcing of Clinical Support Services (Gastroenterology) – The Committee received a procurement recommendation report to award a contract for increased gastroenterology services following a mini-competition via the appropriate Shared Business Services (SBS) framework. This 12-month contract, which starts on the 1st April 2022, is for 5 consultants (an increase from the previous 4 consultant contract) and when two new Salisbury Hospital consultants start working by October 2022, the hospitals gastroenterology team will have increased to 7 consultants (5 external and 2 internal). The Committee accepted the need to increase the clinical capacity of this vital service, to improve productivity and ensure clinical sustainability. However in doing so, the Committee highlighted that the contract recommendation report should have been supported by a wider narrative (business case) that recommended the team increase from 4 consultants to 7, as this only became clear through verbal questions at the meeting. Note the question of the size of the team (and cost) going forward after 1st April 2023 is yet to be decided. Finally the Committee recommended the awarding of the contract and the decision will be put to the Trust Board meeting on the 10th March 2022.

(2) Occupational Health Outsourcing paper – the Committee received a briefing paper which provided context and background to a decision made by the Chairman and Chief Executive to award an external contract for additional occupational health support (starting 18th February 2022). Whilst the Committee fully understood and supported the vital importance of an effective occupational health service, the urgency for action and the challenges the Trust currently faces in providing an effective in-house service, it had difficulty in making a recommendation to the Trust Board on this matter. This was because the briefing paper received at the meeting on the 22nd February 2022, did not include any details about the length of the initial contract or the cost, apart from referring to the fact that a full contract is being prepared. The decision of the Committee was to note the paper and recommend that a "comprehensive document" goes to the Trust Board meeting on the 10th March 2022, to ensure an appropriate audit trial for this decision.

(3) Integrated Performance Report – The key issues to report are nearly the same as previous months (a) the hospital continues to be extremely busy (b) there are still high level of patients with no criteria to reside (an average of just under 60 during January 2022) and (c) there are challenges in meeting elective targets i.e. the number of patients waiting longer than 52 weeks increased by 12 to a total of 664 during January 2022.

(4) Financial Plan 2022/23 – The Committee received an update on progress on next year's Operational/Financial Plan. The presentation made it clear that this work was still "in progress", but the challenges of producing a balanced financial plan that also achieves next year's NHS targets are significant. The timetable is to produce a plan a draft 2022/23 plan to be submitted to NHSIE by the 17th March 2022, before producing a final plan that goes to the Trust Board on the 7th April 2022 (submitted to NHSIE by the 26th April 2022). The key issues the Board may need to form a view on are (a) to undertake more elective work and reduce waiting lists, what is the balance between extra productivity and extra staff (b) if part of the answer is extra staff, what are our plans to recruit them and what are the mitigations if we cannot recruit (c) can we set a financially balanced plan for 2022/23 and if not how far away from a balanced plan could we accept and finally (d) looking forward, 3 to 5 years, going forward how do we recover and maintain a sustainable financial plan that achieves the NHS targets?

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	10th March 2022		

Report from: (Committee Name)	People & Culture Committee		**Committee Meeting Date:**	24th Feb 22
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele; Non-Executive Director			
Board Sponsor (presenting):	Michael von Bertele; Non-Executive Director			

Recommendation

The Trust Board are asked to note the items escalated from the People and Culture Committee meeting held on Thursday 24th Februarys 2022

1. The committee spent time again reflecting on its purpose and terms of reference. The drafting of a comprehensive People Plan will take some time and will in turn lead to a better understanding of the requirement for, and purpose of, sub-committees that are needed to support delivery of the plan. It is becoming clear that there is an extra dimension to this – the requirement to ensure that the working environment is safe and that it supports and enables staff to work effectively. This was reinforced later in the meeting by presentation of a Health and Safety update that demonstrated that the risks in this domain are now being properly recognised and brought under control. An annual report will be prepared for submission to board in March.
2. The risk register was reviewed and adequate mitigation for existing risks was noted. Two new candidate risks were discussed: higher than normal levels of absence have been experienced recently, requiring almost daily management. The OH service has been severely affected by the departure of key staff and a decision was made to outsource significant elements of the service for 4 months initially. This will require careful monitoring.
3. One further issue raised concerns. The completion of staff appraisals is falling, with managers reporting that they are too busy to conduct them. This is an early warning signal, indicating that staff are genuinely too busy, but also that opportunities are being missed to conduct the meaningful conversations with staff, that are necessary at a time of increased pressure and disruption, and when we are trying to launch the Improving Together programme.
4. Finally, the committee noted that papers it is seeing are becoming more focused on delivering the assurance required that the things that should be done, are being done. It was noted, in her absence, that the new Chief People Officer, has started to make a real difference in providing the structure and clarity that the committee requires, but we acknowledged the challenge in delivering the next phase of this work, through a comprehensive People Plan, while there are still many gapped posts among her immediate deputies.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	10 March 2022		

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

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

Executive Summary:
The Trust continues to operate under significant operational pressures in flow, with average occupancy over the month of 93%, however some improvements in performance were delivered. Performance against the 4 hour Emergency access standard improved to 81.25%, the highest this has been since July 2021. For the second consecutive month the number of ambulance handovers reduced to levels not seen since May 2021. The Rapid Assessment Triage pilot is thought to have contributed towards this, with the pilot currently being evaluated. The number of Stroke patients received a CT scan within one hour improved to 54%, the highest performance since April 21, however only 21% of patients reached the Stroke Unit within 4 hours of arrival. As often seen when flow in the organization is challenging, the number of escalation bed days remain high, and the number of non-clinical single sex accommodation breaches increased to the highest level in the last 18 months with 82 occurrences affecting 29 patients. The number of patients not meeting the criteria to reside reduced to 57 (71 in M9), and whilst an improvement this remains significantly above the target of 35. In addition the number of patients in the 21 day + group has increased to the highest number seen in the last two years – the volume of additional escalation capacity opened will have impacted upon this. The impact of high rates of Covid-19 in the community continues to be felt on staffing levels, with

Infectious diseases being the highest cause of absence across all clinical directorates with the exception of Women & Newborn. Absence peaked at 5.1% for the month.

The number of theatre lists per week increased by 9 a week compared to M9, exceeding the plan, but not reaching the 19/20 or plan + threshold. Workforce, cancellations (both hospital and patient) and covid isolation all continue to impact upon the number of lists run.

Both the total waiting list and number of patients waiting over 52 weeks for treatment remain below trajectory levels. A waiting list validation exercise began at the end of M9 so the total waiting list is expected to reduce further in M11. PALS continue to receive high volumes of calls in relation outpatient appointments and waiting list lengths.

Challenges continue to be seen in the delivery of the suspected cancer Two Week Wait standard, with performance dipping to 77%. Key areas of concern are radiology capacity to facilitate additional breast clinics, and endoscopy capacity. The 28 Day Faster Diagnosis standard was also not achieved at 70% (standard 75%).The 62 day standard for time to first treatment for cancer patients was achieved, along with the 62 Day screening and the 31 Day standard.

Recovery of the DM01 6 week diagnostic standard reduced again, to 97.5% (99% standard). The two areas associated with this were audiology and endoscopy with both services experiencing capacity issues. Audiology remains challenging and it is expected that the standard will not recover in M11.

The Trust recorded a deficit of £0.3m in month 10, bringing the YTD position to a small surplus of £35k against the H2 plan. Pressures on the position persist, including from increased staff absence due to Covid and the increased cost of clinical supplies and Purchase of Healthcare. The overall pay position continues to feel the pressure of high staff absence, and the supernumerary costs of this year's planned intake of overseas nurses who have all arrived later than intended due to the international impact of Covid.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

March 2022

(data for January 2022)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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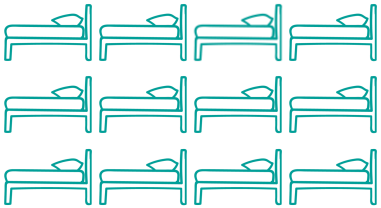
Summary Performance
January 2022

NHS Salisbury NHS Foundation Trust

There were **2,212** Non-Elective Admissions to the Trust

We carried out **238** elective procedures & **1,755** day cases



97.5% ↓ of patients received a diagnostic test within **6 weeks**

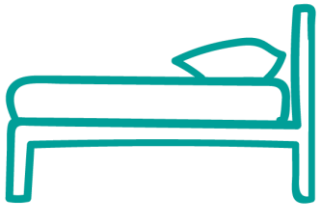
Emergency (4hr) Performance **82.5%** ↑
(Target trajectory: 95%)

We delivered **35,105** outpatient attendances, **18.7%** through video or telephone appointments

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

Our income was **£26,207k** (£1,100k above plan)

90 patients stayed in hospital for longer than 21 days



We met **5 out of 8** Cancer treatment standards

RTT 18 Week Performance: **68.8%** ↓
Total Waiting List: **18,844** ↓

17.9% ↓ of discharges were completed before 12:00

Our overall vacancy rate was **3.65%** ↓

Reading a Statistical Process Control (SPC) Chart

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

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

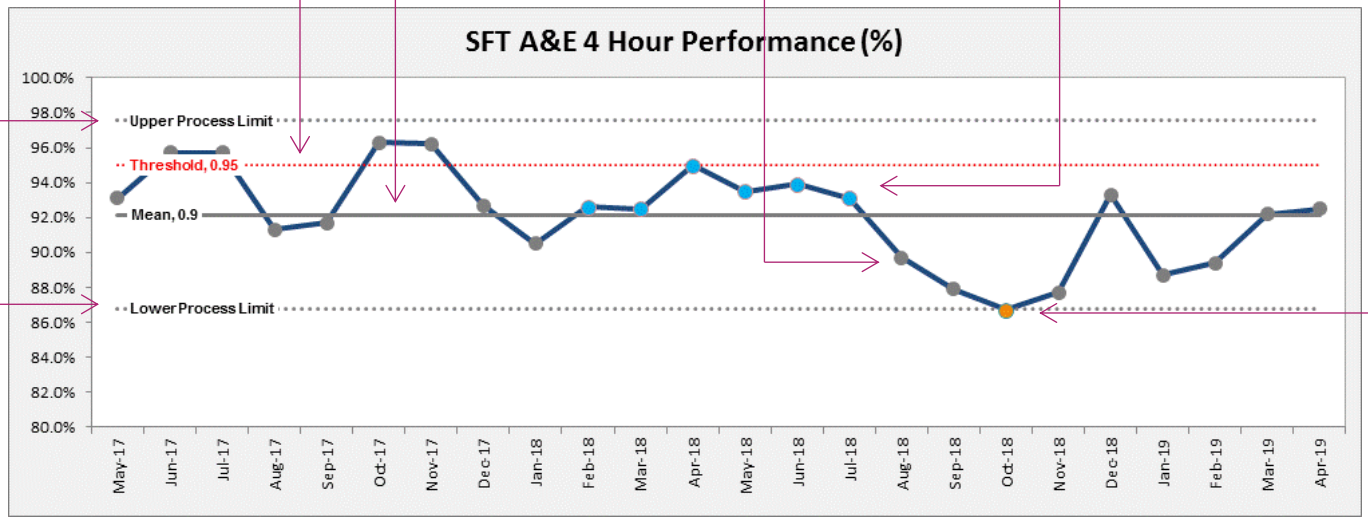
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

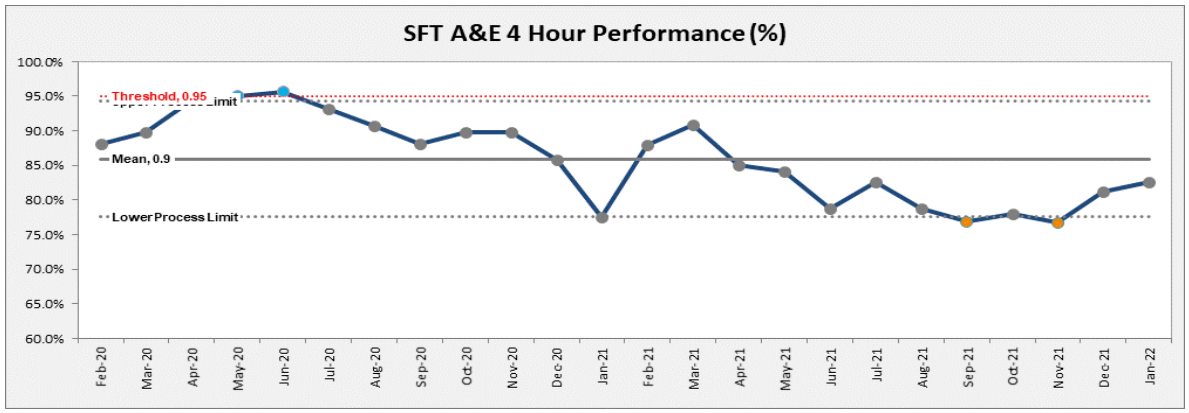
Part 1: Operational Performance

Performance against our Strategic Priorities and Key Lines of Enquiry

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

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	82.5%
Attendances:	5545
12 Hour Breaches:	0
ED Conversion Rate:	33.5%

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

M10 saw a small increase in attendances of 5545 compared to 5509 in M9. There has been a small increase in the 4 hour performance target from 81.2% in M9 to 82.5% in M10.

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

M10 has seen a high level of sickness within the ED department, having lost a total of approximately 265 days to sickness in month, Covid being a large contributory factor. This has impacted on existing staff who have had to manage many unfilled shifts including minors triage.

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

The Free phone Pilot to the Walk in Centre began in M10 but there has been little impact from this currently. SFT ED will continue to promote this pilot going forward.

The RAT (Rapid Assessment Triage) pilot finished at the end of M10. Data is now being collected and interrogated to present findings. RAT will continue in the department when there is a Mid Consultant on shift and when staffing levels allow. Initial findings show that this has had an impact on our ambulance conveyance compliance and time to triage, along with 4 hour performance target.

In M11 initial meetings started to look at triage process /Initial Assessment of patients and how this will integrate with RAT model. ED Improvement and SDEC work groups remain ongoing in the department.

Phase 2 of the minors build is ongoing and is scheduled to be completed within M12.

Successful recruitment of Band 6 TARN Coordinator completed and is due to start this role within M12.

Risks to delivery and mitigations

Phase 2 of the Minors build is having an impact on capacity and also impacting on the waiting room capacity within Minors, which then defaults to Majors waiting room. This is continually monitored by UEC Service Manager.

ED continues to experience delays from specialty teams coming to review their referred patients according to IPS (Internal Performance Standards). This does impact on capacity within the ED Department.

Flow out of the department continues to remain one of the biggest challenges for ED/AMU with trust realizing the majority of its discharges later in the day.

AMU SDEC (Same Day Emergency Care) continues to be escalated into overnight. This results in poor flow out of the ED department the following day and severely limits AMUs capacity to deliver SDEC the following day, often resulting in the medical take being diverted to ED.

Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
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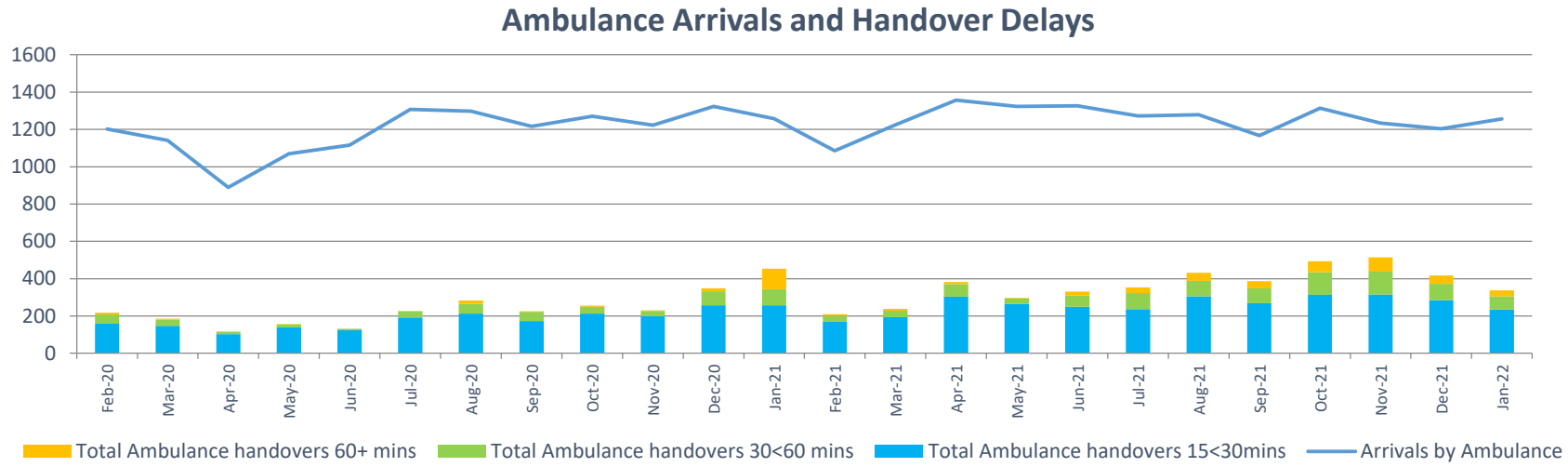
Ambulance Handover Delays

National Key Performance Indicators



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

M10 saw an increase in number of ambulances presenting to SFT of 1256 compared to 1204 in M9. There has been a decrease in ambulance handover delays of 91.88% in M10 compared to 89.04% in M9. Of note there has been a significant increase of 8.02% within the last 2 months.

Breaches >60 minutes have seen a further decrease in M10 to 32 compared to M9 of 44. Breaches >30minutes have also decreased in M10 to 70 compared to 88 in M9. There is also a significant decrease in breaches >15 of 235 in M10 compared to 285 in M9.

RAT (Rapid Access Triage) Trial in M10 has undoubtedly had an impact on ambulance handover performance and audit of this trial is ongoing. ED will continue to RAT when staffing levels allow.

SFT continues to remain with the best ambulance handover rate within BSW.

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

We are awaiting response from SWAST regarding The Physician Response Unit (PRU) car pilot that went ahead in M9.

The department will continue to RAT when staffing levels allows and data audit of pilot is still being collated.

ED are continually looking into pathways for streaming of ambulances into dedicated specialty areas.

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

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

Risks to delivery and mitigations

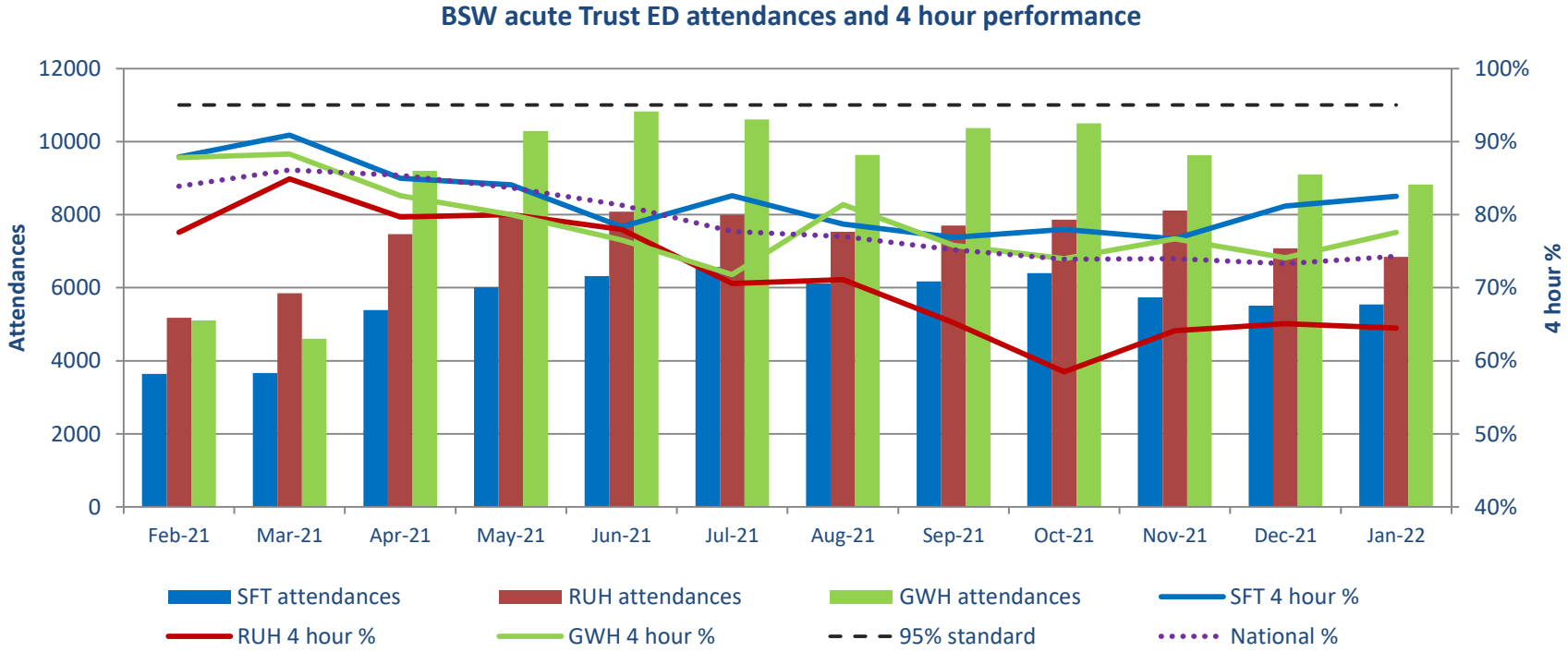
Hospital flow constraints and the resulting impact of the department reaching capacity, remains the biggest challenge in being able to off load ambulances in a timely manner. The Service Manager continues to monitor ambulance handovers in hours.

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

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

BSW Context – Emergency Access (4hr) standard

Are We Effective?

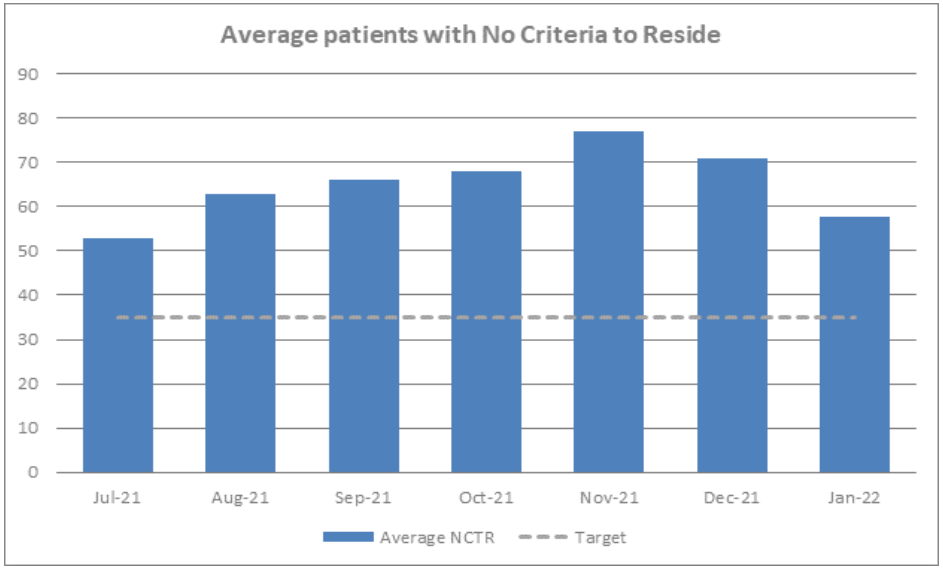


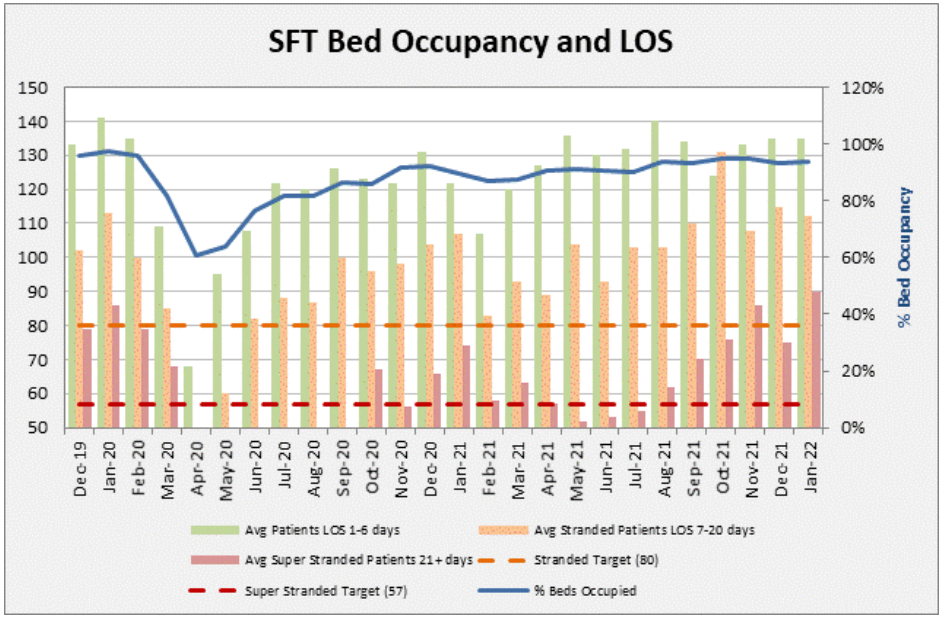
Attendance levels in M10 were broadly in line with M9. All Trusts had fewer attendances than in the same month of 2019/20 (SFT 5545, RUH 6849 and GWH 8830 versus SFT 5992, RUH 7374 and GWH 11211 in the same period of 2019/20).

A similar picture was seen nationally, with attendances slightly lower in M10 than M9, and around 7% lower than the same month than January 2019. Performance against the 4 hour standard was significantly lower in M10, than in the same month 2019/20 (74.3% versus 81.7%).

Patient Flow and Discharge

Are We Effective?





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

The average number of patients with no criteria to reside remains significantly above the target of 35 although receding since November, it is coupled with an increase in the group experiencing the longest length of stay of 21 days +. This group exceeds even the target for 7 days + LOS and is also higher than the level seen pre COVID in January 2020. It reflects the challenges in staffing and capacity in both acute and community health and social care services.

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

The Wiltshire system particularly is exploring additional schemes that are designed to facilitate discharges for patients waiting for pathway 1-3 services. It is anticipated that this will support the reduction of both the average number of patients with no criteria to reside and total length of stay during February.

Risks to delivery and mitigations

Increasing incidence of COVID will influence both staffing and capacity in all settings across acute and community.
Staffing even outside COVID influences is challenging and is likely to determine the availability of pathways 1-3 in existing services, without the addition of new services proposed.

Theatre Performance

Theatre KPI's

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

Measure - Theatre Performance & Efficiency	Area	Target	Jan 22
% Utilisation	Day Surgery Theatres	90%	67%
	Main Theatres	85%	85%
Turnaround	Day Surgery Theatres	8 mins	17 mins
	Main Theatres	12 mins	29 mins
% short notice Hospital Cancellations (0-3 days)	Total	2%	2.87%
% Short notice Patient Cancellations (0-3 days)	Total	2%	7.86%

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

An average of 106 theatre sessions a week were run in M10, an increase of 9 per week on M9, and still achieving more than baseline plan but 21 sessions a week short of 19/20 levels and Plan+. Target of 10.7 baseline weekday theatres open in January (plus 2 for Insourced Teams) but high staff sickness and elective cancellations in the first 2 weeks of the month meant that 9.8 theatres open on average in the week, and some lists at lower list numbers due to late PCR results, bed pressures and patient cancellations

Underperformance of elective activity accounts for overall theatre activity still being lower than plan in M10 as elective activity remained short of pre-Covid levels, at 62%, and below plan however this was a significant increase from 51% in M9. This has been further exacerbated by issues around late starts, high levels of emergency and trauma and high numbers of cancellations.

Daycase performance remains steady with a slight increase to 95% of pre-COVID levels and 107% of plan

Increased cancellations due to the impact of increasing prevalence of COVID and self-isolation requirements were also seen throughout M9 which is reflected in the high percentage of patient driven cancellations.

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

Significant improvements have been maintained in both TXM compliance with contract and quality. TXM workforce now stable and skilled but scrubs still covering HCA shifts at full cost. However, Theatres Recruitment and Retention plan well underway with plans for another Theatre open using substantive staff in March 22

Transition now taking place from TXM (insourced staff) to a more stable substantive workforce. Theatre Staff Incentive Payment Scheme uptake low again in January (£7k), the same as December, but a decrease when compared with £9k in November

Theatre Education continues with increased numbers of Scrub Nurses, ODP's and SFA's in full time training. Theatres Manager appointed and due to start in M1. Recruitment underway for Clinical Lead for Theatres. Interviews planned for w/c 14th February

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

Continuation of High Volume Low Complexity (HVLC) lists running both in week and at weekends for a number of specialties as targeted Waiting List Initiatives. Work ongoing to increase additional capacity by continuing to work to reinvigorate the Theatre Staff Incentive Payment Scheme

Risks to delivery and mitigations

Theatre workforce for local lists continues to be a blocker despite slow improvement. High levels of sickness continued to impact lists in M10 leading to the cancellation of elective work and although the number of theatres opened is on plan this has been supported by TXM staff. The mitigation for this issue is linked to the Theatre Workforce Review being led by OD&P with support from both the Theatres Specialty Team and DMT. The resilience of the local workforce is a particular focus as transition from reliance on TXM (insourced staff) to a more stable substantive workforce

An ongoing risk to elective activity remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand.

Bed pressures continue to impact the elective programme and has led to cancellations throughout M10, especially elective cases, however the simultaneous use of both upstairs and downstairs of DSU for inpatients has also impacted daycase performance. Daily review by the Matrons and DMT, and daily elective planning meeting in place. Issues with the air flow system in DSU also led to numerous cancellations throughout M10

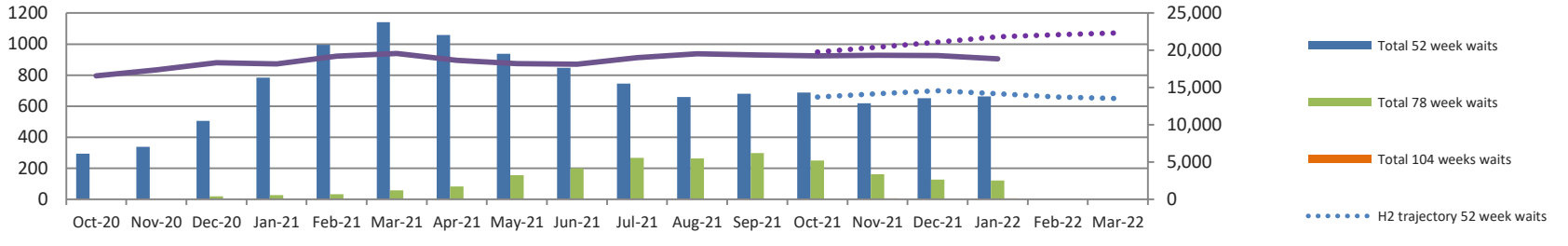
Risk of activity being impacted by cancellations due to increased prevalence of COVID resulting in rise in sickness and isolation of clinicians. Ongoing risk due to patient cancellations which remains high at almost 8% in M10

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

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

National Key Performance Indicators

RTT 52, 78 & 104 week wait submitted breaches (Incomplete PTL)



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

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

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

Treatment function	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	% change from
Plastic Surgery	145	140	133	130	129	129	111	121	132	9%
Urology	94	88	78	52	54	59	60	63	57	-10%
Trauma and Orthopaedic	114	99	85	74	59	56	48	39	45	15%
Oral Surgery	102	87	76	63	63	44	38	38	38	0%
Ophthalmology	158	120	92	92	90	71	55	44	25	-43%

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

The number of patients waiting longer than 52 weeks increased by 12 to a total of 664 in M10, ahead of the H2 trajectory of 681. The number of patients waiting longer than 78 weeks decreased by 6 to a total of 122. Among this cohort who have waited longer than 78 weeks approximately 4% are patients who have requested to pause their pathway.

The number of reportable patients waiting 104 weeks in M10 was 7, with the longest waiting patient waiting 107 weeks. These patients are all dated for surgery in M11/M12 apart from 1 delay due to clinical complexity. This patient is being reviewed by the OMFS clinical team to identify a solution.

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

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

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

Weekend outpatient clinics planned in Ophthalmology in M11 and M12 for patients that are not clinically appropriate for transfer to the IS and some weekend theatre lists scheduled for T&O in M11.

H2 trajectories reflect the national guidance to eliminate 104 week breaches by March 22, hold or reduce the number of patients waiting longer than 52 weeks, and hold total waiting list size around September 21 levels. SFT currently achieving both the 52 week and total waiting list size targets and patient level reviews are being undertaken to support achievement of the 104 week target by the end of M12

Use of IS for Orthopaedic and Ophthalmology patients to Newhall continuing although transfers to IHG are on hold awaiting an updated from them on capacity

Risks to delivery and mitigations

Theatre workforce for local lists including the risk of high levels of sickness. The mitigation for this issue is linked to the Theatre Workforce Review being led by OD&P with support from both the Theatres Specialty Team and DMT. Risks associated with staffing levels as a direct result of COVID-19 also remain prevalent with the risk of activity being lost due to the impact of sickness and isolation although this should improve in M11 with changes to national and local guidelines

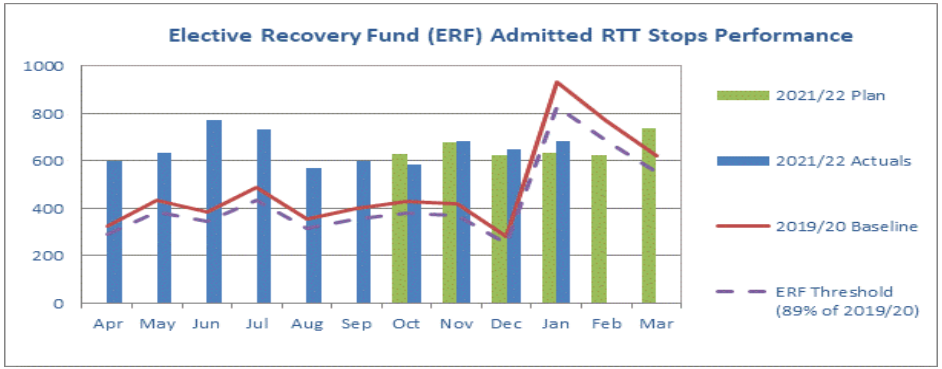
Another ongoing risk remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand as this may result in the cancellations especially of long waiting, clinically routine patients.

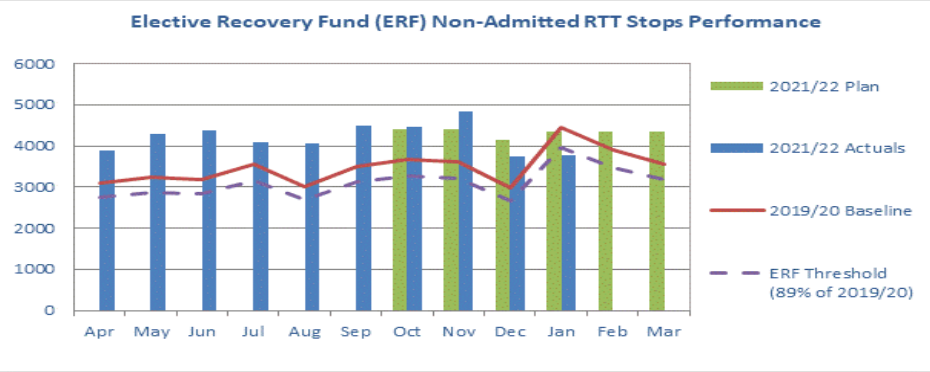
Capacity pressures are now starting to impact the elective programme, especially affecting the case mix, and led to elective cancellations in M10. Daily review by the Matrons and DMT undertaken as required avoiding cancellations whenever practical. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimalise cancellations. Trust wide SAFER week also running to support timely discharges

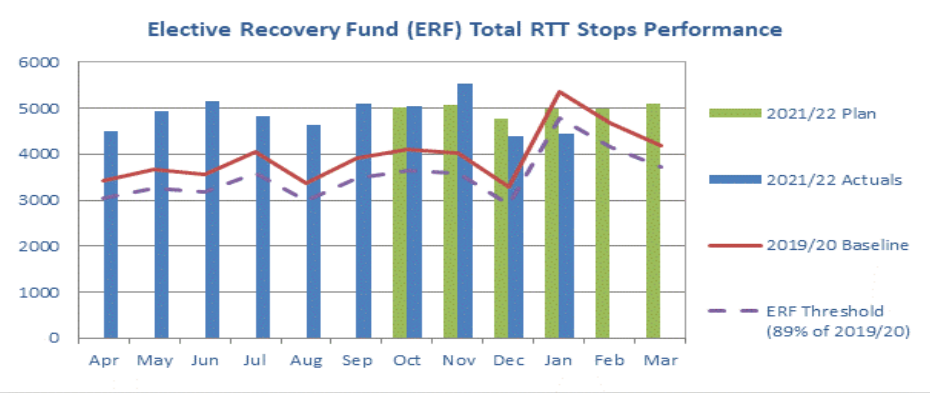
Continued high levels of patient led cancellations are also a risk to delivery especially in light of COVID prevalence, rate of almost 8% in January

Elective Recovery Fund - RTT Stops

National Key Performance Indicators







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

ERF total RTT stops performance continued to be behind plan in M10. The admitted RTT stops performance remained above plan though but the non-admitted was below impacting overall performance

Outpatient attendances in M10 exceeded current month plan, 117%, and achieved pre-COVID levels, 104%.

Virtual appointments continue to work well in a number of specialties with Gastroenterology and Cardiology seeing high numbers of their outpatients virtually and a number of specialties achieving over 100% of pre-COVID levels

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

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

Wait to First Appointment has been selected as a Breakthrough objective as part of the Trust's Improving Together program. Analysis is currently being undertaken to identify challenges and opportunities for improvement and to confirm the Divisional Driver and Watch metrics that will support this objective

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

Continuing lower levels of routine outpatient activity seen in Respiratory and Gastroenterology due to need to prioritise urgent inpatient care

Risks to delivery and mitigations

Continued risk of increased cancellations due to COVID-19

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

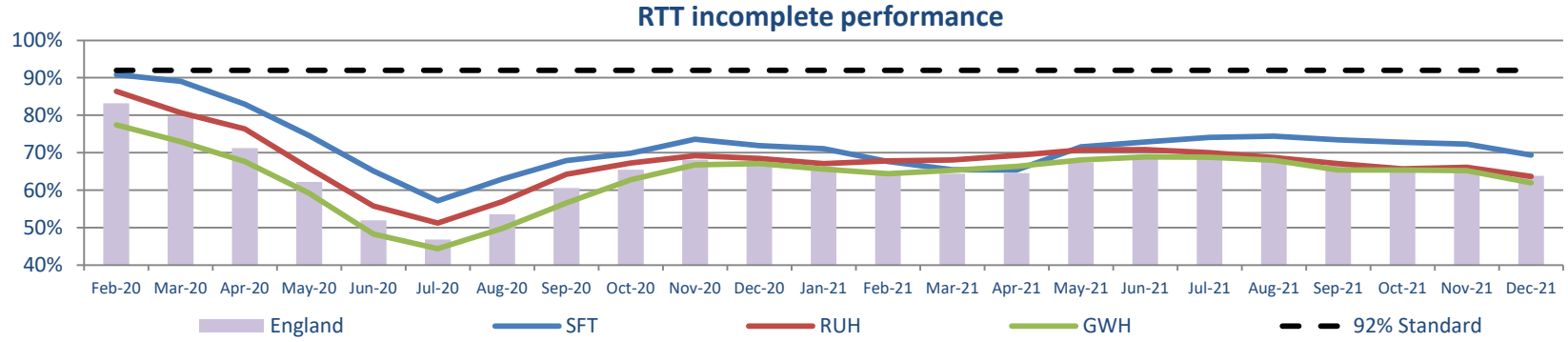
Creep in some specialties back to onsite preferences. Focussed work is being undertaken with DMT's, Clinical Leads and Transformation team to continue to increase this in line with national targets and to improve medium-long virtual models

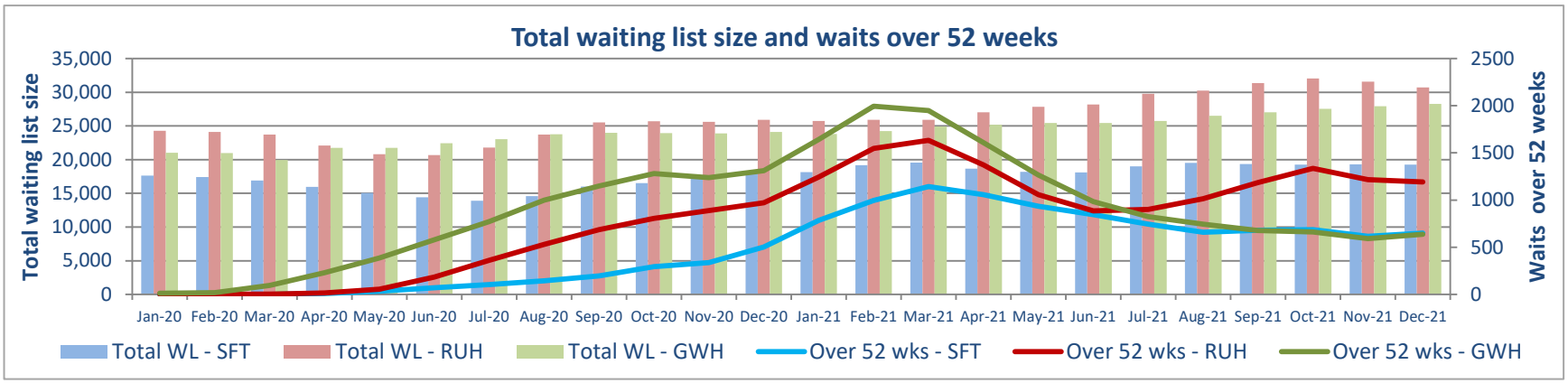
Go live of new rota and clinic templates in Ophthalmology in M11. This returns templates to pre-COVID levels and optimises use of the outpatient department creating increased capacity for non-admitted patients to address the backlog and shortfall of this cohort of patients

Review of capacity in the MedSurg Outpatient footprint commenced to ensure optimisation of capacity and prioritisation of challenged specialties

BSW Context – Referral To Treatment (RTT)

Are We Effective?





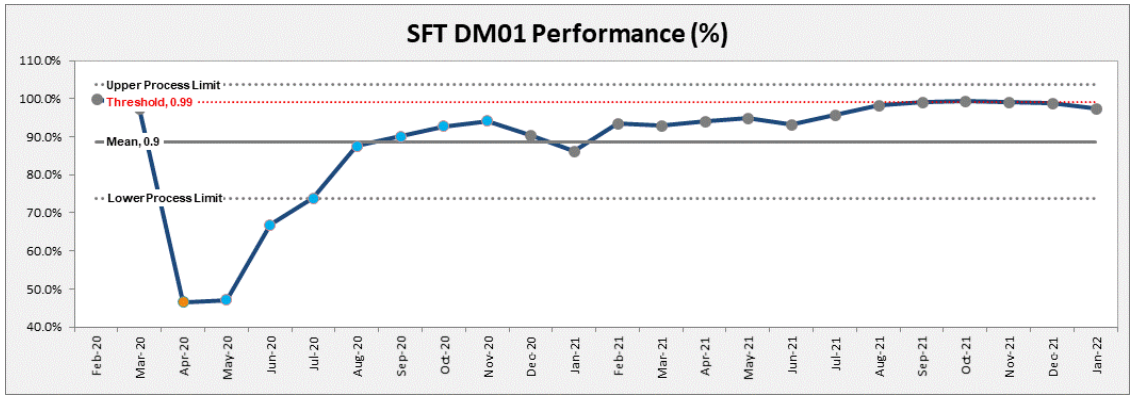
*Due to the time it takes to for NHSE to publish the data, RTT benchmark data on this slide is a month behind the reporting month.

Total waiting list size across the BSW system remains broadly static, with marginal decreases at SDH and RUH, and slight increase at GWH.

The number of patients waiting over 52 weeks increased at SFT (651 versus 617 in M8 and GWH (639 versus 593 in M8), and decreased at RUH from 1217 in M8 to 1193 in M9. Despite increases in numbers over 52 weeks, all three Trusts reduced the number of patients waiting over 78 weeks from a collective 315 to 216.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: 97.5%

Waiting List Volume: 3433

6 Week Breaches: 84

Diagnostics Performed: 7191

Modality performance

MRI	100.0%	US	100.0%	Audio	72.7%	Neuro	100.0%	Flexi sig	96.1%
CT	100.0%	DEXA	99.0%	Cardio	99.3%	Colon	90.5%	Gastro	92.3%

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

Non compliance of the standard and a decrease in performance in M10 from 98.78% in M9 to a 97.55% in M10 representing 84 breaches (and increase from 41 breaches in M9).

79 of the 84 breaches are reported across two modalities (Audiology and Endoscopy).

The Audiology position was expected to remain stable from M9 but deteriorated significantly towards month end due to staff sickness (56 breaches).

Endoscopy was not expected to fail DM01 compliance this month but due to an error in planning lists for the last weekend of the month, capacity was less than required to maintain the DM01 performance and when noticed it was not possible to set weekend capacity up to offer dates in month. The number of patients breaching due to GA requirements remains stable.

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

Trajectory for improvement within Audiology (with expected return to compliance date) has been requested of the Surgery Division. Head of Service continues to work additional hours to increase the complex test capacity. Vacancies are advertised to backfill the team to provide longer term resilience.

Endoscopy will begin weekly validation of their position so as to ensure early warning of any deterioration is known. They are expecting to return to compliance within M11 having increased capacity to mitigate the losses of late January.

Risks to delivery and mitigations

Small workforce in Audiology, growing backlog and case mix will make it unlikely that recovering of DM01 in this modality will be achieved in M11.

Cardiology and USS remain heavily reliant on locum support and in-house overtime although have retained compliance with this in place. USS also have a Sonographer leaving at end of M11 which will put the position at risk into M12 and 22/23 FY. Locum request has been approved by CSFS DMT to try to mitigate this vacancy.

Gastroenterology locum workforce and if there is any covid related sickness may cause risk to endoscopy capacity.

Statistical Process Control Chart Key:

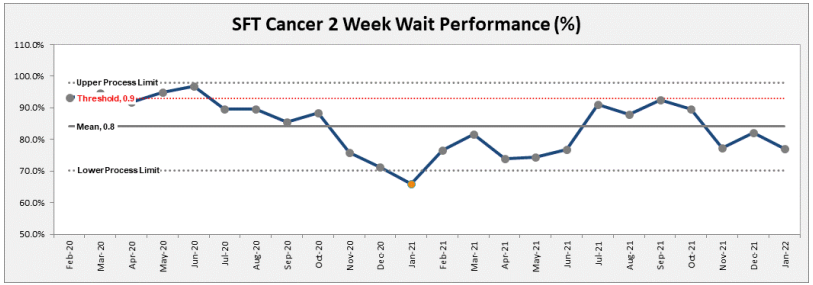
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)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

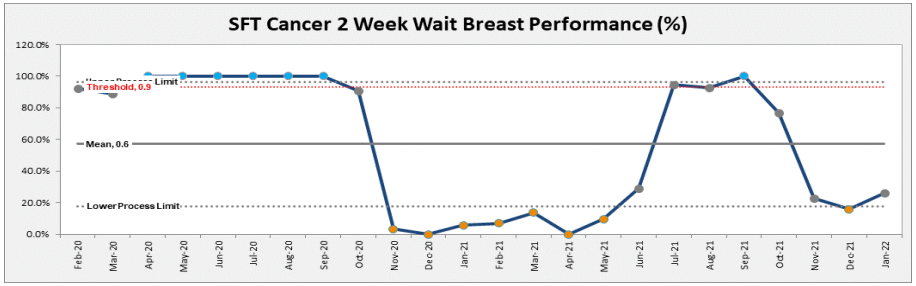
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	77.11%	630/817	187 (27 patient choice)
Two Week Wait Breast Symptomatic Standard:	26.19%	11/42	31

Data Quality Rating:





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

Two week wait standard not achieved for Month 10 with month end validated performance of 77.11% (817 patients seen; 630 in target; 187 breaches). Breach reasons associated with:

- Clinic capacity: 90 breaches (predominantly lack of radiology cover to facilitate additional breast one stop clinics)
- Endoscopy capacity: 36 breaches (associated with lack of consultant cover over the Christmas/New year period)
- Patient choice: 27 breaches
- Incomplete GP referrals: 12 breaches
- COVID-19 delays: 11 breaches
- Administrative delays: 7 breaches (associated with delays in triage due to December bank holidays)
- Radiology delays: 3 breaches
- Prison-related delay: 1 breach

Breast symptomatic two week wait standard not achieved for Month 10 (42 patients seen; 11 in target; 31 breaches). Breaches associated with patient choice and lack of breast one stop capacity due to insufficient radiology capacity to facilitate additional clinics.

28 day Faster Diagnosis Standard not achieved for Month 10, with month end performance of 70.3% (790 patients diagnosed; 555 in target; 235 breaches).

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

Breast two week wait performance: Deterioration in two week wait performance seen from October 2021 due to increase in referrals and lack of radiology capacity to support additional one stop clinics. Radiology and the breast service have agreed to establish ad hoc clinics as required, the first of which is planned for March 2022.

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

Incomplete GP referrals: Inconsistent completion of straight to test referral forms. Significant improvement in uptake of qFIT in line with SWAG recommendations, though conversations with BSW ICS/Hampshire and Isle of Wight CCG partnership ongoing as required to ensure completion remains consistent.

Endoscopy capacity: Constraints over Christmas period associated with locum consultant annual leave/absence. Additional gastroenterologist now in post.

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

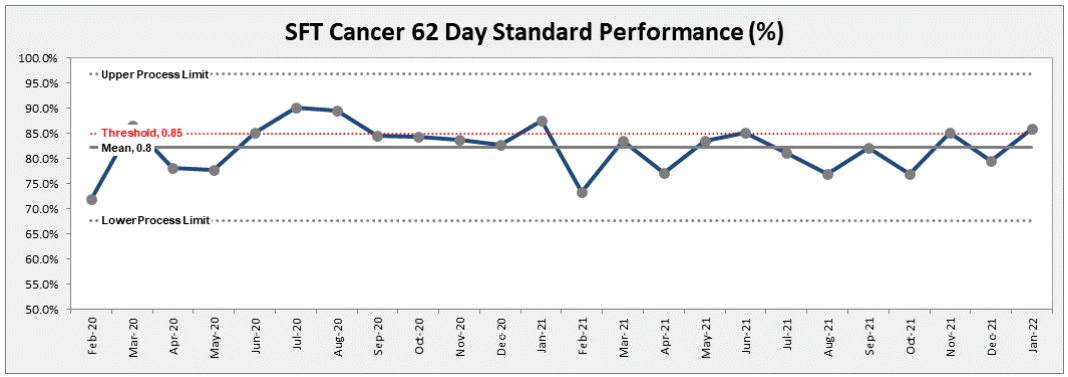
Risks to delivery and mitigations

Consultant radiology capacity to support additional clinics within breast service: Deterioration in 2ww performance seen from October 2021 onwards due to increase in referrals and lack of ability to facilitate additional clinics. Ad hoc clinics now agreed in principle, the first of which is scheduled for March 2022.

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

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

October 21	Performance	Num/Den
62 Day Standard:	87.07%*	50.5/58
62 Day Screening:	100%	2.5/2.5

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

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

Month 10 62 day performance standard achieved, with validated month end performance of 87.07% (58 patients treated; 50.5 in target; 7.5 breaches)

- Breast: 2 breaches (delayed transfer from colorectal, delayed diagnostic reporting)
- Colorectal: 1 breach (delayed radiology reporting and insufficient interventional radiology capacity)
- Skin: 1 breach (patient choice)
- Urology: 3.5 breaches (3 x prostate breaches associated with insufficient diagnostic capacity and subsequent reporting turnaround times, 1 x associated with requiring second opinion)

62 day screening standard achieved for Month 10, with validated end month performance of 100% (2.5 patients treated, 2.5 in target, 0 breaches).

31 day performance standard achieved for Month 10, with validated month end performance of 96.84% (95 patients treated; 92 in target; 3 breaches).

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

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

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

Radiology and histology reporting turnaround times: Increased waiting times for both radiology and histology reporting. Radiology delays associated with insufficient consultant radiologist capacity in light of management of routine backlog. Position now significantly improved though remains under review to ensure sustained. Increase in number of histology reports being outsourced due to staffing constraints locally. Capacity has the potential to adversely affect pathways across all tumour sites and could hinder our ability to deliver the national optimum timed best practice pathways.

Risks to delivery and mitigations

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

Radiology and histology reporting turnaround times: Increased waiting times for both radiology and histology reporting. Radiology delays associated with insufficient consultant radiologist capacity in light of management of routine backlog, though position much improved.

Matron for Cancer vacancy: Matron for cancer has now left the organisation; this will result in a significant gap in the delivery of cancer care on Pembroke unit/ward. Role is currently out to advert alongside separate Lead Cancer Nurse position.

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

Stroke & TIA Pathways

Are We Effective?

SSNAP Case Ascertainment Audit

Highest level = Grade A

Lowest level = Grade E

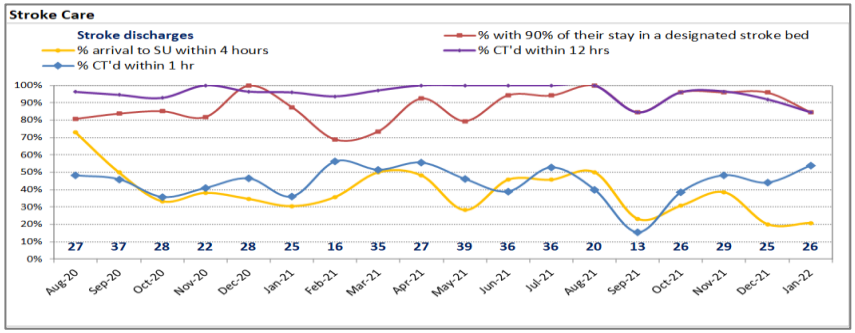
Quarterly	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22	C	C		

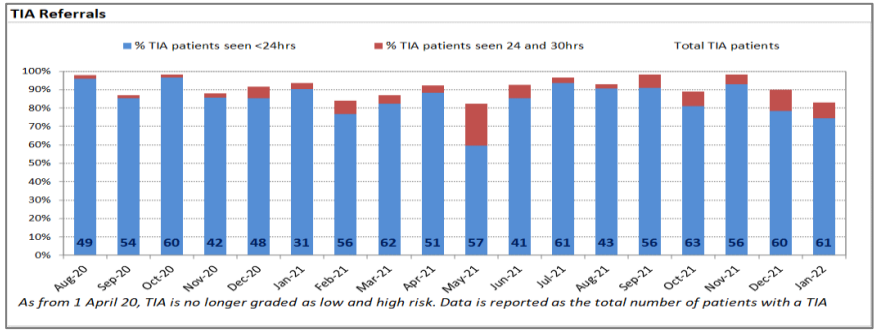
Data Quality Rating:

% Arrival on SU <4 hours: 20.8%

% CT'd < 12 hours: 84.6%

% TIA Seen < 24 hours: 74.6%





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

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

- There were 26 stroke discharges this month.
- There were 2 stroke deaths within the 30 day period in January.
- 90% stay in the stroke unit was 85% this month.
- The number of patient reaching the stroke unit within 4 hours is 21%
- Average Stroke unit length of stay was 22 and an Average total length of 23 days
- 54% of patients had a CT within an hour which is an increase from the last few months. CT within 12 hours was at 85% a slight decrease mainly due to late diagnosis and ED pressures.
- 2 patients were thrombolysed with an average door to needle time of 77 minutes.
- 14 of the eligible 21 patients were referred to ESD in January.
- 75% of the 59 TIA's had treatment complete within 24hrs; with 8 patients affected by full clinics, 1 having MRI next day, 1 late referral, 1 rebooked later that month and 3 declined clinics in other hospitals.

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

Acute Stroke patients continue to be looked after on Farley ward, with the rehab part of Farley still being used to care for respiratory patients. Rehab stroke patient continue to be cared for on Breamore ward.

Unfortunately COVID operational pressures and staff shortages are still impacting on our targets. However, there are plans in place for collaborative efforts with the emergency department, radiology and bed managers to improve these targets.

The stoke lead has recently met with ED leads to agree pathways for improving the handover and transfer of stroke patients from ED to the ward.

Risks to delivery and mitigations

In the last month, site management have moved stroke patients receiving active rehab from the stroke unit to outlier wards on occasions. This should be avoided and will be highlighted through Datix reporting if/when this occurs.

Salisbury NHS Foundation Trust

Part 2: Our Care

Performance against our Strategic Priorities and Key Lines of Enquiry

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

Maternity

Are We Safe?

SFT Assurance Dashboard	2021					2022
	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22
Perinatal Morbidity and Mortality						
Total number of Perinatal Deaths						
Number of late fetal loses (22+0 to 23+6 weeks excl TOP)		1	0	0	2	0
Number of stillbirths (>+ 24 weeks excl TOP)	0	1	0	0	2	0
Number of neonatal deaths : 0-28 days	0	1	1	0	2	0
Medical termination over 24 +0 registered						1
Maternal Morbidity and Mortality						
Number of Maternal Deaths	0	0	0	0	0	0
Number if women requiring admission to ITU	2	0	0	0	0	0
Insight						
Number of datix incidents - moderate or above			3	0	1	0
Datix incidents moderate harm (not SII)			2	5	1	0
Datix incidence SII			1	0	0	0
HSIB referrals		1	0	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request	0	1	0	0	0	0
Coroner Reg 28 made directly to trust	0	0	0	0	0	0
Workforce						
Minimum safe staffing in maternity services :Obstetric cover	40	40	40	40	40	40
Minimum to Birth ratio (aim 1:28)	1.45	1.40	1.27	1.25	1.25	
Midwifery vacancy rate (black= over establishment; red =under establishment)						10 WTE
Provision of 1 to 1 care in established labour	100%	100%	100%	100%	100%	100%
Datix relating to workforce				1	0	1
Compliance with supernumery status of LW coordinator						100%
Numbers of times maternity unit on divert	0	0	0	0	0	0
Involvement						
Service user feedback : Number of Compliments	0	24	9	9	2	19
Service user feedback : Number of Complaints	2	1	1	1	1	2
Number of SOX			12	2	5	5
Assurance/Improvement						
Progress in achievement of 10 safety actions(CNST)	4	4	4	4	4	4
Training compliance - MDT PROMPT %	68	68	68	56.2		74

Perinatal Quality Surveillance Tool

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

What does the data tell us ?

Midwifery vacancy continues to be a challenge, however metrics demonstrate no effect on quality and safety metrics
Covid restrictions has had little impact on ability to continue to provide all key service, to include home birth , through January 22

Maternity Incentive Scheme Year 4 (MIS)
Year 3 compliance with ten safety actions was declared as 4
A recent gap analysis highlights concerns regarding 3 safety action
Safety action 2- Maternity Services Data Set
Challenges with IT system being able to deliver against data set – ongoing work with data analyst
Safety Action 6 -Saving Babies Lives
Currently non compliant with 2 of 5 elements
Safety action 8- MDT training -PROMPT
Increasing compliance with trajectory to be compliant with >90% by submission date of July 22 across all disciplines therefore overall compliance with safety action

What actions are being taken to improve?

Recruitment drives for midwives continues with a focus presently on recruitment for the new midwifery led unit
Training drive continues for both PROMPT and CTG interpretation as identified in SII action plans

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

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

Maternity Clinical Dashboard

Data Quality Rating:

Are We Safe?

Measure	Min	Median	Max	Mar-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov - 21	Dec 21	Jan 22	Q1 Total	Q2 Total
Babies (inc Non Reg)	88	334	545		183	191	222	217	198	187	149		532	630
Homebirth rate %	0.0%	1.7%	7.8%		1.6%	1.6%	4.7%	4.1%	5.1%	4.6 %	4.9%		2.5%	4.6%
Inductions %	21.6%	34.0%	43.0%		32.6%	33.0%	38.3%	32.0%	37.4%	39.1%	36.9%		2.9%	103.2%
Total CS rate (planned & unscheduled)	17.8%	27.4%	73.9%	32% National Dash Mar21	24.1%	29.7%	29.3%	32.4%	26.6%	26.6 %	29.5%		29.5%	30.5%
Elective caesarean sections %	5.9%	11.7%	21.7%	15% National Dash Mar 21	10.2%	12.1%	12.2%	13.7%	10.3%	16.3%	12.1%		13.3%	0.1%
Emergency caesarean sections %	0.1%	15.7%	25.0%	17% National Dash Mar 21	13.9%	17.6%	17.1%	18.7%	16.3%	10.3%	17.4%		16.0%	17.8%
Instrumental deliveries %	5.1%	12.0%	21.0%	12.5% NMPA	12.0%	9.9%	12.6%	9.2%	10.6%	12.8%	12.8%		11.8%	10.6%
PPH >= 1, 500 %	0.0%	3.4%	21.0%	Green <2.7%, red >5.6% NMPA	4.8%	2.2%	4.5%	4.6%	4.4%	3.81%	1.3%		3.8%	3.9%
Apgar less than 6 @ 5 min %					0.0%	0.0%	0.0%	0.9%	0.5%	1.1%	0 %		0.2%	0.3%

Data delayed for Jan 22 due to vacancy– being now supported by BI team

Maternity Safety agenda – focus on PMRT

Perinatal Mortality Review Toolkit (PMRT/ MBRRACE) – systematic MDT review of all stillbirths; neonatal death

- Safety action 1 – MIS
- Completion within certain time frames with family involvement
- Focus on learning with quarterly reports presented at Trust sub committee
- Reported to MBRRACE and PMRT review and report published and given to family within certain time limits – fully complaint with all these standards for quarter 2 and quarter 3

	Q2	Compliance	Q3	Compliance
Number of late fetal loses (22+0 to 23+6 weeks excl TOP)	1		2	
Number of stillbirths (>+ 24 weeks excl TOP	1		2	
Number of neonatal deaths : 0-28 days	1		0	
Family involvement	100 %		100%	

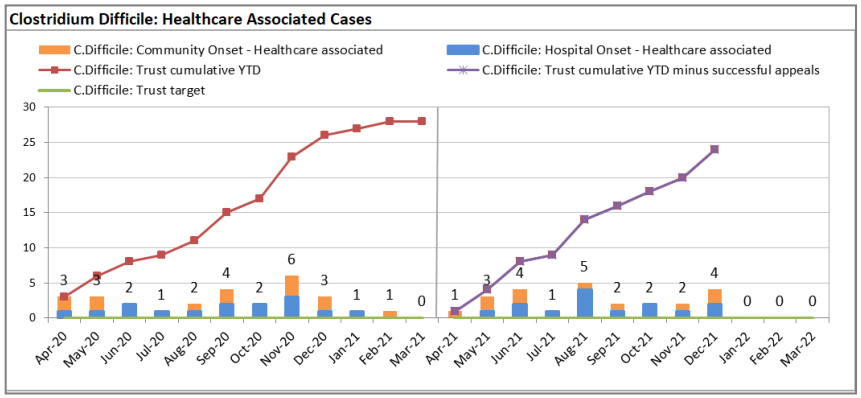
Infection Control

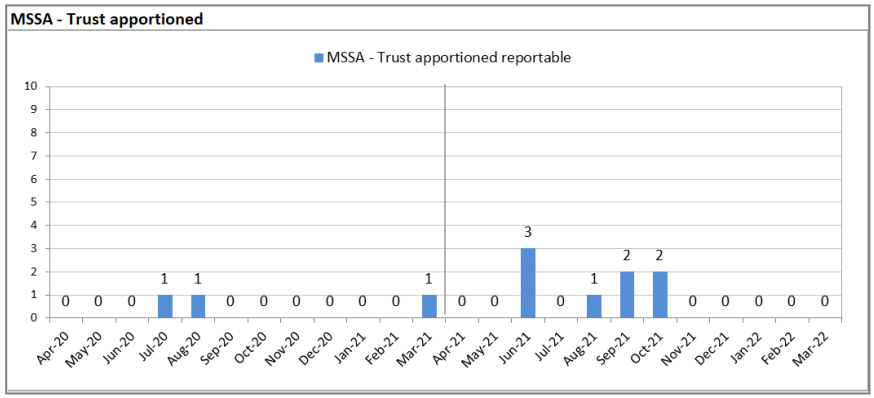
Data Quality Rating:

Are We Safe?

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

MRSA	2020-21	2021-22
Trust Apportioned	3	0





Summary

MRSA bacteraemia = zero hospital onset cases.

MSSA bacteraemia = zero hospital onset cases.

E.coli bacteraemia = 6 hospital onset cases (unrelated cases)

- 2 cases were related to lower urinary tract (Breamore Ward and Britford Ward)
- 1 case related to lower respiratory tract (Radnor Ward)
- 1 case related to an intravascular device (PICC line) (Hospice Unit)
- 2 cases were unknown source (Pembroke Ward and Odstock Ward)

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

- Hospital onset; healthcare associated reportable cases = 1 (where sample sent for inpatient on Odstock Ward).
- Community onset; healthcare associated reportable cases = 0

Pressure Ulcers

Are We Safe?

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

Summary and Action

Category 2 PUs have decreased slightly to 23 in January from 25 in December with Medicine continuing to contribute the majority of this number (18 in medicine and 5 in Surgery). There were 4 device related cat 2 PUs within this number but there was no commonality between the devices involved. Cat 2 PUs were most commonly found on buttocks/sacrum or heels. There is evidence that pressure relieving devices (air mattresses and orthotic boots) are being used sporadically, but we continue to encourage their use as a preventative measure for high risk patients. All ward areas with multiple PUs acquired will present their learning at Share and Learn where any specific themes or actions for these ward areas will be identified.

One category 3 PU was identified in January within the medical division. A SWARM has taken place and 72 hour report completed and this case has been discussed at the weekly patient safety summit where no new learning was identified. Good practice was identified in all aspects of care delivery and the patient's complex medical needs and consistent fluctuation and overall deterioration of condition were appropriately factored into causation of wound.

No category 4 PUs have been identified in January.

11 Deep Tissue Injuries were identified in January (8 acquired in Medicine and 3 in Surgery) which is the same as December's DTI figures. DTI's continue to be most commonly found on heels and the lack of orthotic boot use is a repeated theme. We continue to remind and encourage the use of pressure relieving boots or strict elevation of the heels, alongside regular monitoring of skin. As in December, it is likely that there were missed opportunities for early identification of vulnerable heels due to staff shortages and missed education opportunities.

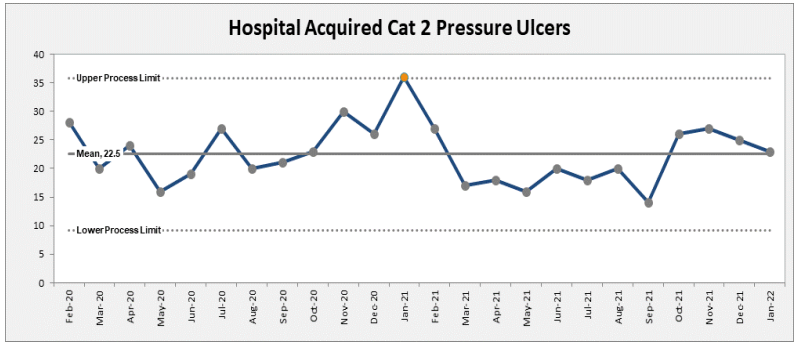
Unstageable PUs have continued to decrease and we have had none in January.

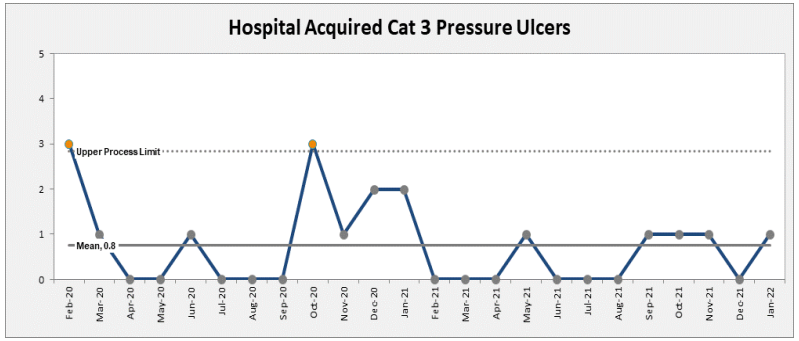
Pressure Ulcer Prevention education had minimal attendance in January with only 2 people attending the session. We continue to chase this and the recurring theme for non-attendance is ward acuity and/or poor staffing levels. Non-attendance of staff is always reported to ward leads for chasing/monitoring. Tissue Viability continues to offer Pressure Ulcer Prevention education sessions twice a month and encourage attendance from all staff. Pressure Ulcer Prevention education remains a non-mandatory education subject.

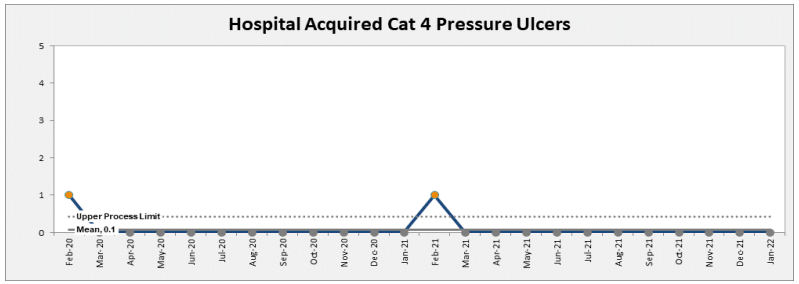
All categories of PU will continue to be discussed at the weekly Matron huddle meeting (as operational pressures allow) and key learning identified at the monthly Share and Learn meeting from ward RCA investigations. Causes for the hospital acquired PUs will be discussed, noting the significant operational pressures and staffing problems across both divisions, as well as the increased acuity of patients being admitted into the trust. Matrons from both divisions continue to highlight staffing issues each week and wards continue to report delays in pressure area care due to high patient acuity and poor staffing levels/skill mix.

January Share and Learn meeting did not take place due to hospital operational pressures. Share and Learn meeting has not taken place since October 2021 so there have been no ward or division specific themes or actions identified. February meeting to discuss January figures will take place on 16th February.

Data Quality Rating:





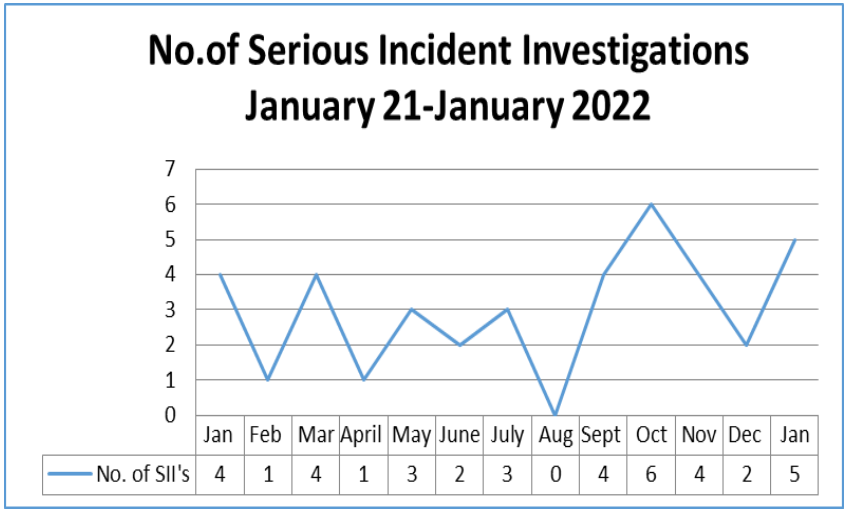


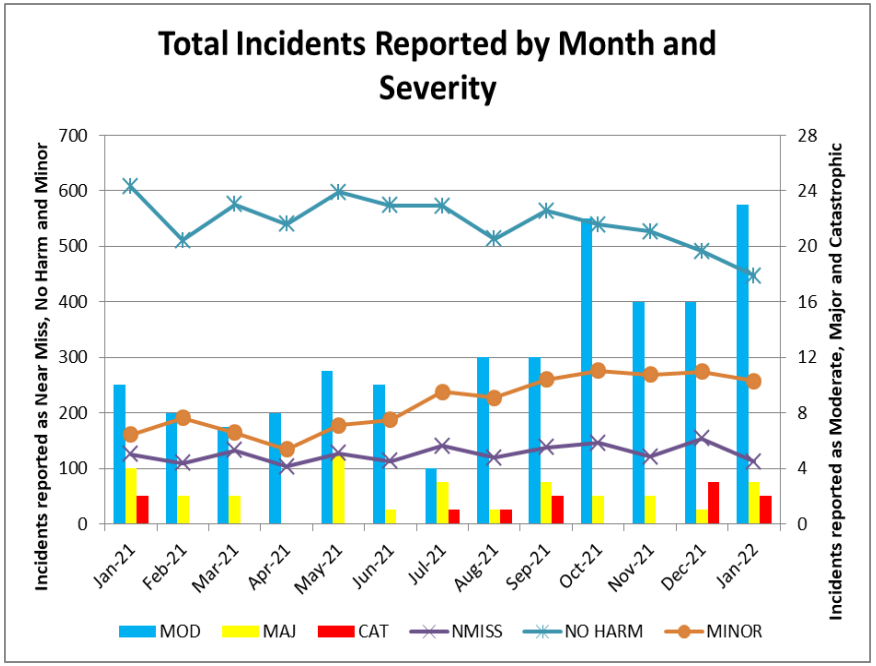
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

Incidents

Are We Safe?

Year	2020-21	2021-22
Never Events	0	3





Summary and Action

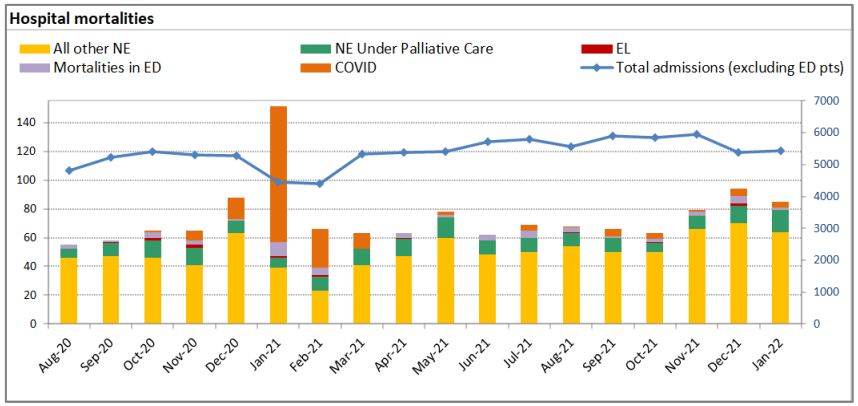
There were 5 SII's commissioned in January (no never events):

- **• SII 455:** Due to Resectoscope equipment failure after general anaesthetic was administered, surgery needed to be abandoned and rescheduled.
- **• SII 457:** Imaging Request failures within CRIS system.
- **• SII 458:** Patient's printed EDS ReSPECT form is incorrectly showing that CPR attempts are not recommended for a cohort of patients due to a system error.
- **• SII 460:** An unnecessary GA
- **• SII 461:** A Screening Incident – Wrongly labelled sample

Mortality Indicators

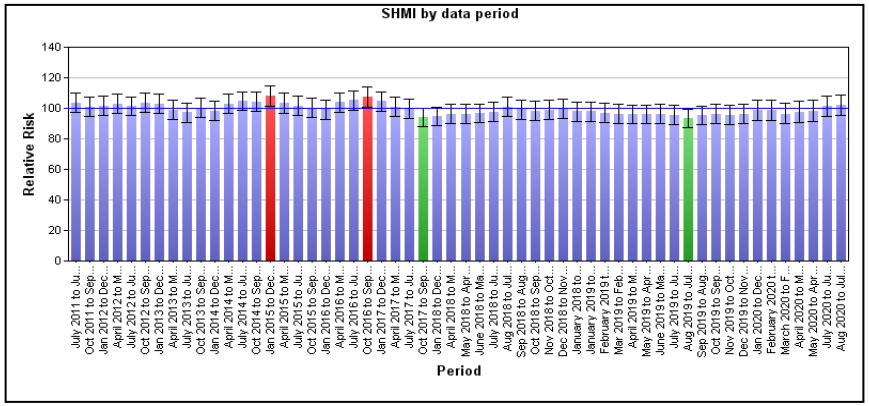
Data Quality Rating:

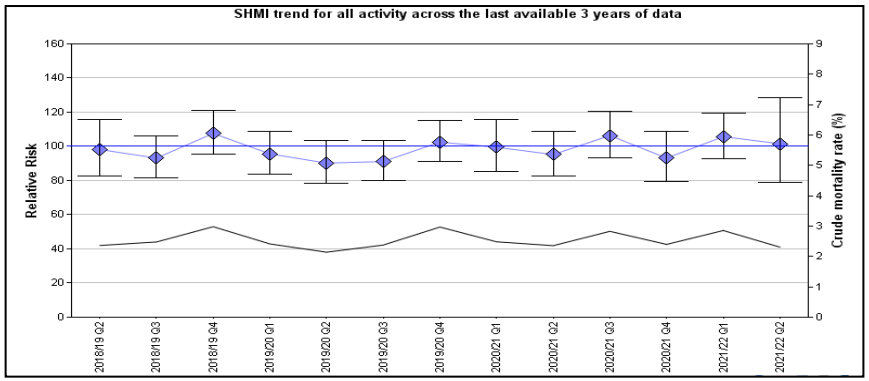
Are We Safe?

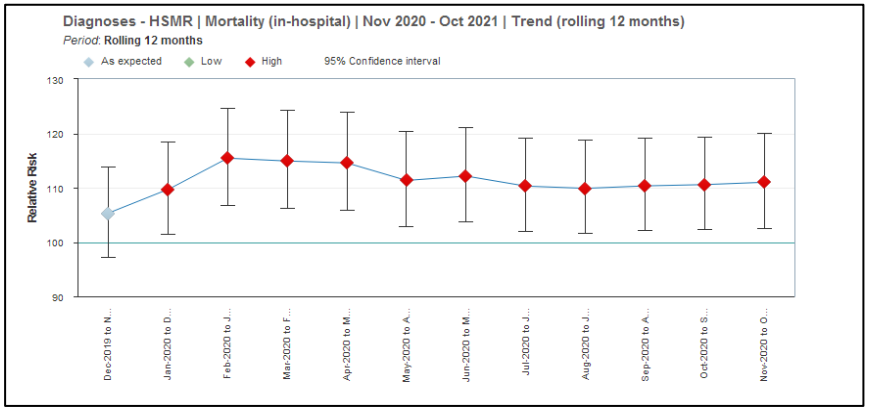


Summary and Action

- There were 4 COVID deaths reported in January
- The latest SHMI for Salisbury District Hospital (as published by NHS Digital) for the 12-month rolling period of October 2020 – September 2021 is **1.0261**. This is within the expected range.
- The latest HSMR for the 12-month rolling period of November 2020 – October 2021 is **111.0**. This is statistically higher than expected. The latest data has shown an increase in the relative risk figures, and this follows some changes in how the data is being reported by our mortality partners at Telstra UK. The HSMR remains within the expected range when COVID deaths are excluded.
- For the period of November 2020 – October 2021 the weekend HSMR is **116.0** and the weekday HSMR is **109.5**. Both are statistically as expected.

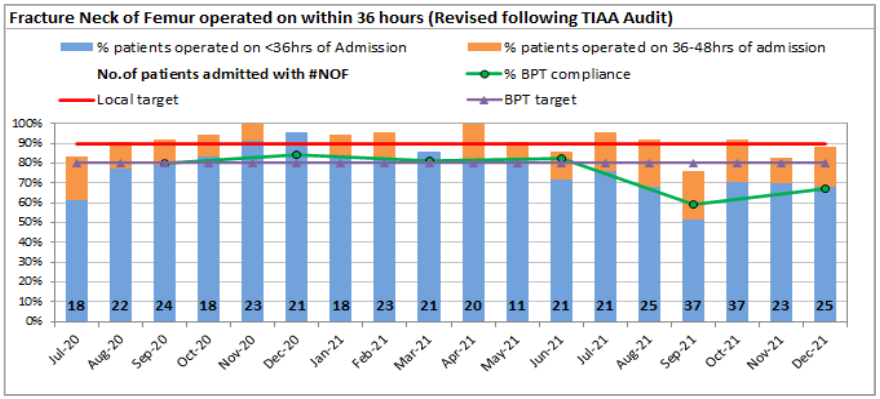






Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?



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

BPT%: January 2022

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

Reason for failure:

- Awaiting Theatre Space: 3 patients
- Awaiting medical review/investigation or stabilisation: 1 patient
- Other (Awaiting Surgeon) & Time to Geriatrician: 1 patient
- Awaiting orthopaedic diagnosis/investigation & Time to Geriatrician: 1 patient

BPT %: 78.57% **Average LOS = 17.91 days**

An example of a recent route cause analysis:

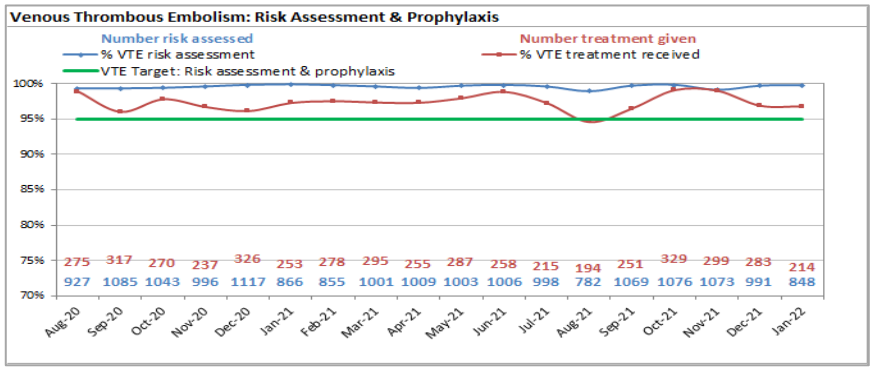
A patient is admitted on a Tuesday at 17:30 with a BPT breach time of 05:30 on the Thursday. The patient goes to theatre on Thursday at 09:30. This makes the time to theatre 40 hours. Theatre availability:

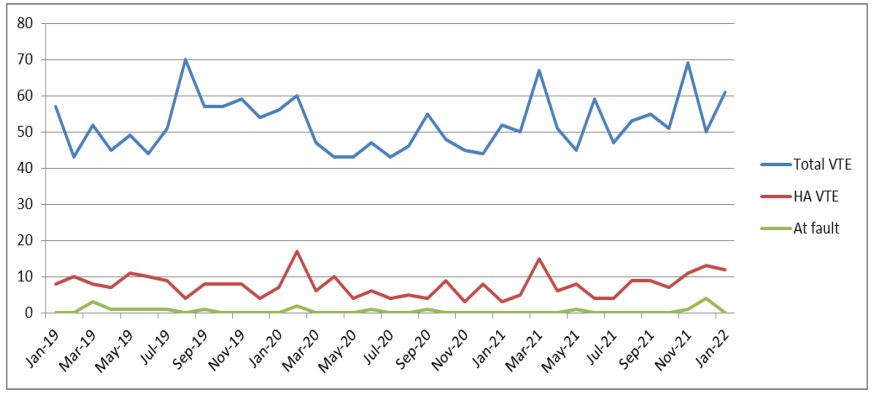
Trauma theatre Wednesday
1) Achilles tendon repair
2) Achilles Tendon repair
3) NOF fixation

Wednesday's elective spinal theatre is running with 3 spinal patients. The patient is first on the list on the Thursday trauma list.

Recent improvement plans have centred on increasing prioritisation of cases and BPT% is increasing.

Data Quality Rating:





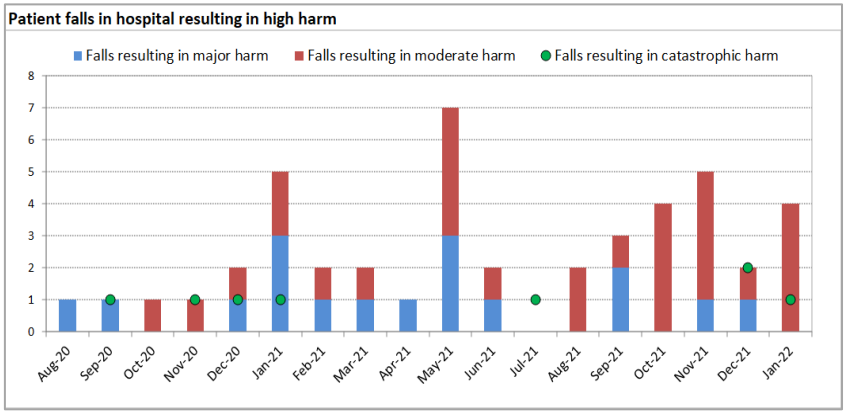
Hospital Associated VTE

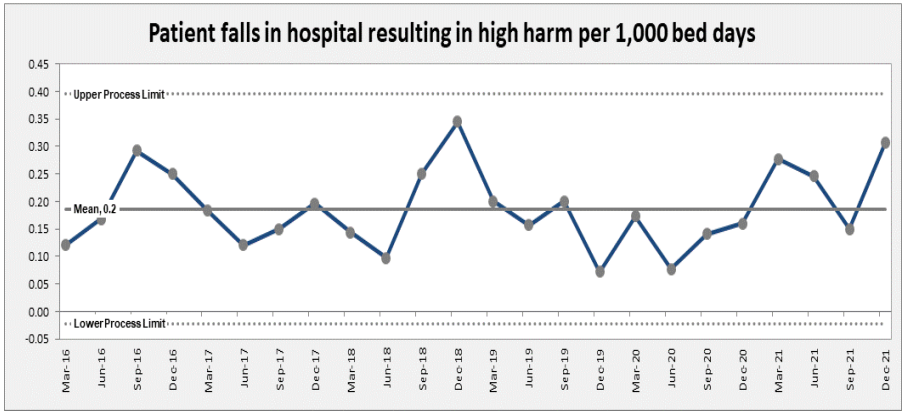
- Total number of VTE in January 2022 : 61
- Hospital Acquired (HA) VTE: 12
- 0.11% of total admissions. National average: 0.5 – 1.6%
- All patients diagnosed with a VTE are assessed and flagged as HA if associated with a hospital admission / surgery within 90 days of their diagnosis and a root cause analysis is completed.
- All VTE events in January developed a VTE despite being provided with appropriate VTE prophylaxis.

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

There were 4 falls graded as moderate in January - 3 of these were subarachnoid and subdural haematomas and 1 resulted in multiple rib fractures.

There was 1 catastrophic fall resulting in death from a subarachnoid and subdural haematoma.

BUSINESS AS USUAL:

- A real time post falls review by the Falls Reduction Specialist is providing staff and patients with advice and guidance
- SWARMs for falls causing high harm continue to be submitted to the weekly Patient Safety Summit in a timely manner with good compliance
- Weekly written reports for the matrons and heads of nursing are presented, so that causes and themes can be reviewed for their areas. 3 examples of themes have been:

1. Lack of lying and standing blood pressure monitoring
2. Lack of correct and accurate risk assessments and interventions
3. Staffing for enhanced care nurses (1:1)

- The Share and Learn meeting was cancelled due to Trust Operational Pressures, but January's data will still be presented at the February meeting. From the wards that have to present, key learning points will be shared in February's data.

OTHER IMPROVEMENT WORK:

A **Falls Reduction Action Plan** linked to the Falls Strategy (with key highlights on progress against the actions) is to be reported quarterly.

The Improving Together programme has identified 'Falls' as a 12-month Trust Breakthrough objective. Reporting requirements are yet to be determined as part of this work.

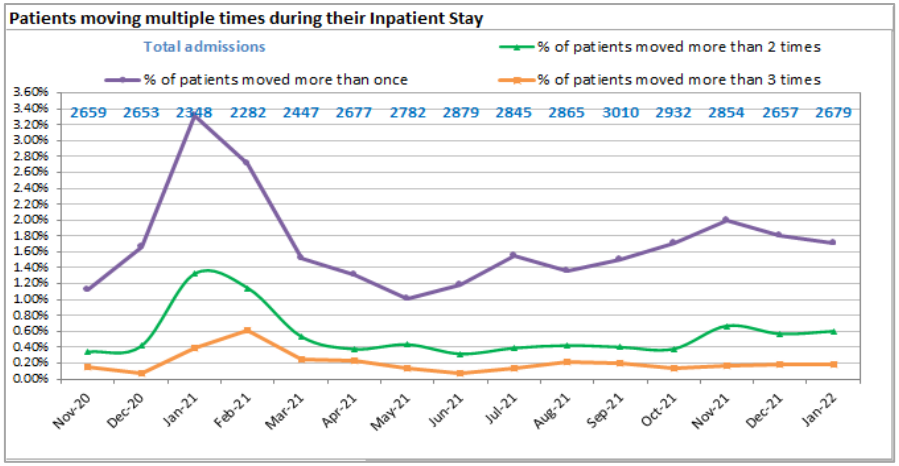
Statistical Process Control Chart Key:
Target
Mean
Upper / Lower Process Control Limits (UPL/LPL)
Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
Special Cause Variation Concern (6 or more points worse than the mean, or a single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

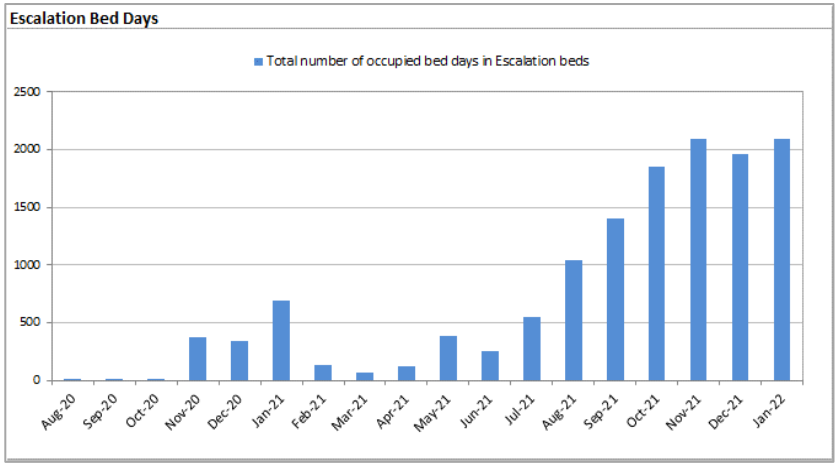
Patient Experience

Are We Safe?

Last 12 months	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22
Bed Occupancy %	86.8	87.6	90.8	91.2	90.8	90.0	93.9	93.0	94.6	95.0	93.2	93.8

Data Quality Rating:





Summary and Action

Sustained escalation and system pressure has resulted in January seeing a continued high level of both patient moves and occupied bed days in escalation beds. Whilst the proportion of 3 moves plus is small, the negative impact on both the experience and length of stay for patients is critical to recognise and remains a focus of improvement.

Accommodating COVID, potential COVID and contacts of COVID has been a challenge for the teams and has been a significant contribution to both the use of escalation beds, and the moves required to ensure the safety of all our patients as far as is possible.

Escalation areas have included the Day Surgery Unit either upstairs or downstairs and additional beds in existing ward areas . The use of all this capacity has been consistent throughout January, and additional quality reviews by divisions and risk assessments regarding patients to move into escalated beds have been made.

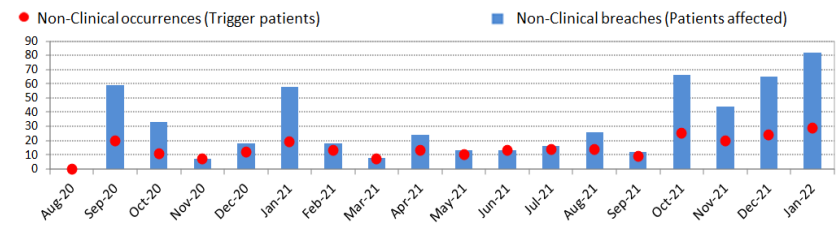
Until the Trust experiences a significant impact in discharging patients no longer meeting the criteria to reside or a reduction in the pressures associated with managing COVID safely, it is anticipated that the use of escalation areas will continue through February.

Patient Experience

Are We Safe?

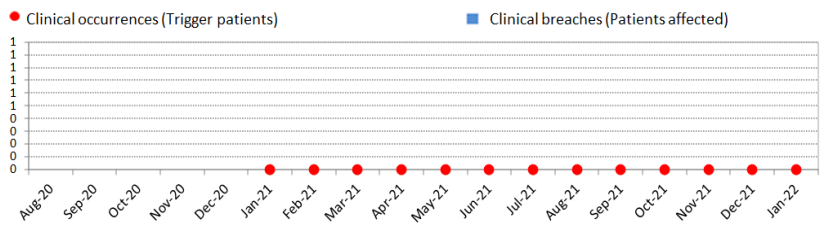
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
■	0	59	33	7	18	58	18	8	24	13	13	16	26	12	66	44	65	82
●	0	20	11	7	12	19	13	7	13	10	13	14	14	9	25	20	24	29

Delivering Same Sex Accommodation - Clinical



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

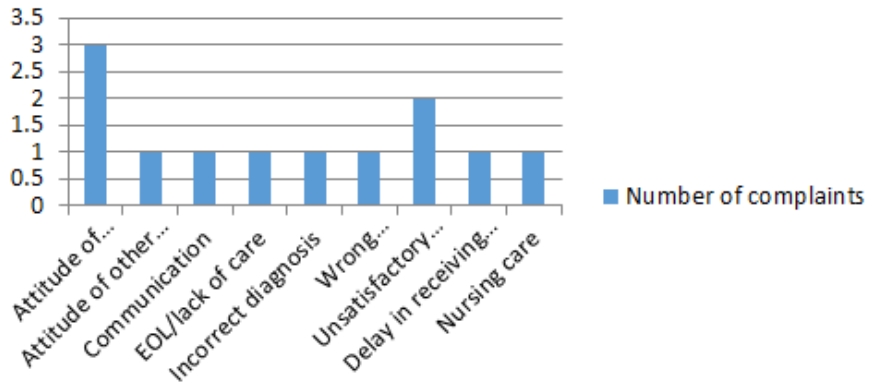
- There were 17 breaches affecting 17 patients which occurred on Radnor. These were all patients who were unable to be moved off the department within 4 hours of being declared fit to move.
  - 9 breaches were resolved within 24 hrs.
  - There were 8 patients who had a breach time of over 1 day while awaiting a speciality bed.
  - Privacy and dignity was maintained at all times within the patients bed space
- There were 12 breaches affecting 65 patients on AMU assessment bay. All patients had access to single sex bathrooms within the ward, and screens were used to maintain privacy and dignity.
  - 10 of the breaches were resolved within 24 hours.
  - The remaining 2 were resolved within 48 hours.

Patient & Visitor Feedback: Complaints and Concerns

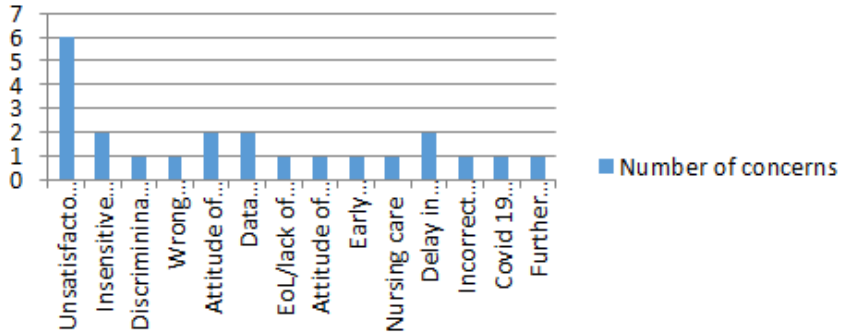
Are We Responsive?

Data Quality Rating:

Number of complaints & trends Jan 2022



Number of concerns and trends Jan 22



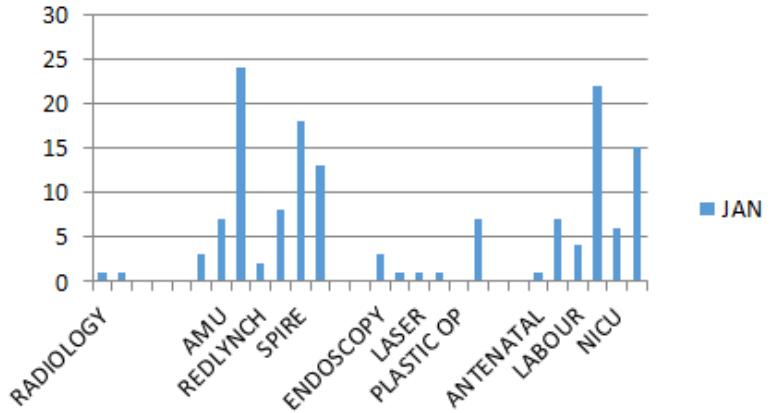
Summary and Actions:

Themes from complaints: There were 12 complaints raised in January 2022. As can be seen from the graph above there are a wide range of categories used when logging complaints on Datix. The theme s noted are still attitude of staff

Themes from concerns: There were 23 concerns raised in January 2022. As can be seen from the graph above there are a wide range of categories used when logging concerns on Datix. The themes generally relate to unsatisfactory treatment mainly due to relatives being unable to visit and understand the treatment and care given . PALS continue to receive a large volume of calls in respect of outpatient appointments. This reflects national concerns regarding waiting list lengths and similar increases in PALS contacts are seen across the NHS.

There were 136 compliments in January which far outweighs the number of complaints and concerns.

JAN 22 compliments



Part 3: Our People

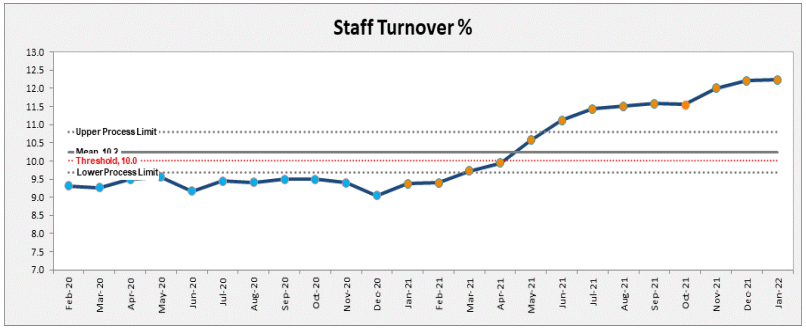
Performance against our Strategic Priorities and Key Lines of Enquiry

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

Workforce – Turnover

Use of Resources

Total Workforce vs Budgeted Plan - WTEs



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

12 month turnover for month 10 is 12.24%. This was a slight increase from last month which was 12.21%. There were 29 leavers and 45 starters by headcount in month. The most common reason, where recorded, for leaving was "Retirement Age" 17% of all reasons for leaving.

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

In order to help increase retention and increase our understanding of the reasons why our people leave, HR Operations are:

- Finalising the exit interview process which will be published on 1st April 2022. Line Managers will feel more able to conduct exit interviews and the information will increase our evidence base of the reasons for leaving. This will enable the People BPs to understand Departments we then need to focus on for themes that arise from the exit interviews.
- Updating the stay process to ensure fit for purpose, which will maximise our chances of retaining valuable staff before they have made the decision to leave. The impact of this will be lower turnover and increased staff retention.
- Identifying staff in the 50+ age group to identify possible retirement hot spots, begin late career/ stay conversations with the ambition to retain staff for longer, increase the number of retire and returns and ensure recruitment to replace in sufficient time.

Risks to delivery and mitigation

Detraction from proactive interventions due to an increase in absence management or urgent operational performance activity – mitigation is to ensure regular resource planning/ deployment of task and finish approach to work

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

January 22	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	443.41	459.09	(15.7)
Nursing	1,030.79	1,060.25	(29.5)
HCAs	540.72	537.24	3.5
Other Clinical Staff	632.11	676.49	(44.4)
Infrastructure staff	1,266.38	1,341.05	(74.7)
TOTAL	**3,913.4**	**4,074.1**	**(160.7)**

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

Vacancy rate in month 10 (January) was 3.65%, compared to 3.64% in December. The Division with the highest vacancy rate was Medicine at 6.97%.

Of the 118 staff who have left medicine in the last year, 27 (23%) left to relocate elsewhere, 20 (17%) left with no reason given, 19 (16%) left due to work life balance, and 14 (12%) left due to retirement – age. and 9 (8% left due to health reasons.

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

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

A 2nd successful recruitment event held in the Guildhall with Facilities and Estates which resulted in 23 offers being made with 71 individuals attending. Offers were predominantly made to bank workers across the whole of Facilities, Housekeeping are still running with a vacancy gap of 21 posts, this is made up of a mix of substantive and fixed term roles.

Already planning to hold a 3rd event with scoping being undertaken to extend to a 2nd day for other staff groups to attend. 3rd event planned for early April.

From 1st round of Health Care Assistant (HCA) , interviews held with a total of 14 offers being made. 2nd round of advertising due to commence 14.02. The Trust is looking to recruit 36.74 wte HCA's.

Procurement exercise to appoint agencies in support of collaborative international nurse recruitment across BSW will be completed by 01.03.2022.

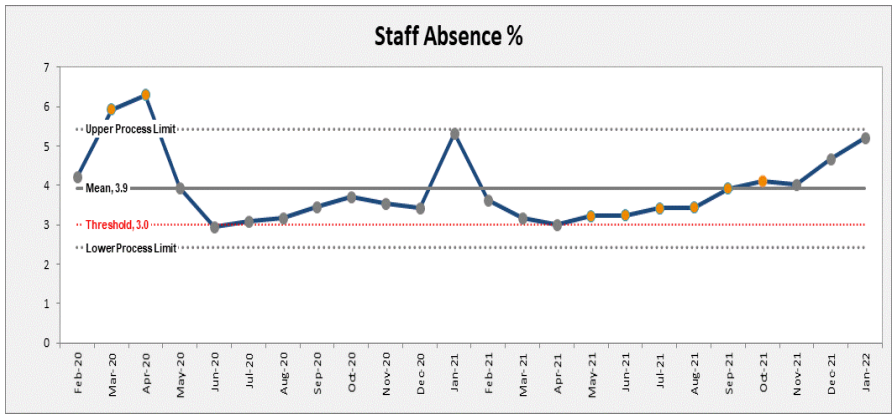
Recruitment agency appointed to support recruitment of international midwives, with 2 applications now being received (collaborative recruiting with GWH and Gloucester, to recruit a total of 15 midwives by July 2022, 5 per Trust).

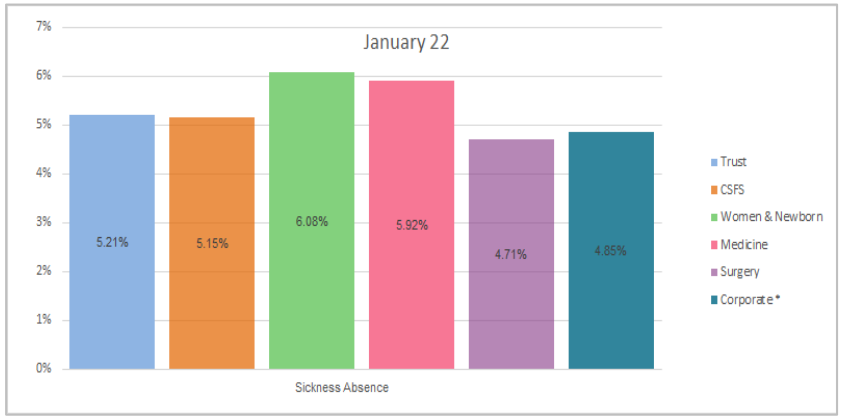
Risks to delivery and mitigation.

Independent consulting support is to be secured to overhaul our recruitment practices and ensure our end to end process both meets the EDI 6 point plan and provide an efficient and welcoming experience for all candidates – this work will require time and information from the Recruitment team. Mitigation – to prioritise recruitment activity through month of March into April / secure additional help from LM and People Advisors.

Workforce - Sickness

Use of Resources





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

Sickness in month 10 saw an increase to 5.21%, sickness for the rolling year remained at 3.82%. All Divisions are above the Trust target of 3%. For the month of January, "Infectious Diseases" was the top cause of sickness across all Divisions, with the exception of Women and Newborn Division, where Stress/Anxiety/Depression was the top cause of sickness absence.

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

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

Wellbeing phone calls with staff on long term sickness have commenced, these will be completed by end February. Discussions about redeployment to encourage earlier returns to the workplace form part of these conversations where appropriate.

Working with Occupational Health teams to priorities case referrals where it is felt an employee is ready to return to work in some capacity.

CSFS have a particular focus this month in reviewing all short-term triggers to ensure staff are being supported in line with trust absence policy.

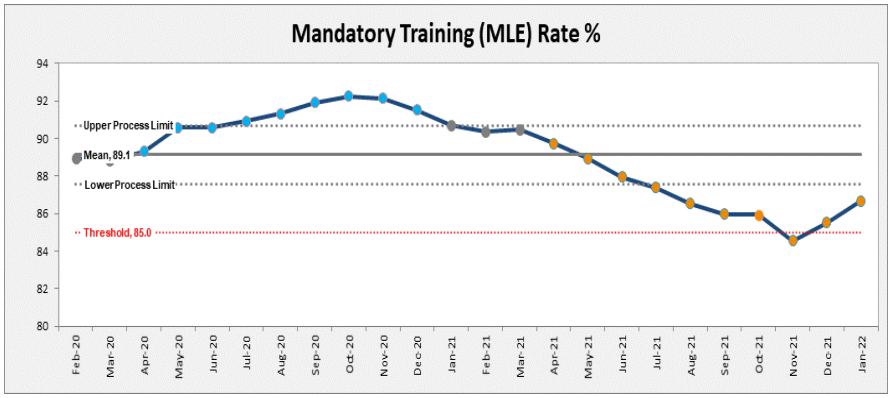
Wellbeing communications, such as sleep health workshops are being promoted within Medicine to ensure staff are aware of available support.

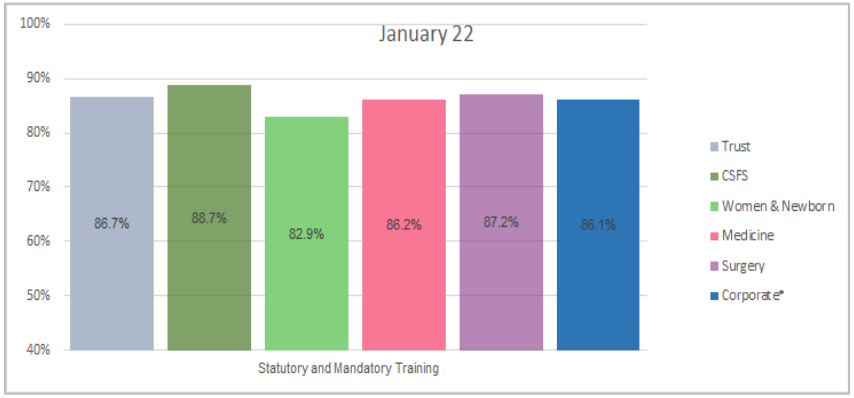
Risks to delivery and mitigation.

Wellbeing phone calls not resulting in staff returning to work, however early feedback is staff are appreciating the proactive supportive contact.

Workforce – Staff Training

Use of Resources





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

The Trust's mandatory training compliance rate was 85.67% for month 10. This is slightly above the previous month but below the same time last year. All 5 Divisions are below target.

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

We currently have over 1000 staff non-compliant with Hand Hygiene. Some of these are Bank staff or staff currently working from home or on other sites.

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

BP's to contact DMT's to priorities mandatory training subjects pertinent to individual services with lists to be returned to Education team

Education to contact Departmental Heads to seek support to enable completion of 1st priority area

Commence Hand Hygiene focus 14/02/22 for 2 weeks

Education Team are working with Subject Matter Experts to establish errors in assigning training to staff in order to correct. Prioritising Safeguarding and Resuscitation due to inaccuracies in levels and intention is for all records in these areas to be correct by 31st March 2022.

New process implemented for assigning Safeguarding Levels going forward.

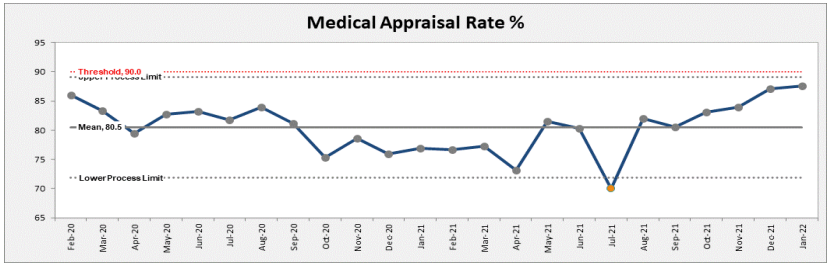
All ward areas contacted to provide accurate and up to date information to resus department, to allow errors to be corrected.

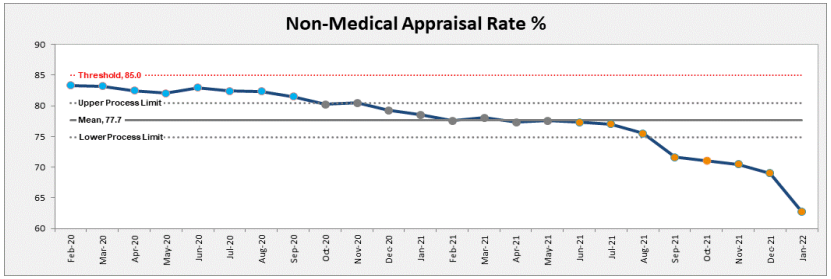
Risks to delivery and mitigation.

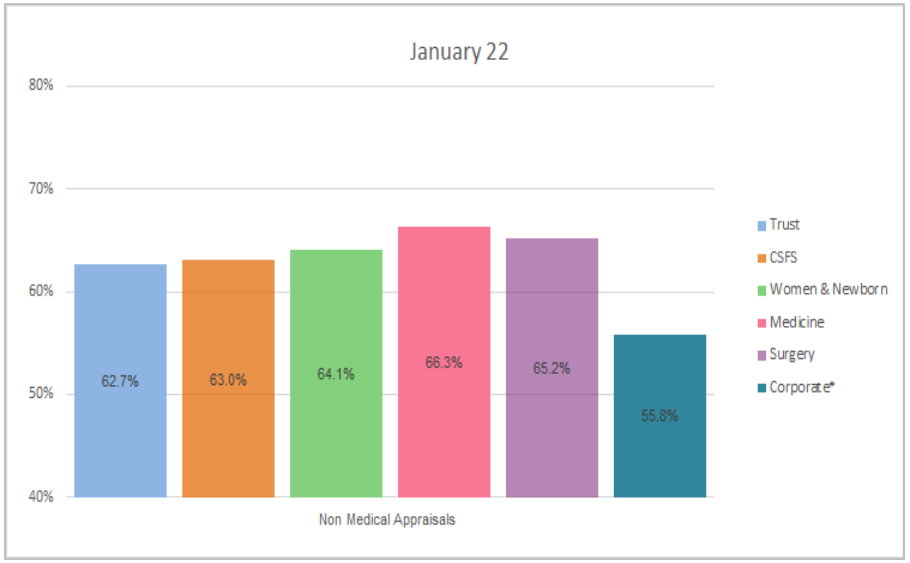
- Staff unable to be released to attend training. Remains challenging to release staff for BLS and Moving and Handling training as required operationally.
- DMT's unable to prioritise due to operational pressures - prioritization will take place based on performance
- Lack of admin support to contact all department leads to ask for focus on priority areas, resulting in that action not being completed - Admin task carried out by Senior Manager

Workforce – Appraisals

Use of Resources







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

Non Medical Appraisals for month 10 remain under target at 62.7%, this is a decrease on the previous month position (69.0%). Hotspot areas are Corporate (55.8%) and CSFS (63.0%)

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

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

BPs to work with DMTs to review list of staff with overdue appraisals, identifying those most out of date/ those LM who have the most to complete and offering support.

Breakdown of information to be ready by end of February and plans for completion to be agreed.

Providing Divisions with additional training required for new appraisal system through the Workforce Information team.

Risks to delivery and mitigation.

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

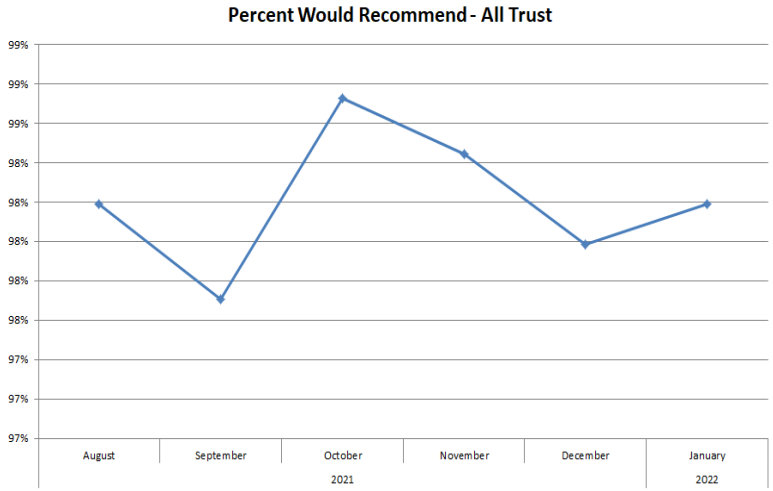
Feedback from Friends and Family test - January 2022

Are We Responsive?

"Unbelievable, so caring, they talked me through everything. My hand was held throughout. Barry White was played. The staff made me laugh. My doctor was fantastic and very gentle" *Plastics Surgery Theatres*

"The friendliness and efficiency of all the staff who showed that they had patience with difficult behaviours. Nothing was too much trouble for all the nursing staff and other hospital staff during my admission. I would especially like to commend student nurse and Associate NP. I did not notice anything that needed to be done better. The staff had a wonderful work ethic and their professional approach was the best I had witnessed anywhere" *Britford*

"Door left open a lot after visits. A more sensitive teenager liked her privacy. Lots of people coming in but never knocking. Why were they all coming into her room" *Sarum*



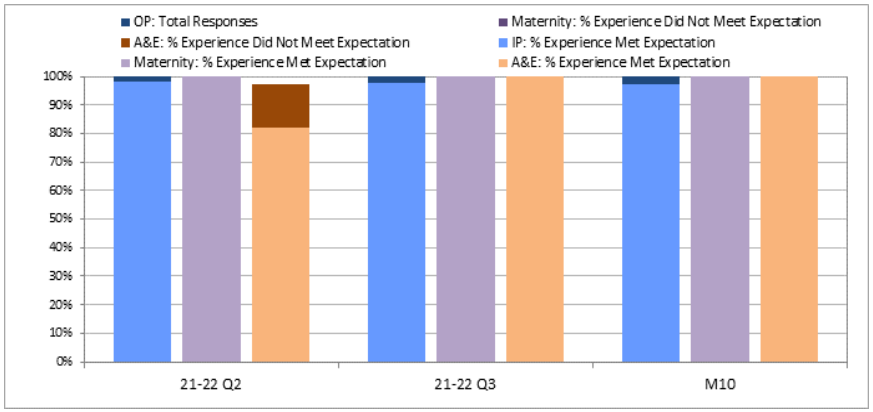
"The only thing that made me feel uncomfortable about the whole appt was unfortunately the doctor who made me feel like that. They were rude and unapproachable, maybe their 10th procedure of the day, but I felt their bedside manner was poor especially as I was dreading the procedure" *Endoscopy*

"The ward manages to be relaxed and friendly, yet well fun and professional. This suggests good leadership by the sisters resulting in a happy team who demonstrate kindness and compassion. The ward is blessed with some exceptional HCA's with good nursing instincts. Particular thanks to the discharge nurse who listened to our wishes for my father and gave ongoing care and was helpful in all matters relating to this" *Spire*

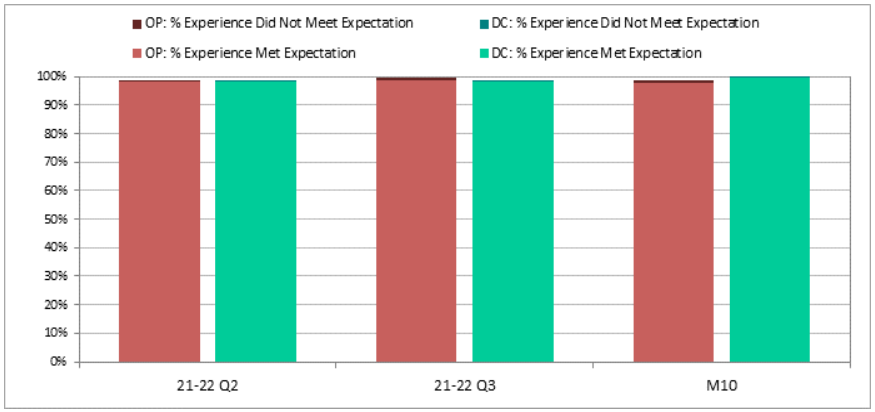
Friends and Family Test – Patients and Staff

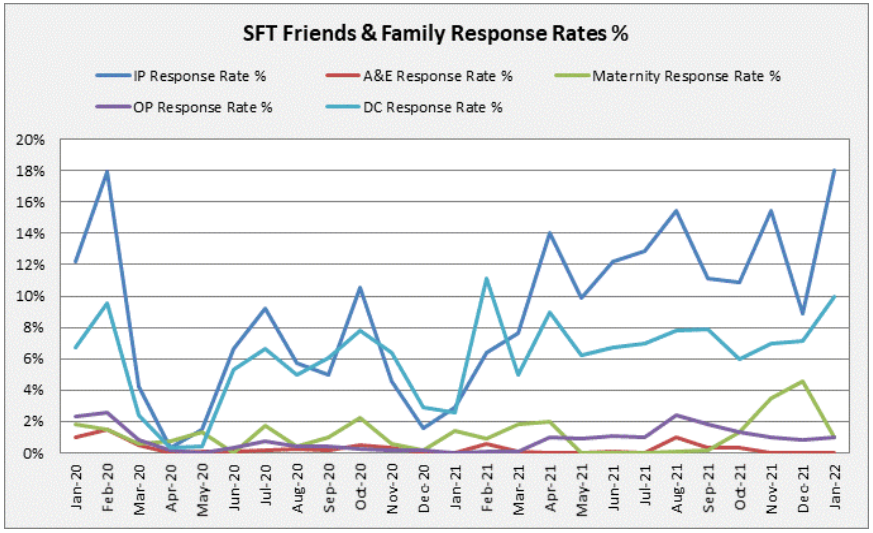
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





We are continuing to encourage use of Friends and family feedback forms in all areas but numbers have dropped off again this month.

Some more great figures on wards:

- Chilmark received feedback from over 68% of patients
- Tisbury received feedback from 46% of patients
- Pembroke received feedback from over 33% of patients

Part 4: Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

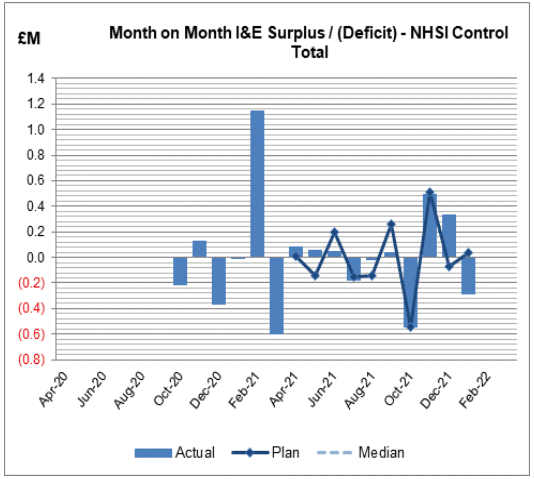
Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	Jan '22 In Mth				Jan '22 YTD				2021/22
	Plan £000s	Actual £000s	Variance £000s		Plan £000s	Actual £000s	Variance £000s		Plan £000s
Operating Income									
NHS Clinical Income	20,691	22,077	1,386		206,906	215,732	8,826		248,288
Other Clinical Income	1,251	1,044	(207)		13,330	7,551	(5,779)		15,832
Other Income (excl Donations)	3,165	3,086	(79)		29,335	28,859	(476)		35,658
Total income	**25,107**	**26,207**	**1,100**		**249,571**	**252,142**	**2,571**		**299,778**
Operating Expenditure									
Pay	(15,879)	(16,650)	(771)		(155,366)	(156,869)	(1,503)		(187,141)
Non Pay	(7,515)	(8,291)	(776)		(78,268)	(79,723)	(1,455)		(93,280)
Total Expenditure	**(23,394)**	**(24,941)**	**(1,547)**		**(233,634)**	**(236,591)**	**(2,957)**		**(280,421)**
EBITDA	**1,713**	**1,266**	**(447)**		**15,937**	**15,551**	**(386)**		**19,357**
Financing Costs (incl Depreciation)	(1,679)	(1,558)	121		(15,958)	(15,516)	442		(19,313)
NHSI Control Total	**34**	**(293)**	**(327)**		**(21)**	**35**	**56**		**44**
Add: impact of donated assets	*(49)*	*(62)*	*(13)*		*(413)*	*(550)*	*(137)*		*(511)*
Surplus/(Deficit)	***(15)***	***(355)***	***(340)***		***(434)***	***(515)***	***(81)***		**(467)**



Variation and Action

The final plan for H2 2021/22 was agreed in mid-November, this included an assumption of an allocation of BSW revenue to cover the Trust's initial planned deficit of £3.3m. This revenue is made up of a combination of ERF, ERF+, and discretionary system allocation. The nature of elements of this funding stream include elements of risk (e.g. ERF is contingent on the system delivering the planned level of activity as a whole) but £1.7m has been recognised in line with the underpinning assumptions of the system's H2 operating plan.

The Trust recorded a deficit of £0.3m in month 10, bringing the YTD position to a small surplus of £35k against the H2 plan. Pressures on the position persist, including from increased staff absence due to Covid and the increased cost of clinical supplies and Purchase of Healthcare.

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

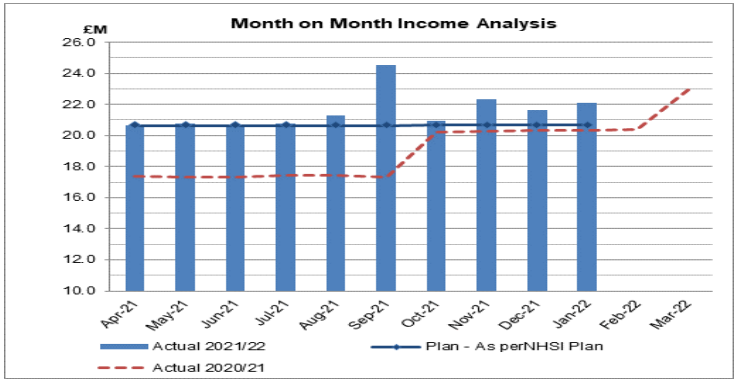
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	7,561	8,081	520
Day Case	12,534	13,544	1,010
Elective inpatients	11,062	8,191	(2,871)
Excluded Drugs & Devices (inc Lucentis)	17,319	17,670	351
Non Elective inpatients	52,695	54,510	1,815
Other	84,580	88,059	3,479
Outpatients	21,155	25,676	4,521
TOTAL	**206,906**	**215,732**	**8,825**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	126,893	133,177	6,284
Dorset CCG	20,807	21,122	315
Hampshire, Southampton & IOW CCG	15,658	15,897	239
Specialist Services	28,320	29,796	1,476
Other	15,228	15,739	511
TOTAL	**206,906**	**215,731**	**8,825**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	57,504	57,165	(339)	43,682	13,483
Day case	16,488	17,165	677	12,204	4,961
Elective	3,048	2,324	(724)	1,784	540
Non Elective	23,535	23,514	(21)	21,213	2,301
Outpatients	193,755	224,654	30,899	177,910	46,744

Variation and Action

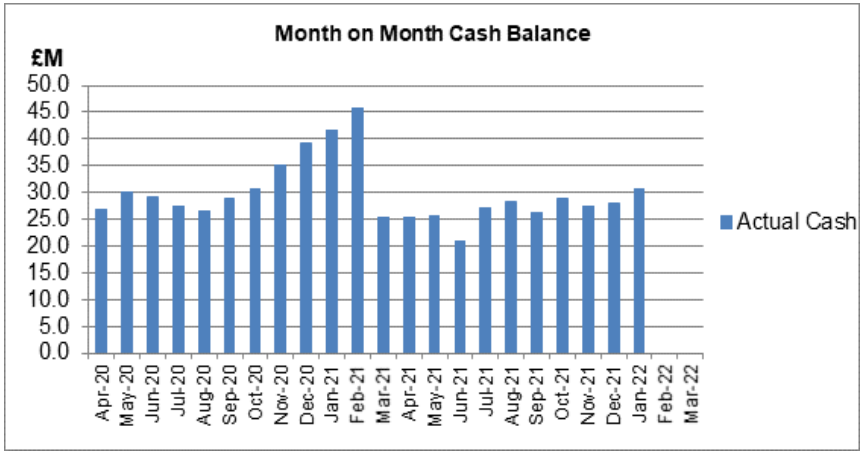
Activity in January in day cases recorded 156 spells more than in December but fell short of the plan for the month by 111 cases. Day case activity remains above plan and has improved this month in the specialties of Cardiology (31 cases) , Urology (57 cases), Oral Surgery (19 cases) and T&O/Spinal (25 cases) but activity levels have dipped this month in General Surgery (19 cases). Activity in elective inpatients remains below plan and actual activity was higher than in December with improved performance in Urology (14 cases), Plastic Surgery (12 cases) and Colorectal Surgery (11 cases). Non-Elective spells were higher than in December and are marginally below plan year to date. Activity pressures continue in Obstetrics and less spells were reported in Medicine. Outpatient activity increased this month in most specialties. Activity levels in A&E remain below the plan year to date.

For the second 6 months of the financial year (H2) the block allocations from commissioners have been uplifted. The plans have not been adjusted and remain at H1 levels The .Elective Recovery Fund (ERF) income for the first 6 months of the financial year (H1) of £2.02m has been included in the financial position against BSW CCG. Additional H2 income from BSW CCG of £2,507k has been included in the position in January, this represents the value agreed as part of the final H2 planning process.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



Prepayments have increased by £1.3m as a result of the requirement to pay NHS Resolution contributions for CNST over the first 10 months instead of the full year. The charge covering the calendar year for the fully managed EPR system of £1.2m has also been included in prepayments in the month.

Creditors have risen since the year end partly due to the move to SBS which has resulted in taking longer to clear supplier invoices involving queries. Work is ongoing to identify where the issues arise and to take steps to improve efficiencies. Purchase order related invoices, where quantities and prices match, are moving smoothly through the system. They also include £1.4m PDC accrual, as this is paid in two instalments in the year, the next being due in March 2022.

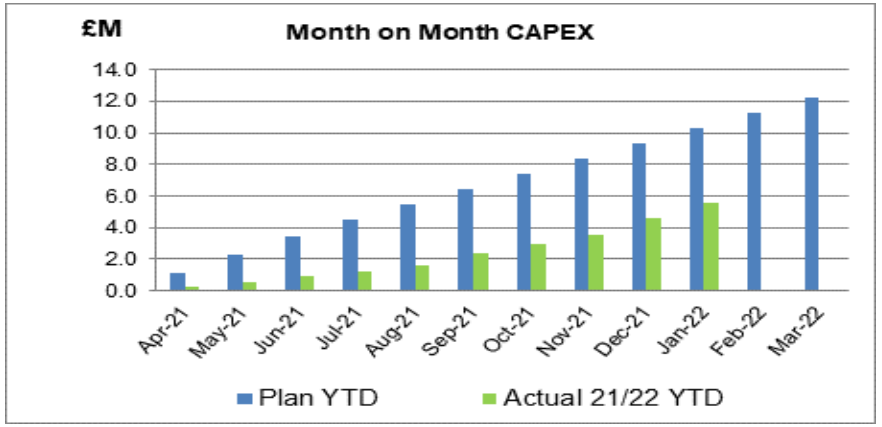
The Trust has now returned to the pre-Covid mid-month contractual payment arrangements. Block contracts have been agreed for the second half of the year.

The base assumption from a cash forecasting perspective is that the Trust will continue to report a balanced revenue position throughout 2021/22.

The cash position increased in January primarily as a result of the payment of Elective Recovery Funding. Cash still remains higher than anticipated as the capital programme remains behind plan and creditors are higher than expected.

Capital Expenditure Position

Schemes	Annual Plan £000s	Jan '22YTD Plan £000s	Jan '22YTD Actual £000s	Jan '22YTD Variance £000s
Building schemes	1,175	1,080	1,272	(192)
Building projects	4,979	4,150	1,289	2,861
IM&T	3,872	3,230	1,929	1,301
Medical Equipment	1,728	1,461	683	778
Other	450	367	367	0
Additional Funds approved in year	2,778	0	37	(37)
TOTAL	**14,982**	**10,288**	**5,577**	**4,711**



Summary and Action

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

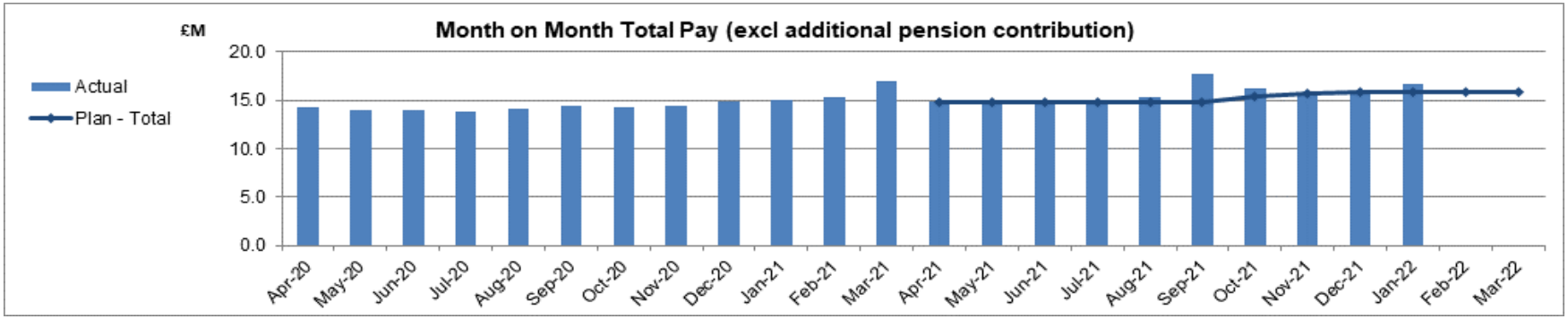
The original capital plan was based on a fairly even distribution of spend throughout the year. However, some building schemes have either been delayed or have been revised. A revised detailed profile plan of how all elements of the programme will be achieved by the end of the year has been developed.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

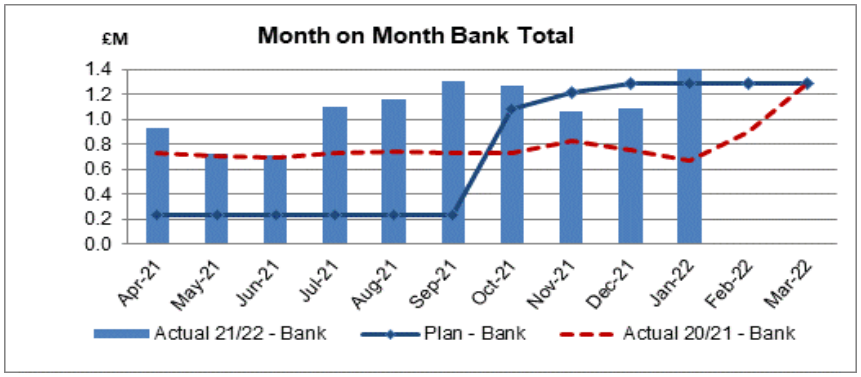
The trust has now been notified that bids for additional capital, including through the Trust Investment Fund, totalling a further £3.6m, have been approved. Plans are now being prepared to procure the equipment and works identified as part of these schemes, whilst continuing to ensure the remaining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

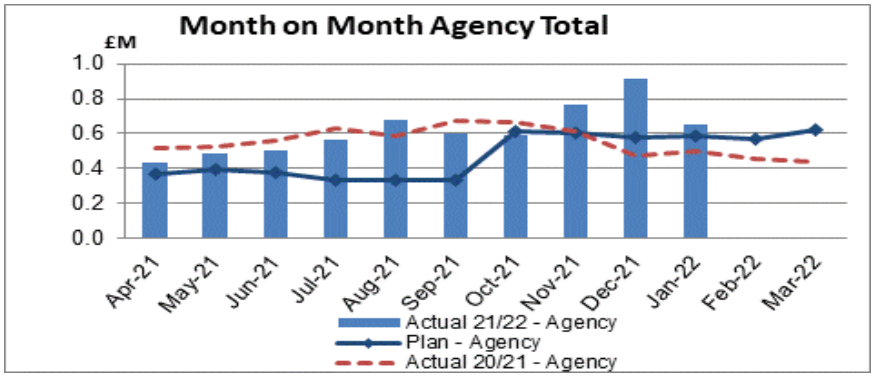
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay costs increased in Month 10 by £672k (4.2%). The reported figures include a revision of the provision for the Trust's liabilities with respect to enhancements on annual leave pay.

Expenditure on agency reduced by £260k, but this was more than offset by an increase in bank (£345k - mainly in registered nursing and support to nursing) and substantive costs (£588k, of which £455k was in registered nursing). Most of the increase in nursing and support to nursing expenditure can be accounted for in the Medicine division. Increased costs here are driven by a number of issues including, last minute sickness , self isolation (children testing positive for Covid), vacancy levels (particularly band 5 nurses) and increased use of escalation.

The Trust has welcomed a further two overseas nursing recruits in December, bringing the total to 37 this year. A further 13 are expected by the end of the calendar year, as both those delayed due to Covid and the 2021/22 recruitment pipeline begin to arrive. The Trust is receiving funds to cover the costs of appointment, but supernumerary expenses in the first weeks are the Trust's responsibility: this equates to approximately £7.5k per recruit.

Although activity at the vaccination centre has slowed, the Trust has still reported 9.28 WTE infrastructure support staff (cost £31k in month) over planned levels relating to the vaccination centre at Salisbury City Hall, where the plan is for staffing to be provided by RUH, but any staffing provided by SFT is considered 'out of envelope' and directly reimbursed through NHSEI.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	10 March 2022		

Report Title:	Health and Safety Annual Report 2020 -2021			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Gordon Perry, Health and Safety Manager David Cotterill,, Health and Safety Advisor			
Executive Sponsor (presenting):	Melanie Whitfield, Chief People Officer			
Appendices (list if applicable):				

Recommendation:
The Trust Board is asked to review and note the contents of the annual report.

Executive Summary:	
Executive Summary The period 2020/21 saw a change to the Health and Safety team with the departure of the Health and Safety Manager, Health and Safety Advisor and the COSHH Advisor near the middle of this period. Recruitment for the roles of Health and Safety Advisor (David Cotterill) and Health and Safety Manager (Gordon Perry) was successful with the Advisor taking up the role at the beginning of January and the Manager mid -June. The main focus was the COVID-19 pandemic, the challenges arising from this are well documented, changes to working practices, travel, healthcare priorities were all presented. Through monitoring the changes to the guidance provided by HSE, government, PHE, etc. Remedial actions were agreed and implemented admirably by SFT as a team. Some elements of Health and Safety such as safety inspections, walk - rounds, face to face training etc have been postponed in order to manage the spread of infection and protect staff members who were classified as high risk.	**Annual H&S Statistics** **2020/2021** **(Figures in brackets are 2019/2020)** **469 (531)** Total Incidents Reported **448 (507)** Incidents resulted in No or Low harm **21 (23)** Incidents resulted in Moderate harm **0 (1)** Incidents resulted in Severe harm **15 (11)** Reported RIDDORs

Improvements to the incident review process led to better recognition of the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 (RIDDOR) reportable incidents (including a specific process for COVID-19 related potential RIDDOR submissions) The Trust incident reporting system shows a slight decrease in incidents against 2019/20.	**Physical abuse 156 (208)** Top reported incident category to staff

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

1 Purpose

1.1 The purpose of this report is to provide the Trust Board with summary information that Health and Safety during the period August 2020 to August 2021 has been a key priority and managed within Salisbury NHS Foundation Trust (SFT) by sharing information on progress and delivery.

The report also highlights progress of the programme of work being delivered by the corporate Health and Safety Team in partnership with colleagues within the Divisions. This programme aims to achieve further continued improvements in health and safety management, whilst also highlighting and mitigating associated risks. An important focus of current activity is to encourage and support an organisational culture in which a positive and proactive approach is taken to health and safety management.

2 Background

2.1 All organisations have a legal duty to put in place suitable arrangements to manage health and safety. Ideally, this should be recognised as being a part of the everyday process of conducting business and/or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

2.2 The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing health and safety legislation. The HSE also fulfils a major role in producing guidance on health and safety issues, and on the interpretation and application of the provisions of the legislative framework.

2.3 Regardless of the size, industry or nature of an organisation, the keys to effectively managing for health and safety are:

- leadership and management (including appropriate and effective processes);
- a trained/skilled workforce;
- an environment in which people are trusted and involved.

3. Local Health & Safety Governance

3.1 The Trust Board is responsible for providing leadership in the recognition and management of principal health and safety risks, and in the continuous improvement in health and safety performance. The Board fulfils its obligations through the designated Board lead for health and safety management, the OD & Culture Lead, Workforce Redesign Team who, in turn, is responsible for the activities of a team of health and safety qualified professionals, including at least one Institute of Occupational Safety and Health (IOSH) member in line with NHS Workplace Health and Safety Standards. The team is led by the Trust's Health and Safety Manager, who is line managed by the Deputy Chief People Officer.

3.2 With the support of the Board Lead for Health and Safety, and under the direction of the Health and Safety Manager, the principal responsibilities of the health and safety team are as follows:

- Developing and reviewing associated Trust policies, procedures and guidance;

- assisting the Board lead in the development of strategic health and safety objectives;
- establishing and implementing a programme of health and safety audits;
- co-ordinating and monitoring the effectiveness of safety arrangements across the Trust;
- identifying health and safety risks and implementing response plans;
- providing accessible and responsive advice and guidance to Trust staff on all health and safety-related matters;
- ensuring that all health and safety training needs and competence reviews are identified and met;
- Reporting RIDDOR incidents to the HSE and liaising with external statutory bodies.

3.3 The OD & Culture Lead, Workforce Redesign Team, on behalf of the Board Lead, chairs the Trust Health and Safety Committee, which meets on a bi-monthly basis. Providing assurance to the Workforce Committee, the Committee is responsible for ensuring the development, implementation and maintenance of a health and safety policy, and supporting procedures, and for overseeing all aspects of health and safety management. The Committee membership includes all members of the health and safety team, representation from the Occupational Health and Wellbeing Service, nominated representatives of the clinical and corporate Divisions, and staff side health and safety representatives.

3.4 A number of health and safety sub-committees routinely report to the main Committee. The sub-committees are as follows (currently under review):

- Waste management group
- LSMS and security development group (Including violence and aggression)
- Radiation protection committee
- Fire working party
- Medical gases group
- Medical Devices Group
- Water safety group
- Laboratory safety group (Genetics and Pathology)

Following changes to the reporting structure the minutes of these groups are received from the sub-committees. A summary of their activities in this period are available. The minutes of the Health and Safety Committee are tabled at (the People & Culture Committee) and are posted on the intranet.

3.5 The Trust aims to establish and maintain suitable, sufficient and proportionate standards of health and safety management that will ensure the welfare of employees and others who may be affected by its activities, and to minimise its losses (both financial and reputational) arising from ill health and injury.

3.6 In 2020/2021 the achievement of this principal aim was supported by the progression of a number of key objectives, which are summarised as follows:

- Continue to develop and support the health and safety union representatives with regulatory updates

- Assess the relevant sections of the Risk Register
- Update of MLE packages where appropriate
- Policies to be kept up to date
- Support all the various sub-committees

3.7 Some elements have yet to be delivered in full:

- Develop, in conjunction with Occupational Health, a strategy for identifying and then implementing health surveillance through policy. This is part way through as part of the HSE plan
- Assessment of space usage under the workplace regulations is a continuous programme of work as the Trust continues to develop.

3.8 Aims for 2021/22 have been identified as follows:

- To rationalise the H&S Committee, defining attendees including sub-committees, ensuring committee meetings are effective with minimum agenda items and any assigned actions are monitored to closure.
- Review the Health and Safety Policy and develop a set of Trust Safety Instruction (TSI's) which will include procedures, guidance and training e.g. Risk Assessment, Audit/Inspection etc.
- Introduce a fit for purpose Audit and Inspection programme and documentation. This will include monthly inspections carried out by H&S Team, department manager or deputy, H&S local Rep. The site will undergo a full audit (frequency and detail to be determined)
- Determine compliance with completion and suitability of workplace risk assessments, produce TSI including a standard risk assessment form then deliver training and support.
- Improve reporting by aligning frequency of meetings and subsequent reports. Provide in depth data relating to incidents, types of injury, RIDDOR details.

5 Recommendations

5.1 The Trust Board is asked to review and note the contents of the annual report.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	10 March 2022		

Report Title:	Nursing Skill Mix Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	x
Approval Process (where has this paper been reviewed and approved)	Written for Board, reviewed by Chief Nursing Officer			
Prepared by:	Henry Wilding – Interim Deputy Chief Nursing Officer			
Executive Sponsor (presenting):	Judy Dyos – Chief Nursing Officer			
Appendices (list if applicable):	Included within document itself 1. Summary of Sept 21 full skill review 2. CHPPD by division 3. Safe staffing RAG – purple and black 4. Supporting docs and Board Assurance Framework			

Recommendation:

The Board is asked to:

- Note the findings of the 6 monthly skill mix review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.
- Note the analysis completed which will be further updated in next full skill mix review expected to be completed August/September 2022.
- Note the continued challenge that arises from the impact of Covid surges on our ability to meet the planned and required CHPPD with our actual nursing resources.
- Note the roll out of Safer Nursing Care Tool across the Trust to ensure future skill mix reviews will have fully evidence-based staffing data as a triangulation point.
- Note that nurse staffing is subject to change due to changes in acuity, dependency, patient volume and these will be reported on in subsequent skill mix reviews. Particular focus is being given to the following areas who are experiencing change in model and/or demand (additional areas may arise through the full skill mix review):
  - Downton and its persistent use to support medical outliers
  - Breamore as a stroke rehab ward displaced by the presence of RCU
  - Britford SAU plans
  - Spinal workforce review
  - Paediatric workforce review

Executive Summary:

- This six month review has not quite followed the 'historical standard' due to unique challenges of the past six months to provide the best level of safe care we can as an organisation - utilising all available strategies and resources across the organisation to keep our patients safe, whilst recognising that sadly gaps and shortfalls have occurred and persisted.
- The ward staffing numbers have been specifically challenged over the past six months, driven directly and indirectly by the Covid-19 pandemic. Staff sickness, absence and resilience has been affected, along with the need to manage new ward and clinical environments, escalation areas, and an increasing acuity of patients with no criteria to reside. This is reflected in the consistent red flag escalation of staffing number to NHS regional teams, and the corporate risk of 7039 with a current risk score of 20.
- In terms of funded establishments, no further requests or increases are made as a result of this review, as primarily, the wards have been unable to achieve the current funded establishment levels, to be able to demonstrate that they are in way insufficient. It is however, worth noting that certain wards will be pushing the limits of their available establishments as they care for alternative patient groups with differing acuity and care needs, resulting in additional staffing requests to their funded templates. This has been predominantly seen with,
    - Downton ward - general surgical ward which continues to support approximately 12-15 medical outliers at any one time
    - Pitton ward – geriatric medicine ward caring for displaced respiratory patients from Laverstock ward and need to support Non-Invasive Ventilation
    - Amesbury ward – due to limitations and restrictions of Chilmark ward as elective environment, increased proportion of high acuity trauma and orthopaedic patients focused within Amesbury ward required enhanced care.

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

Trust Board March 2022

Title	Nursing Skill Mix Review Update
Meeting Date	March 2022
Sponsoring Executive	Judy Dyos – Chief Nursing Officer
Author	Henry Wilding – Interim Deputy Chief Nursing Officer

1.0 Background

This report provides an update on the full skill mix review that took place in August 2021 and forms part of the reporting requirements that every Trust is expected to have in place. The National Quality Board guidance on Safe Staffing (2016) sets out in expectation 1 that *' Boards should ensure there is an annual staffing review, with evidence that this is developed using a triangulated approach. …. This should be followed with a comprehensive staffing report to the Board after 6 months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.'*

The last full skill mix review was presented to Board in September 2021. This paper is presented to provide an update and report on key areas and provide assurance of current staffing levels.
It is important to note that nursing requirements do change overtime and within the year, due to the acuity/dependency and overall case mix changes, and in our response to the continuing Covid-19 pandemic and maintenance of elective recovery programme.

This review is intended to provide an update and will focus on the following areas:

- Update and review of recommendations from 2021 skill mix review
- Overview of Insights Data to assure the workforce is deployed efficiently and effectively
- Care Hours Per Patient Day summary
- Maternity/Neonates
- Reflection of winter 2021/22 and impact of Covid-19
- Next steps and relationship with BSW

2.0 Review of Previous Recommendations

In April 2021 an increase in headroom was applied across all inpatient areas moving from 19% to 24%. This resulted in sudden increase in vacancy rates amounting to approximately 28 RNs and 15 HCAs. At the time of the previous skill mix review in August 2021 there was varying levels of communication and understanding amongst the wards and divisions as to this uplift and previous awards of 2020/21 reviews, which meant this vacancy, coupled with other covid changes and increasing turnover rates, meant that previous staff increases and awards had not been consistently applied in terms of recruitment and impact for nursing hours provision.

As a result of the previous uplift and further time needed to review and evaluate the impact, only a few recommendations in terms of the 2021 review were presented to Board. These are summarised

in Appendix 1. The highlighted areas requesting further support (listed below) are now in the budget setting process to confirm this uplift for 2022/23.

Ward	Banding and WTE	Role/Shift	Cost	Comments
Hospice	B4 1.24	Early 5/7	£43,904	Unit is an outlier for only 2 RNs, increasing acuity, interventions, complex discharge, non-malignancy all impacting need for additional resource
Tisbury	B6 1.0	Uplift of x1 B5 to B6	£11,204	To allow provision of x1 B6 on each shift, support supervision, education, liaison with SUHT.
Sarum	B2 1.0	Play Assistant	£24,311	Previous fixed term post funded by Stars. Request to confirm as substantive role within funded establishment
Maternity	B6	1.96 (Birthrate Plus) + 4.29 (Continuity of Carer at 35%)	£355,818	Employed as B5 for first year. Costed as B6. Funding partially offset by Ockenden funding.

Extract from 2021 Skill Mix review, costings correct at the time of Board report September 2021.

Given the budget setting process for 2022/23 is ongoing, these previous recommendations are yet to be confirmed and realised. Similarly, with the ongoing increased turnover, high sickness and absence rates, and need to support ongoing escalation areas, our wards have had limited options to again fully utilise and experience the additional uplift of 2021.

3.0 Overview of Insights Data to assure the workforce is deployed efficiently and effectively

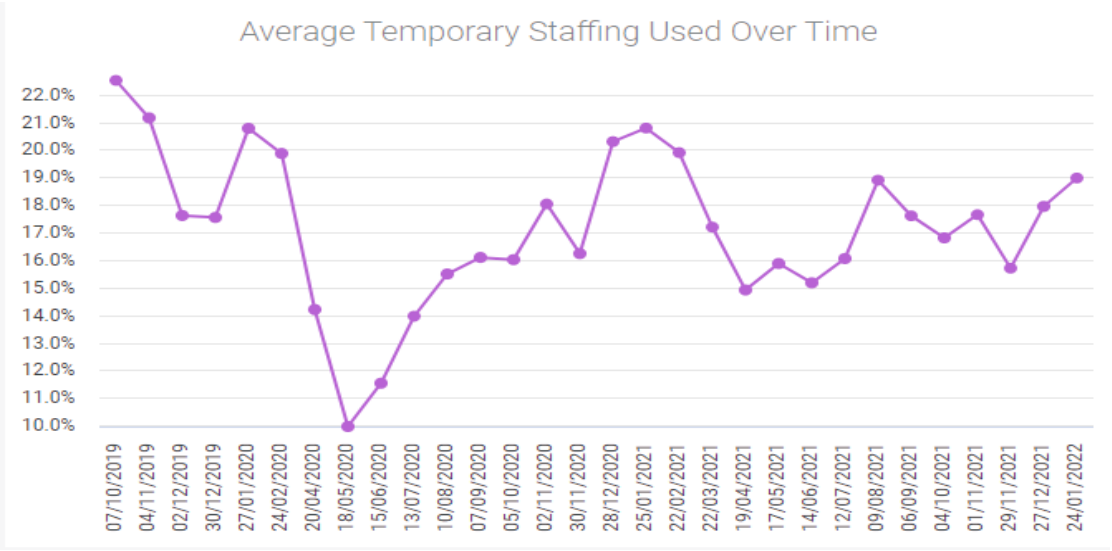
The Trust compares favourably when benchmarked providing assurance of effective deployment of substantive and temporary workforce efficiently. The Safe Staffing Steering Group (reporting to OD&P management board) monitors five core KPIs with two further additional nursing matrixes. In addition to this monitoring, the E-Roster lead regularly supports and proactively engages with leads and services at risk of deviation.

- **Temporary staff** - % of temporary staff used on rosters
- **Approvals** – % of rosters 2nd level approved 6 weeks in advance
- **Hours balance** – maintaining individual staff over/under-contracted hours balance
- **Unavailability** – % of total time staff are unavailable due to absence broken down by various leaves (study, parenting, sickness, AL) within set limits (headroom)

- **Additional Duties** - % of duties that are in addition to the agreed demand template levels
- **Unfilled duties** – % of duties that remain vacant in that roster period
- **Hours balance** – the balance of net hours utilised within the 4 week rota period

These metrics are viewable via a portal and enables a view of our performance both as a Trust with comparisons at ward level and also against all other Trusts using the portal, including those of similar size, Foundation Trusts and acute Trusts. Analysis below provides detail of each key metric and our current performance. An overview graph has been provided for each metric.

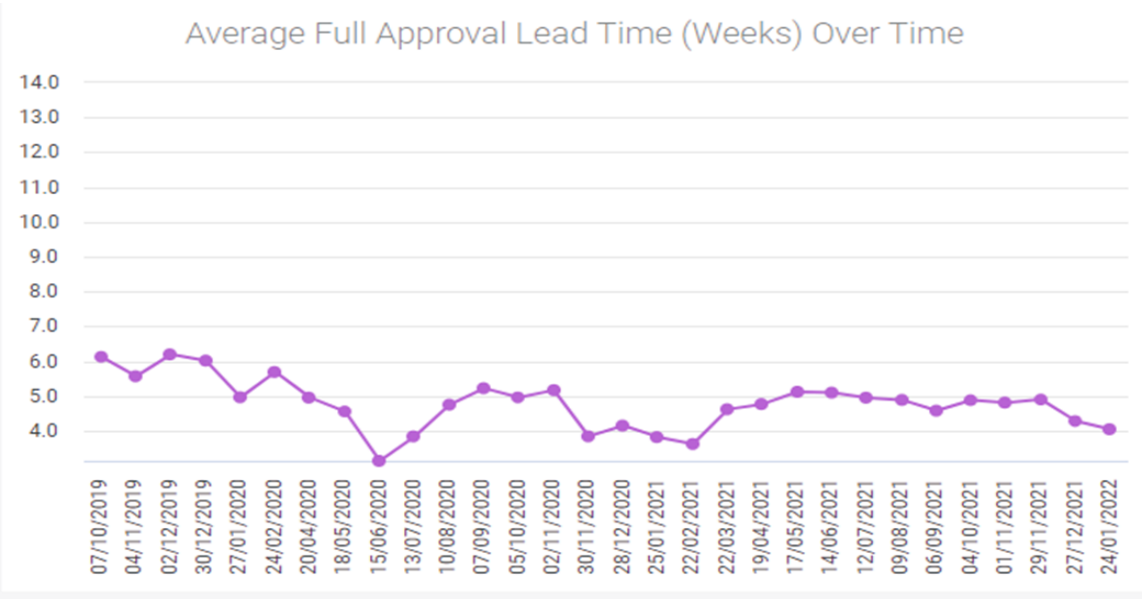
3.1 Temporary staffing



Trust average over the past year January 21 to January 22 is 18.7% of temporary staffing used (5.4% of which was agency). Total temporary staff use is made up of Bank and Agency assigned shifts. The percentage is a calculated proportion of the substantive shifts put out on a roster. Having rosters approved up to 6 weeks in advance has shown to reduce the reliance on the use of temporary staffing.

Within data the offered, the impact of covid and it's waves can clearly be identified, with the ow percentage of temporary staffing in May 2020 as a result of available capacity and low staff impact, through to the peaks of January/February 2021 and the current Omicron surge.

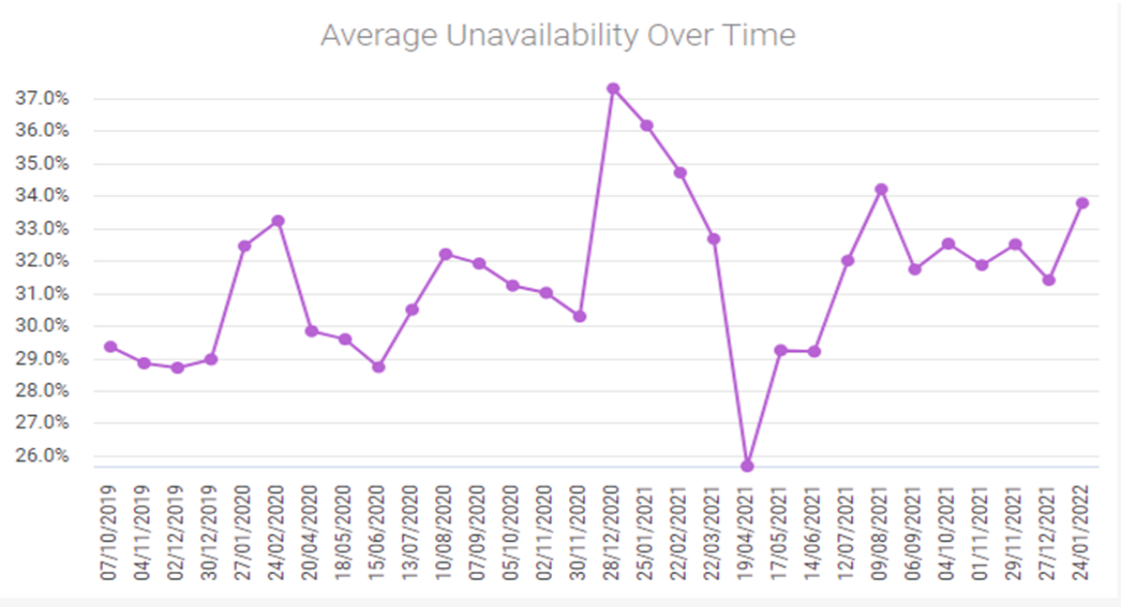
3.2 Approvals



Approval lead time January 2021 to January 2022 was an average of 4.8 weeks (Average approval lead time is calculated from the day the roster is fully approved to the day that it is worked). It is a KPI that rosters are approved 6 weeks in advance. Longer approval lead times can have a positive effect on other metrics such as sickness, temporary staff use and annual leave as well as staff satisfaction and wellbeing.

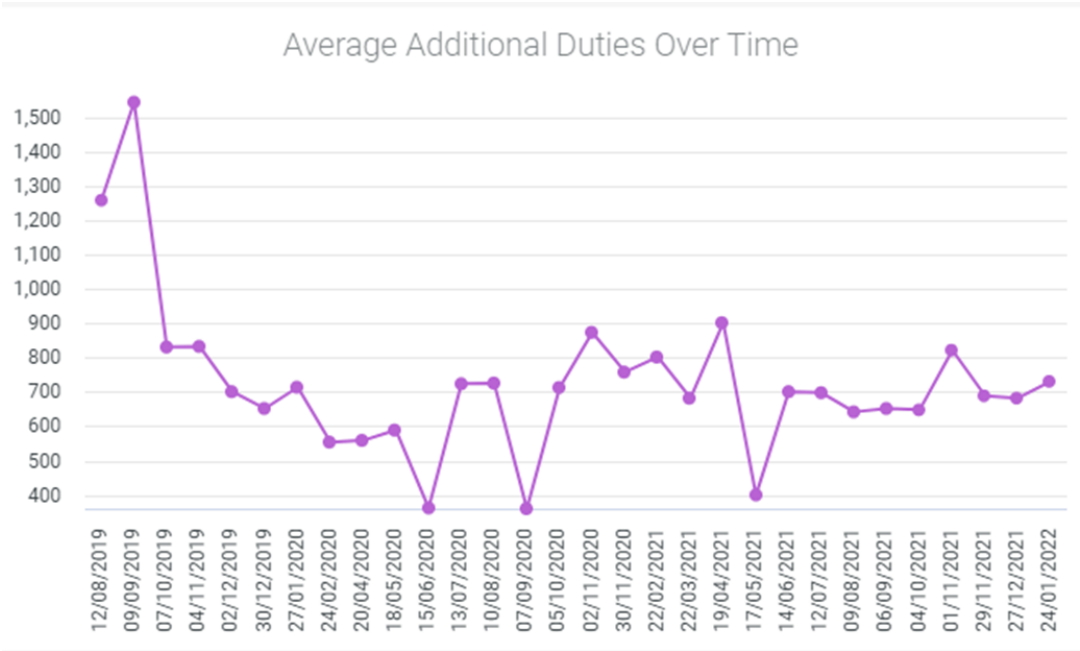
Whilst wards strive to complete their rotas six weeks in advance, it is acknowledged that rota construction over the time period offered has been horribly complex driven primarily by the Covid pandemic and requirement to redeploy staff, risk assess and reallocate staff, and the repurposing of wards to accommodate alternative specialisms. Again the low points of June 2020 and January 2021 correlate with periods of increased flux, adjustment and reorganisation as a result of the pandemic.

3.3 Unavailability



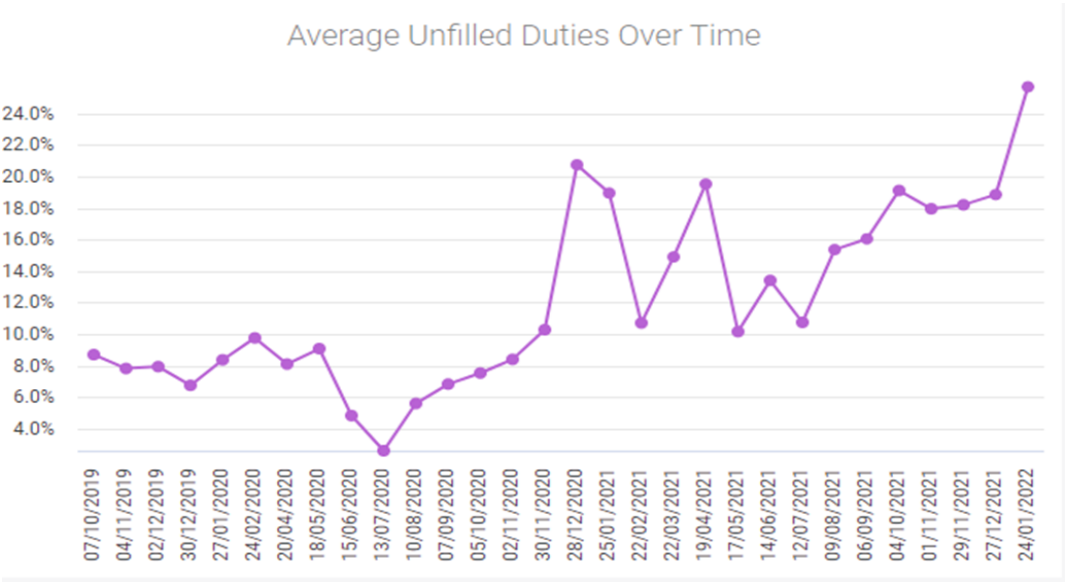
Average unavailability January 21 to January 22 was at an average 31.97% with a variance to headroom of 7.97%. This was mostly caused by annual leave, sickness, and parenting leave. It is worth noting this figure would increase compared to other years as a result of the additional award of a birthday leave day, and surge in pregnancies and maternity leave, with some wards experiencing up to 40% maternity leave amongst their staffing groups.

3.4 Additional Duties



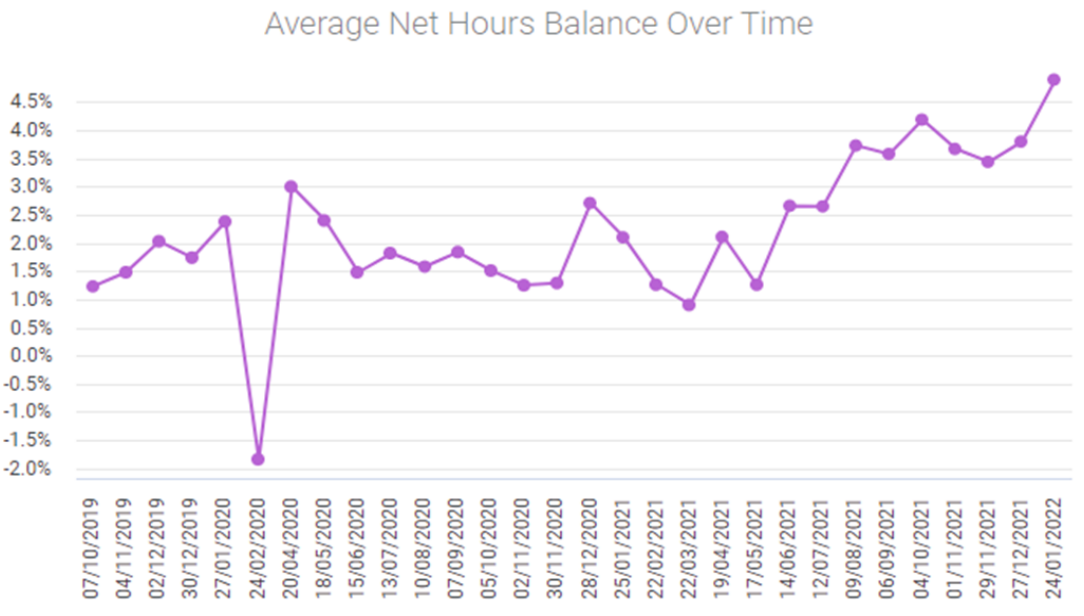
Average additional duties January 21 to January 22 was 696 (2.9%). Additional Duties are shifts that are added to the roster above and beyond the established templated duties. Reasons for Additional Duties can vary from legitimate reasons, such as High Patient Acuity, Seasonal Pressures & Enhanced Care, to avoidable reasons, such as using up staff hours & staff requests. This metric is heavily correlated with high annual leave use and short approval lead times on rosters. Similarly, the impact of Covid and current bed pressures will contribute to an increase in additional duties, as wards are repurposed or utilised to support outliers, which in turn require a temporary uplift in resources to safely care and manage the patient group. This is frequently seen within wards such as Downton (surgical ward) and Amesbury (trauma) and their support with medical outliers.

3.5 Unfilled duties



Average unfilled duties January 21 to January 22 was 17.6%. These unfilled duties are shifts that go unworked or are cancelled and not removed from a roster. Again, the impact of covid is visible with subsequent waves and surges that has impacted the hospital through increased patient environments and escalation and staff absences. Aspects of the most recent spike in unfilled duties will also be driven by our own tactics in achieving whatever form of coverage of temporary staffing we can, by making additional shifts available to wards and environment that may result in coverage to support other areas. However, aspects of general rota housekeeping should pull back and close these unfilled shifts, but with concurrent pressures, this has not always been consistently achievable. This is an ongoing focus of the Safe Staffing Steering Group and E-Roster lead, as these artificial additional unfilled 'planned' shifts will also impact our CHPPD figures (see section 4.0).

3.6 Hours Balance



Average hours balance January 21 to January 22 was 2.8%. The net hour percentage is the calculated balance between over-contracted and unused hours on the demand template for substantive staff. Best practice has shown that the recommended threshold for both net hours and four weekly hours balance should be +/- 2%. Wards showing a particularly high net value could indicate housekeeping issues.

It is felt that the increasing proportion of net hours balance observed since August 2021 directly correlates with staffing risk that has been consistently reported regionally over the same time period reflecting the shortfall in nursing hours. The increase in hours balance is seen because of staff consistently working over their time balance and unable to recover and balanced position due to increasing and persisting challenges.

4.0 Care Hours Per Patient Day

In Lord Carter's Review (2016) Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted variations.; an approach of reporting Care Hours Per Patient Day (CHPPD) was recommended, to provide a single comparable metric for recording and reporting nursing and care staff deployment. Revised guidance was produced by NHS England (NHSE) in March 2021. The guidance mandates the use of planned versus actual CHPPD to measure deployment of the workforce and this report reflects this methodology.

CHPPD data is designed to offer a picture of how staff are deployed and how productively, comparing a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals.

Every month, the hours worked during the day and night shifts by registered nurses and midwives and healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate the daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

It is worth noting that CHPPD does not reflect the total amount of care provided on a ward (some staffing groups not included e.g. students, therapists, medical staff) nor does it directly show whether care is safe, effective, or responsive. To incorporate these aspects, the use of an acuity tool to inform the 'required' CHPPD must be utilised together with the 'planned' and 'actual' CHPPD figure. The use of Safer Nursing Care Tool as described in section 5.09 will address this 'required' aspect.

4.1 CHPPD by ward for selected months

		January 2021			June 2021			January 2022		
WARD	**Speciality**	**RN**	**HCA**	**Total**	**RN**	**HCA**	**Total**	**RN**	**HCA**	**Total**
AMU	Gen Medical	5.73	2.98	8.71	6.33	3.42	9.75	5.3	2.3	7.6
Breamore	Stroke	3.0	3.09	6.09	3.52	3.5	7.02	2.2	1.9	4.1
Durrington	Gen medicine	3.63	2.13	5.93	4.14	3.68	7.82	3.0	2.3	5.3
Farley	Stroke	5.47	2.74	8.21	4	3.15	7.15	4.0	2.5	6.5
Hospice	Palliative	5.47	2.7	8.17	6.78	4.7	11.45	5.2	3.6	8.8
Laverstock	Resp medicine	No data			4.9	1.65	6.55	4.3	1.7	6.0
Longford	Spinal	4.83	4.05	8.88	4.17	4.22	8.39	4.4	3.1	7.4
Pembroke	Oncology	6.46	2.54	9.0	6.25	2.35	8.6	6.3	2.4	8.7
Pitton	Geriatric Med	3.7	2.08	5.78	3.5	2.34	5.84	3.3	2.4	5.7
Redlynch	Gastroenterology	3.43	2.63	6.06	3.38	2.75	6.13	3.1	2.0	5.1
Spire	Geriatric Med	3.15	2.69	5.84	4.83	4.33	9.16	2.6	3.5	6.1
Tisbury	Cardiology	4.98	1.66	6.64	4.83	1.45	6.28	4.4	1.3	5.7
Whiteparish	Gen medicine	3.2	2.11	5.31	3.27	2.46	5.73	3.4	2.2	5.6
Amesbury	T&O	3.21	2.41	5.62	3.38	2.69	6.07	3.5	2.7	6.2
Britford	Gen Surgery	5.05	2.46	7.51	6.92	2.85	9.77	6.4	3.2	9.6
Chilmark	T+O/Elective	4.48	2.68	7.16	3.45	2.35	5.8	2.2	1.8	4.0
Downton	Gen Surgery	3.76	2.78	6.54	4.62	3.53	8.15	3.7	3.1	6.8
Radnor	Critical care	20.6	2.06	22.66	30.22	2.75	32.97	28.4	1.8	30.2
Odstock	Plastic & Burns	4.99	2.14	7.13	5.0	3.05	8.05	5.0	2.5	7.5
Sarum	Paediatrics	11.03	1.32	12.35	8.73	2.84	11.57	9.1	1.9	11.0
Maternity	Obstetrics	14.04	0	14.04	10.51	0	10.15	10.2	2.9	13.1
NICU	Neonatology	9.99	0	9.99	16.71	0	16.71	9.9	0	9.9
	TOTAL			177.6			209.1			180.9
	Average			8.5			9.5			8.2

Data from 2021 sourced from NHSE NHS England » Care hours per patient day (CHPPD) data
Data for January 2022 informatics NHSE submissions

Over the past 12 months the available CHPPD has varied, ranging from 8.2 to 9.5. Some variation is expected as adjustments are made to staffing templates in response to skill mix reviews, patient needs in the form of enhanced care needs (use of specials) and how effective staffing coverage and roster housekeeping is maintained.

By reviewing the CHPPD totals by division, Medicine appears to suffer the most noticeable decline in CHPPD, with the exception of Pembroke and Hospice – as these staffing templates represent the minimum of accepted staffing levels (x2 RNs on shift at any one time), so any shortfall is automatically supported by other wards.

Appendix 2 offers further detail of CHPPD by division, which highlights the shortfall predominantly experienced by Medicine.

4.2 Peer Comparison

SFT – Salisbury District Hospital
RUH – Royal United Hospital
GWH – Great Western Hospital
Nat – National average

	2019/20			2020/21			2021/22		
	SFT	RUH/ GWH	Nat	SFT	RUH/ GWH	Nat	SFT	RUH/ GWH	Nat
CHPPD – RN/RM	5.8	5.9	5.3	6.2	5.7	5.6	4.6	4.8	4.8
CHPPD - HCA	3.1	3.9	3.7	3.1	3.7	3.7	2.5	2.7	3.2
CHPPD – TOTAL	8.9	10.2	9.1	9.3	9.5	9.3	7.1	7.6	8.1

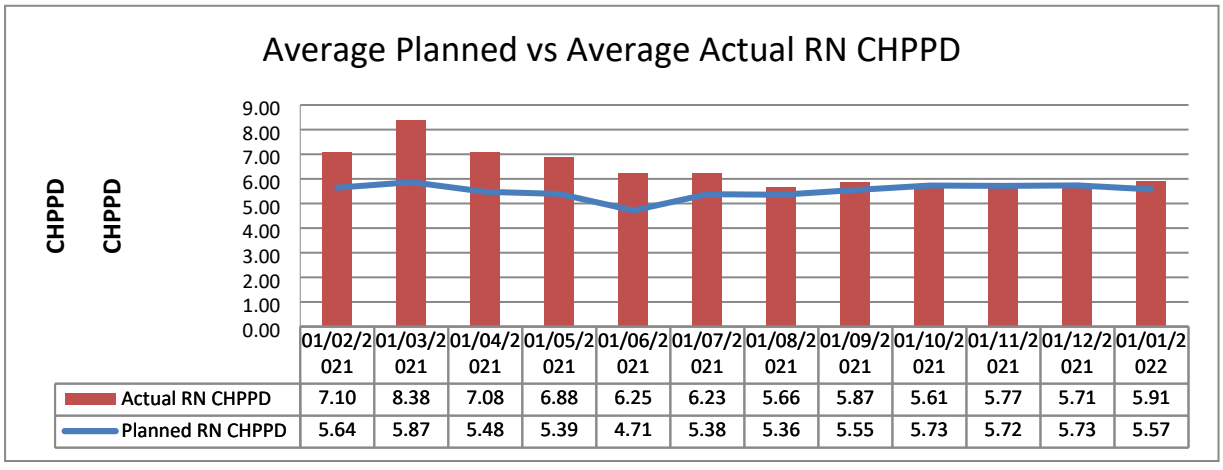
Data from Model Hospital. 2021/22 data is average up to November 21. Accessed February 2022.

Comparing our CHPPD data with that of our ICS colleagues and the national figures highlights a similar pattern with 2021/21 as the lowest point across the three years. Whilst CHPPD is a useful comparator with other organisations, some caution should be applied as the total number of ITU services and similar high nurse/patient ratios (where CHPPD rates are consistently much higher) can influence overall data, whereas comparing similar services will be more beneficial. This approach is within the plans for 2022/23 (see section 7.0) as a combined BSW workforce review is undertaken.

4.3 Planned vs Actual CHPPD

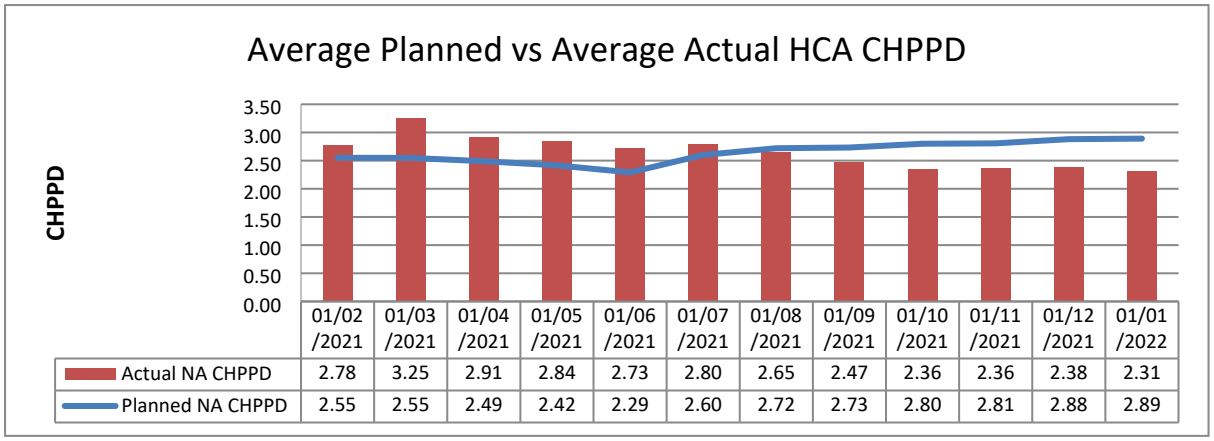
Planned CHPPD represents what our wards are established to and the number of RNs and HCAs rostered to work a shift in line with their funded establishment. Actual CHPPD represents that number of staff who actually worked the relevant shift. Therefore, if a shift is short staffed, there will be a discrepancy between actual and planned CHPPD with actual CHPPD being lower than the planned figure.

RN planned/actual



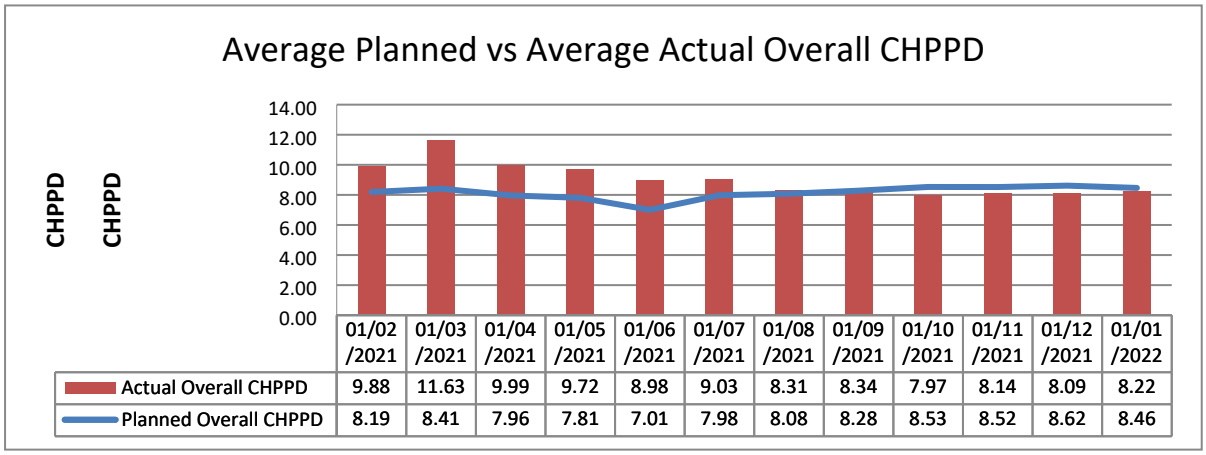
	01/02/2021	01/03/2021	01/04/2021	01/05/2021	01/06/2021	01/07/2021	01/08/2021	01/09/2021	01/10/2021	01/11/2021	01/12/2021	01/01/2022
Actual RN CHPPD	7.10	8.38	7.08	6.88	6.25	6.23	5.66	5.87	5.61	5.77	5.71	5.91
Planned RN CHPPD	5.64	5.87	5.48	5.39	4.71	5.38	5.36	5.55	5.73	5.72	5.73	5.57

HCA planned/actual



	01/02/2021	01/03/2021	01/04/2021	01/05/2021	01/06/2021	01/07/2021	01/08/2021	01/09/2021	01/10/2021	01/11/2021	01/12/2021	01/01/2022
Actual NA CHPPD	2.78	3.25	2.91	2.84	2.73	2.80	2.65	2.47	2.36	2.36	2.38	2.31
Planned NA CHPPD	2.55	2.55	2.49	2.42	2.29	2.60	2.72	2.73	2.80	2.81	2.88	2.89

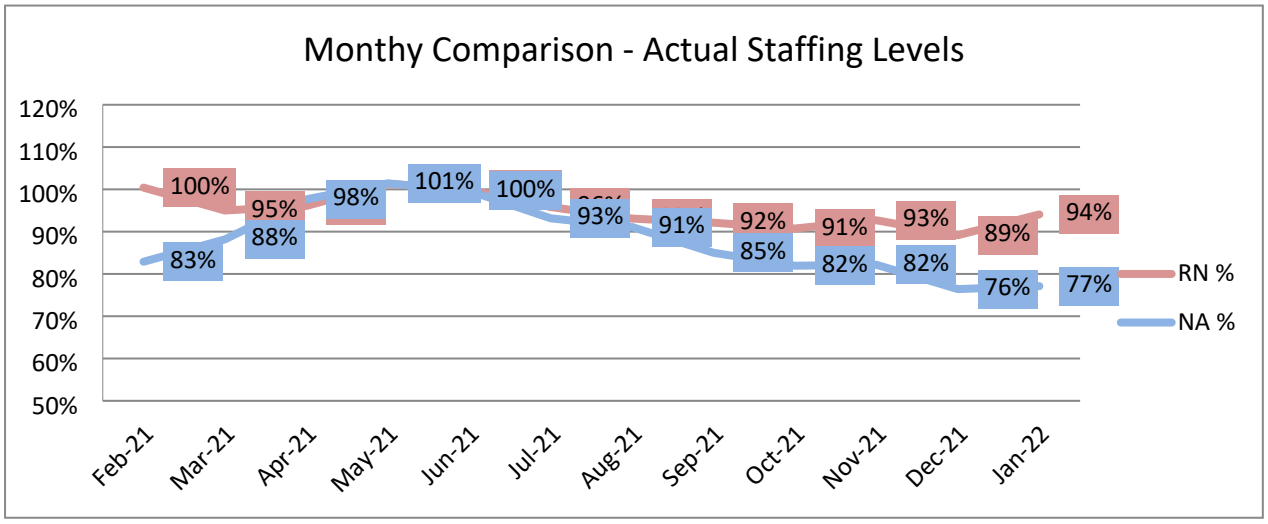
Combined total planned/average CHPPD



	01/02/2021	01/03/2021	01/04/2021	01/05/2021	01/06/2021	01/07/2021	01/08/2021	01/09/2021	01/10/2021	01/11/2021	01/12/2021	01/01/2022
Actual Overall CHPPD	9.88	11.63	9.99	9.72	8.98	9.03	8.31	8.34	7.97	8.14	8.09	8.22
Planned Overall CHPPD	8.19	8.41	7.96	7.81	7.01	7.98	8.08	8.28	8.53	8.52	8.62	8.46

Reviewing both the RN and HCA planned and actual CHPPD highlights the current gap and shortfall of our HCAs. The level of RNs is holding together reasonably well, but the gap of HCAs is widening. This is reflected in our current vacancies and ability to retain our HCA workforce. OD&P and the divisions are working together closely with a renewed approach to recruitment with divisional recruitment drives, videos and engagement of matrons and targeted leads to support this.

4.4 Fill Rates



Fill rates refer to the actual staffing levels achieved against the requested shifts. These figures are related to planned CHPPD but will also include the additional shifts posted designed to capture and increase temporary staff coverage. The year follows our covid journey, with poor coverage of HCAs to requests during the covid wave of January- March 2021 during which time we received external military support. This HCA decline is further repeated during the Omicron surge during December and January 2021/22. Whilst current data does not cover February 2022, it is expected that fill rates of RN and HCA will have continued to rise in response to the availability of incentive schemes.

5.0 Safer Nursing Care Tool

Developing Workforce Safeguards underpins the requirements for trusts to undertake a systematic annual staffing review in which evidence-based staffing levels are triangulated with nurse sensitive indicator data and professional judgement. To date the trust has taken the evidence-based staffing element of this from SafeCare, part of the electronic e-rostering system (Allocate). Whilst the actual values and approach are similar between SafeCare and SNCT, current licencing restrictions has meant that for future skill mix reviews we adopt the licenced and evidenced based tool Safer Nursing Care Tool (SNCT), which is currently the only tool to have been endorsed by NICE.

Licenses for the use of SNCTs (adult wards, children and young people and acute admission unit) were obtained in August 2021, and request for the recently produced ED SNCT tool is currently being processed. Sarum ward was the first ward to formally review its acuity data in January 2022 utilising the formal SNCT model, with further wards following from March 2022. The ED leadership have also subscribed to some formal bespoke training with SNCT in March 2022.

Using SafeCare within Allocate does allow assessment of the acuity and dependency levels of the patients in real-time i.e. on a shift, against both the budgeted roster template (planned) and the actual staff on duty and is fully embedded across the Trust. The use of SafeCare had been operationalised in the daily staffing meetings and used to support decisions to review any gaps in shifts and review where staff can be moved or whether escalated to agency. However, with the evolving staffing challenges driven by escalation and staffing absences and in line with our regional staffing red flag escalations, staffing allocations have been driven predominantly by the staffing RAG

rating (see section 7.0) to ensure even coverage of available resources. It is envisaged, and the plan of the DCNO that with the renewed focus and use of SNCT examinations, that the use of planned, actual and required CHPPD, again becomes the common currency in determining staffing levels and allocations within the thrice daily staffing meetings.

The use of SafeCare data is currently used as a proxy for the Safer Nursing Care Tool and is likely to continue for a further 12 months, until the SNCT can be fully implemented and data collected which will take the minimum of 1year – as at least 2 data points are required across the year for SNCT effective adoption.

6.0 Maternity and Neonatal

The Midwifery workforce is reviewed on a monthly basis alongside acuity and activity, using the evidence based tool Birthrate+©. Over the last few years the midwife to birth ratio has decreased from 1:30 to 1:28, which is the nationally recommended level and also needs to be seen in the context of rising acuity levels amongst pregnant women. As referenced in the previous skill mix review, maternity services requested an uplift of 1.96 wte (Birthrate Plus) + 4.29 wte (Continuity of Carer at 35%), and the service continues to carry a vacancy of around 10 WTE.

As reported separately through W&NB governance and reporting structures the midwife to birth ratio is tracked trough the dashboard.

Month	Actual Establishment (minus mat leave, sickness, vacancy	Total Births	Midwife to Birth ratio (rounded) Actual establishment	Midwife to Birth ratio (rounded) budgeted establishment	12 Month average actual
Oct-20	79.3	210	1:32		29.1
Nov-20	74.4	198	1:32		29.8
Dec-20	66.25	183	1:33		30.2
Jan-21	67.29	173	1:31		30.5
Feb-21	67.29	162	1:29		30.2
Mar-21	67.29	169	1:30		30
Apr-21	74.55	186	1:30		30.4
May-21	73.28	157	1:26		30.1
Jun-21	64.66	180	1:33	1:24	30.5
Jul-21	64.66	191	1:35	1:26	30.9
Aug-21	65.55	222	1:41	1:30	31.9
Sep-21	64.55	217	1:40	1:29	32.7
Oct-21	77.16	198	1:31	1:27	32.6
Nov-21	77.16	187	1:29	1:25	29.9
Dec-21	77.16	149	1:23	1:25	27.2
Jan-22	74.82	161	1:26	1:20	24.6

<=1:28	Ratio now includes separate data on budgeted establishment vs actual.
>1:28-<1:35	Budgeted establishment 88.64 wte
>=1:35	

The ‘birthrate plus’ calculation is included in a 6 monthly staffing review/paper which is due to be presented at CGC in March 2022, with the official birth-rate calculation needing to be done every 2 - 3 years.

The Neonatal Service remains a level 2 Local Neonatal unit with 10 cots and continues to comply with the standards set by the British Association of perinatal Medicine (BPAM); an expectation of the National Neonatal network. Key challenge within the neonatal service continues to be maintaining level 2 status within the network, where this is a drive to re-designate smaller units alongside a national drive to keep babies out of neo-natal unit.

7.0 Safe Staffing approach

The ward staffing numbers have been specifically challenged over the past six months, driven directly and indirectly by the Covid-19 pandemic. Staff sickness, absence and resilience has been affected, along with the need to manage new ward and clinical environments, escalation areas, and an increasing acuity of patients with no criteria to reside. This is reflected in the consistent red flag escalation of staffing number to HSE regional teams, and the corporate risk of 7039 with a current risk score of 20.

To ensure staffing resources have been distributed evenly and supported, a number of refinements have been made over the past months. This has included the facilitation of staffing meetings three times a day by the DCNO, adoption of RAG staffing matrix, which has included the development of two further levels of staffing deterioration – purple and black – reflecting further gaps in staffing numbers and mass casualty events. Whilst the opening the Springs restaurant as in-patient environment has been avoided to date, along with other suggested environments (Nunton, Pembroke Suite), the Spinal Clarendon gym opening in February has stretched available staffing to the point of deploying purple staffing numbers at times. When this has occurred, this has been escalated to CNO and/or executive on call.

Unfortunately, despite the ward’s best attempts, with such paucity of staffing resources has led somewhat inevitably to an increase in harm for patients with the number of falls, delays in care and omissions increasing, and such limited resources will have no doubt contributed to hospital acquired infections including spread of Covid-19 and declarations of outbreaks. This has been desperately hard for the ward teams and nursing leads to wrestle with and led to moral injury amongst many to varying degrees. A copy of the newly developed purple and black staffing numbers are included in appendix 3. Whilst we (D/CNO) have been required to communicate these numbers with our senior nursing teams, the construction and development of the staffing numbers and levels was undertaken by the CNO and DCNO directly. The exclusion of the senior nursing team was meant as a protective measure to reassure our teams that any steps into such depths would be an executive decision, with the level of risk carried corporately.

Since the previous workforce review, the Safe Staffing Board Assurance Framework has been completed and presented to CGC in December 2021. This framework offered by NHSE, has been embedded within appendix 4 as part of the further policy links and information, and is anticipated to be re-presented at CGC in May 2022.

The development of ward buddies has been a welcome and appreciated support for the wards, and feedback from the volunteers themselves have proven to be positive. Similarly the introduction of the winter incentive schemes from 26/12/21 to 28/02/22 has proven to be successful, in particular the short notice golden incentive. These incentives will be subject to a separate review, and whilst

the golden scheme has somewhat predictably influenced behaviours (staff holding out for offer of golden shift rather than booking shifts proactively), we have been able to increase our shift coverage, offer consistency and continuity for our patients, and financially reward our own staff for their loyalty and commitment.

An exciting new development for the year ahead, will be the development of a BSW workforce review. The CNO and DCNOs for the three acute Trusts have recently meant to agree and plan an approach to review, share and develop agreed standards and principles towards ward staffing numbers. This will include plans to have an agreed equitable headroom percentage, nursing ratios, use and proportion of B4s, and clarity regarding shift coordinators and supervisory time of ward leads, in addition to regular benchmarking of CHPPD. Draft terms of reference are currently being approved, but it is envisaged this will run for six months, leading to a published review, and subsequent skill mix reviews reflecting this comparison and relationship.

The next six months should also see the completion of previously requested Spinal and Paediatric workforce reviews. These reviews were requested at the time of the previous skill mix review (September 2021) as a result of previous CQC assessment for Spinal services, which also included a review of therapy and psychology provision in addition to nursing. The need for a Paediatric service review stemmed as a result of the reliance of the previous outreach support role in maintaining Sarum ward safe staffing numbers and the gap this left behind for ED, DSU etc along with subsequent review and peer assessment, which resulted in a number of recommendations (practice educator role, dedicated paediatric ED and DSU RNs).

This six month review has not quite followed the 'historical standard' due to unique challenges of the past six months to provide the best level of safe care we can as organisation, utilising all available strategies and resources across the organisation to keep our patients safe, whilst recognising that sadly gaps and shortfalls have occurred and persisted. In terms of funded establishments, no further requests or increases are made as a result of this review, as primarily, the wards have been unable to achieve the current funded establishment levels, to be able to demonstrate that they are in way insufficient. It is however, worth noting that certain wards will be pushing the limits of their available establishments as they care for alternative patient groups with differing acuity and care needs, resulting in additional staffing requests to their funded templates. This has been predominantly seen with,

- Downton ward - general surgical ward which continues to support approximately 12-15 medical outliers at any one time
- Pitton ward – geriatric medicine ward caring for displaced respiratory patients from Laverstock ward and need to support Non-Invasive Ventilation
- Amesbury ward – due to limitations and restrictions of Chilmark ward as elective environment, increased proportion of high acuity trauma and orthopaedic patients focused within Amesbury ward required enhanced care.

8.0 Summary and Recommendations

The Board is asked to:

- To note the findings of the 6 monthly skill mix review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.
- To note the analysis completed which will be further updated in next full skill mix review expected to completed August/September 2022.

- To note the continued challenge that arises from the impact of Covid surges on our ability to meet the planned and required CHPPD with our actual nursing resources.
- To note the roll out of Safer Nursing Care Tool across the Trust to ensure future skill mix reviews will have fully evidence-based staffing data as a triangulation point.
- To note that nurse staffing is subject to change due to changes in acuity and dependency and patient volume and these will be reported on in subsequent skill mix reviews. Particular focus is being given to the following areas who are experiencing change in model and/or demand (additional areas may arise through the full skill mix review):

    - Downton and its persistent use to support medical outliers
    - Breamore as a stroke rehab ward displaced by the presence of RCU
    - Britford SAU plans
    - Spinal workforce review
    - Paediatric workforce review

Appendix 1

August /September 2021 Skill Mix Review – Summary of Ask

Shaded boxes refer to requests that can be made within existing budgets, subject to separate Covid-19 funding bids, or not supported by CNO.

WARD	BANDING and WTE	ROLE/SHIFT	COST	COMMENTS OF DCNO	Supported by CNO?
MEDICINE					
ED	B7 0.6	Education Facilitator	£31,662	Role is 1.0, but 0.2 available in funded establishment and intention for Education facilitator to work clinically one a week, therefore 0.6 requested	Not supported. Ongoing review and usage of teams/leads/ matron
	B4 1.9	To accommodate existing NA roles		Confirmation sought - ? To be picked up as part of B5 funded establishment	Accommodate within B5 vacancies and turnover
	B5 2.6	Night shift 7/7 as second resus nurse in line with guidance	£118,891 maximum cost (see alternative option)	Data to follow re resus attendance at night. Option of upgrading existing TW to full night as cheaper alternative	Not supported. Await resus data and review of consistent use of TW shift
Hospice	B7 1.0	To cover current substantive role	£52,771	Previous B7 shared between community and ward, which has since been separated in to two roles	Not supported. Medicine DMT to manage cost pressure
	B4 1.24	Early 5/7	£43,904	Unit is an outlier for only 2 RNs, increasing acuity, interventions, complex discharge, non-malignancy all impacting need for additional resource	Supported by CNO
Whiteparish	B4 1.74	Late 7/7	£61,608	Increase in complex unstable diabetic patients, theatre involvement, VAC therapy, pressure ulcer management	Not supported. Review in six months when previous skill mix uplift embedded.
Durrington				Nil to add, just need appointments in to funded establishment	
Longford	B5 1.74 +2.6	Late shift + Night shift (7/7)	£198,456	Further detail requested on respiratory patients' acuity/number/level of	Not supported. Commission

				injury. Recommend separate review against bespoke spinal guidance and standards	separate staffing review of Spinal Centre.
Spire	B2	TW and night shift (7/7)		Spire to confirm extent of previous skill mix reviews and coverage of these shifts as DMT requested to enact changes from previous award	Not supported. Review in six months when previous skill mix uplift embedded.
Laverstock				No specific ask, but request confirmation re B4 1.8 establishment (or do we continue to pay from B5 establishment expecting turnover/vacancy etc?)	Accommodate within B5 vacancies and turnover
Redlynch	B2 1.74	Late shift 7/7	£52,381	Previous skill mix only just embedded so previous impact/stretch/flexibility yet TBC, but 2021 request for additional B2 on late to reflect acuity changes and incident reporting	Not supported. Review in six months when previous skill mix uplift embedded and recruited in to.
Farley	B5 5.3	LD and N (7/7)	£242,354	Only required if RCU staying in current location with Breamore continuing as is. Required to support and recover SSNAP results. If RCU to close and Breamore (rehab) stroke returned to Farley stroke, then current skill mix sufficient.	Supported. Changes as a result of Covid. Recommend funding sought as part of bidding process for second part of year.
Breamore				Funded through escalation/covid monies due to requirement to accommodate RCU. Will require covid funding for part 2 of year. No change in terms of skill mix	Currently under budget. DMT to review as part of Farley request above
Tisbury	B6 1.0	Uplift of x1 B5 to B6	£11,204	To allow provision of x1 B6 on each shift, support supervision, education, liaison with SUHT.	Supported by CNO
AMU				Nil to add	
SURGERY					

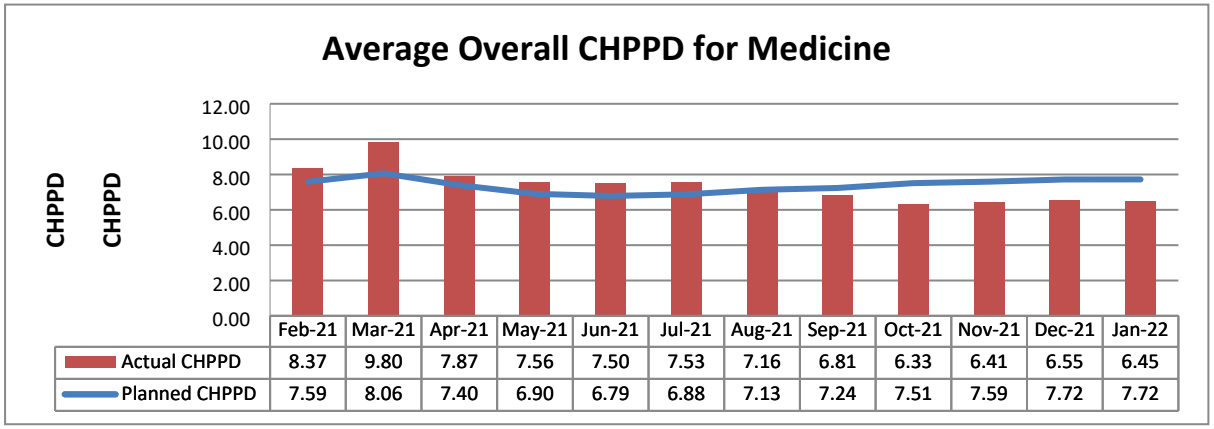
DSU				Nil to add	
Amesbury	B4	Current night shift 3+0+4 (RN+B4+B2). Request to move to 3+1+3 (7/7)		Able to be absorbed within existing budget	
Chilmark	B5	Uplift current B4 on N to a B5 (7/7)		Current night 3+1+2. Request to move to 4+0+2 due to separation of trauma/elective. Previously part of covid funding bids for first part of year. Part 2 TBC	
Odstock	B2	BDC (Burns Dressing Clinic) coverage M-F		Has been able to be absorbed from ward budget so far, but need dependent on final destination of BDC if laser activity resumes.	
	B5	Fourth RN on late (5/7)		Has been trialled for past 12/12. Support for training/ supervision/burns referrals/ theatre returns. Covered within existing budget – DMT advised to confirm approach and financial coverage and request rota template change.	
Downton	B4 2.6	Night 7/7	£92,058	To support increased acuity and ENT, trachea care patients. Electives now on Chilmark, so reduced number of 'simpler' turnaround pts.	Not supported as direct uplift. To be managed internally as required and SD beds in use. Six month review
Britford				Nil to add. Ongoing trial re SAU and DMT to review +/- business case	
Radnor				Nil to add. Continue 9+1	
CS&FS					
Sarum	B5 RMN 1.0	As required		Direct link and causation with Covid. Recommended to seek funding through covid bids for second half of year	Not supported as part of skill mix uplift. Seek Covid bid +/- use of AWP bank
	B5 PASS Fri-Mon N Sat–Sun	2.28	£104,257	Recommend PASS assessment and evaluation, as purpose merged primarily	Not supported. Undertake

	LD			to provide uplift to support Sarum ward	PASS assessment and evaluation
	B6 0.5	Education Facilitator	£24,402	0.2 B6 available within current establishment. Additional 0.5 to create education role	Not supported. Review impact of newly created Paed Matron and existing B7
	B2 1.0	Play Assistant	£24,311	Current fixed term post funded by Stars. Request to confirm as substantive role within funded establishment	Supported by CNO
W&NB					
Maternity	B6	1.96 (Birthrate Plus) + 4.29 (Continuity of Carer at 35%)	£355,818	Employed as B5 for first year. Costed as B6. Funding partially offset by Ockenden funding.	Supported by CNO
NICU					
TOTAL COST			£435,237 (unshaded and CNO supported)		

Appendix 2

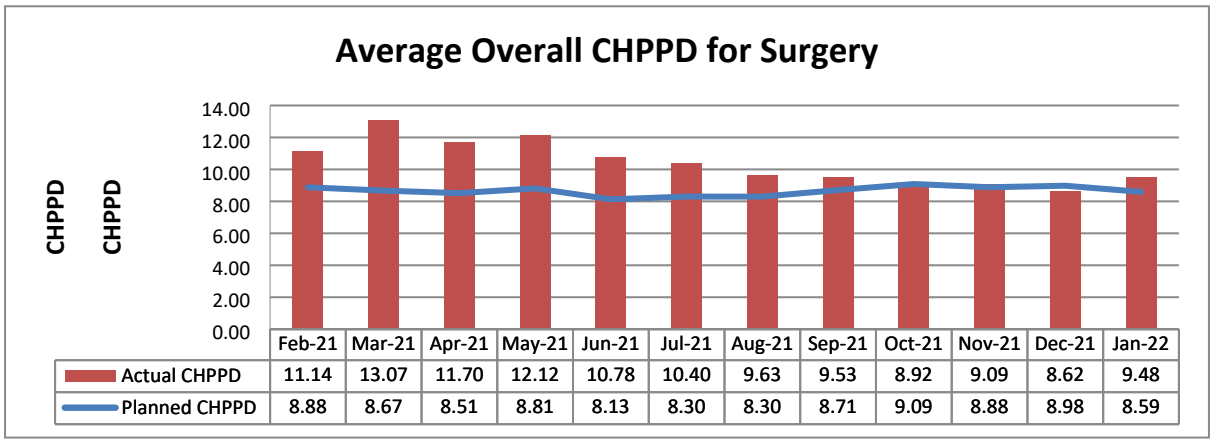
CHPPD by Division

Medicine



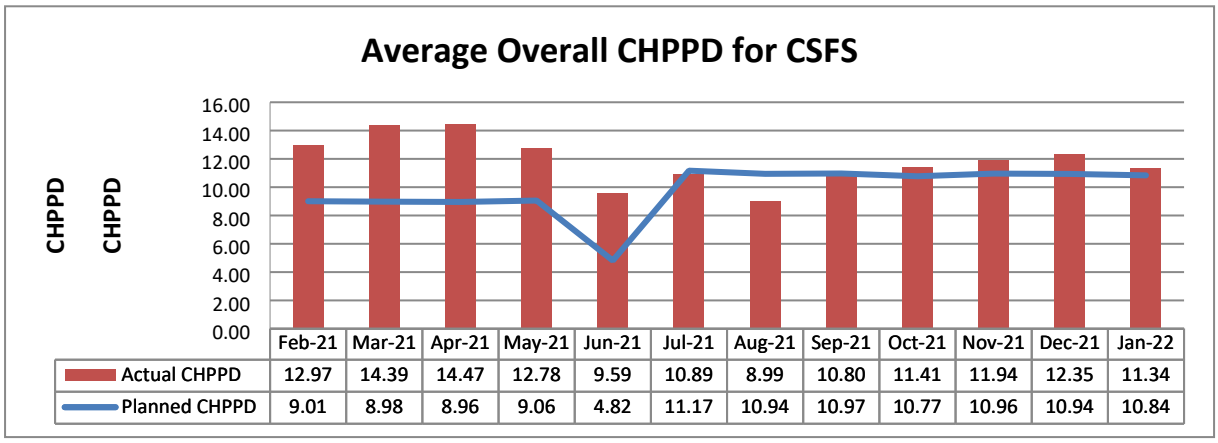
	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Actual CHPPD	8.37	9.80	7.87	7.56	7.50	7.53	7.16	6.81	6.33	6.41	6.55	6.45
Planned CHPPD	7.59	8.06	7.40	6.90	6.79	6.88	7.13	7.24	7.51	7.59	7.72	7.72

Surgery (including Radnor ITU)



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Actual CHPPD	11.14	13.07	11.70	12.12	10.78	10.40	9.63	9.53	8.92	9.09	8.62	9.48
Planned CHPPD	8.88	8.67	8.51	8.81	8.13	8.30	8.30	8.71	9.09	8.88	8.98	8.59

CSFS (includes Sarum, Maternity and NICU)



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Actual CHPPD	12.97	14.39	14.47	12.78	9.59	10.89	8.99	10.80	11.41	11.94	12.35	11.34
Planned CHPPD	9.01	8.98	8.96	9.06	4.82	11.17	10.94	10.97	10.77	10.96	10.94	10.84

Appendix 3

Safe Staffing RAG

Red/Purple/Black

In light of the evolving pandemic and omicron variant expected to impact nationally from early January 2022, further review, evaluation and preparation required as to how further deterioration in nursing resource coupled with increased demand can be managed and accommodated.

NOTE: Whilst obvious, it is worth noting, that these measures represent an extreme event, and must only be applied in the context offered (overwhelming patient numbers and significant staffing absence caused by the pandemic).

The risk this represents is well understood by the executive team, Trust Board and our regional and national counterparts. Risk 7039 (current score of 20) features on the corporate risk register, with the organisation carrying the burden of this risk. Whilst individuals will understandably be impacted by the notion and delivery of care in this manner, this is a collective and shared response to these unprecedented times.

Indemnity and regulation

- NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.
- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. With any request a risk-based approach is used to mitigate emerging risks using available resources effectively and responsibly.
- The Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards.

A note on the numbers

- The offered numbers represent the very basic core minimum numbers of Registered and Un-Registered Nurses conceivable, and does not reference or include additional ward support roles that would be utilised to bolster and support ward teams
- Additional support roles would include and termed ‘other’
    - students
    - volunteers
    - non-patient facing staff
    - military
    - floating matron/senior nurse to undertake drug checks (FM)

PURPLE Further deterioration of 'red' staffing numbers. Significant risk and omissions in care, documentation, ability to protect and maintain patient safety. Bare minimum

Laverstock	19	1												
Early			3		2		2		2		1+FM		1	2
Late			3		2		2		2		1+FM		1	2

of essential tasks undertaken (medication, meal time support)

BLACK Surge ++. Demand far exceeding capacity needing to open novel mass patient accommodation

MEDICINE	TOTAL BEDS	SD BEDS	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA	Other
AMU	19	0												
Early			4		3		3		2		2		1	2
Late			4		3		3		2		2		1	2
Night			3		2		3		2		2		1	2
Durrington	21	2												
Early			2		2		2		1		1+FM		1	2
Late			2		2		2		1		1+FM		1	2
Night			2		1		2		1		1+FM		1	2
Farley (+RCU)	30	0												
Early			4		3		3		2		2		1	2
Late			4		3		3		2		2		1	2
Night			4		3		3		2		2		1	2
Hospice	10	0												
Early			2		0		1	1			1+FM		0	1
Late			2		0		1	1			1+FM		0	1
Night			2		0		1	1			1+FM		0	1
Pembroke	10	0												
Early			2		0		1	1			1+FM		0	1
Late			2		0		1	1			1+FM		0	1
Night			2		0		1	1			1+FM		0	1
Pitton	25	2												
Early			3		2		2		2		1+FM		1	2
Late			3		2		2		2		1+FM		1	2
Night			2		2		2		2		1+FM		1	2
Redlynch	24	3												
Early			3		2		2		2		2+FM		1	2
Late			3		2		2		2		2+FM		1	2
Night			3		2		2		2		2+FM		1	2
Spire	30	0												
Early			3		4		2		3		2		1	2
Late			3		3		2		3		2		1	2
Night			2		3+tw		2		3		2		1	2

Night			2		2		2		2		1+FM		1	2
Breamore	20	4												
Early			2		2		2		1		1+FM		1	2
Late			2		2		2		1		1+FM		1	2
Night			2		1+tw		2		1		1+FM		1	2
Tisbury/CCU	23	0												
Early			4		1		3		1		2+FM		1	2
Late			4		1		3		1		2+FM		1	2
Night			3		1		3		1		2+FM		1	2
Whiteparish	23	0												
Early			2		2		2		1		1+FM		1	2
Late			2		2		2		1		1+FM		1	2
Night			2		1		2		1		1+FM		1	2
Longford	39	0												
Early			5	1	6		4		4		3		2	2
Late			5	1	4		4		4		3		2	2
Night			4		4		4		4		3		2	2

Please note, that staffing numbers reflect opportunity for neighbouring wards to support each other, e.g. Redlynch may have additional nurse to Pitton, but expectation that Redlynch third RN float and support with medications, drug checks etc on both Redlynch and Pitton ward.

Tisbury + Whiteparish

Redlynch + Pitton

Britford + Downton

SURGERY	TOTAL BEDS	SD BEDS	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA	Other
Britford	20	1												
Early			3		2		2	1	2		2+FM		1	2
Late			3		2		2	1	2		2+FM		1	2
Night			2	1	2		2		2		2+FM		1	2
Downton	19	5												
Early			2	1	2		2		2		1+FM		1	2
Late			2	1	2		2		2		1+FM		1	2
Night			2		2		2		2		1+FM		1	2
Odstock	17	0												
Early			2	1	2		2		2		1+FM		1	2
Late			2	1	2		2		2		1+FM		1	2
Night			2		2		2		2		1+FM		1	2
Amesbury	32	0												
Early			3	1	3		2		3		2		1	2
Late			3	1	3		2		3		2		1	2
Night			3		3		2		3		2		1	2
Chilmark – Elective	24	0												
Early			3	1	1		2		2		2		1	2
Late			3	1	1		2		2		2		1	2
Night			2	1	1		2		2		2		1	2

Escalation and mass casualty

	TOTAL BEDS	SD BEDS	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA	Other
DSU	11 up	1												
Early			2		0		1		1		1		0	1
Late			2		0		1		1		1		0	1
Night			2		0		1		1		1		0	1
DSU	18 down	0												
Early			2		1		2		1		2		0	1
Late			2		1		2		1		2		0	1
Night			2		1		2		1		2		0	1
Endoscopy	10	0												
Early			2		0		1		1		1		0	1
Late			2		0		1		1		1		0	1
Night			2		0		1		1		1		0	1
Clarendon Spinal Gym	6 10	2 0												
Early											2		1	
Late											2		1	
Night											2		1	
Pembroke Suite	6	2												
Early											1		1	
Late											1		1	
Night											1		1	
Nunton	6													
Early											1	1		
Late											1	1		
Night											1	1		
Springs	25	0												
Early											2		2	
Late											2		2	
Night											2		2	

Staffing numbers offered reflecting number of beds, location and access to neighbouring support, and the environment itself.

Appendix 4

Supporting documents, policies and Board Assurance Framework presented to CGC December 2021

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time
https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

Care hours per patient day (CHPPD): guidance for all inpatient trusts. Updated March 2021
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0473-care-hours-per-patient-day-chppd-guidance-for-all-inpatient-trusts-updated-march-2021.pdf

2021/22 priorities and operational planning guidance
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf

Staff Assurance Framework.
Presented to CGC December 2021


Staff Assurance Framework - HW.xlsx

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	**Agenda item:**	4.1
Date of Meeting:	28 February 2022		

Report Title:	Constitution Annual Review 2022 – update			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Approval Process (where has this paper been reviewed and approved)	Approval needed by both Trust Board and Council of Governors.			
Prepared by:	Kylie Nye, Head of Corporate Governance Lucinda Herklots, Lead Governor			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	N/A			

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

Executive Summary:
The constitution is considered and approved by the Trust Board and Council of Governors on an annual basis. Further to the Trust Board in January 2022 some further amendments were proposed to provide consistency. These changes have also been highlighted yellow in the attached constitution for ease of reference: **Annex 6 - Additional Provisions – Council of Governors – Disqualification:** • The wording has been updated in point 3 to be consistent with the wording for the same point in Annex 9 in relation to Board members disqualification. *"A person who is a director of the Trust, or a governor, director, Chairman or chief executive of another NHS Foundation Trust or NHS Trust; However, a governor (other than the lead governor) may be a governor or non-executive director (other than chairman) of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two governorships or directorship and governorship."* • The wording in point 4 has also been updated to be consistent with the same point in Annex 9 in relation to Board members disqualification, *"A person whose physical or mental wellbeing is such that their ability to act as a governor of the Trust is materially affected."*

- The original point 7 has been removed which was outdated; "*A person who has been removed from any list prepared under Part II of the National Health Service Act 1977, or has been removed from a list maintained pursuant to regulations made under section 28X of that Act, and has not been reinstated.*" And replaced with the wording now highlighted in yellow under point 7;
  "A person who has had his name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list and, due to the reason(s) for such removal, he is considered by the Trust to be unsuitable to be a Governor."

Annex 9 – Additional Provisions – Directors – Disqualification:

- Point 6 has been added to reflect the same criteria in Annex 6, point 7, as stated above.

Code of Conduct

- It was agreed that the Code of Conduct within the Council of Governors Standing Orders on pg. 60 should be referenced in the main contents page e.g. "*Annex 7.1 Council of Governors Code of Conduct."*

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

Salisbury
NHS Foundation Trust

SALISBURY NHS FOUNDATION TRUST

CONSTITUTION

Post Holder Responsible for Policy:	Director of Integrated Governance
Directorate Responsible for Policy:	Chief Executive's
Contact Details:	Ext: 2774
Date Written:	2005
Date Revised:	January 2022
Approved by:	Council of Governor's/ Trust Board
Date Approved:	TBC
Next Due for Revision:	January 2023
Date Policy Becomes Live:	TBC

Version No.	Updated By	Updated On	Description of Changes
1.0	Director of Corporate Governance	See amendment history below	
1.1	Director of Corporate Governance	April 2020	Annex 9 Updated
2.0	Director of Corporate Governance	October 2020	Complete revision
2.1	Corporate Governance Manager/ Membership Manager	December 2020	Further amendments as per amendment history below agreed at CoG.
2.2	Head of Corporate Governance	January 2022	Small amendments to wording to provide consistency in document

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Amendment history – 2013 to 2019

- **2014:**
  - The addition of paragraph 21 of the Council's Standing Orders was approved by the Council on 21 July 2014
- **2016:**
  - Amendment of paragraph 37 of the Constitution was approved by the Board of Directors on 29 February 2016 and by the Council of Governors on 11 April 2016.
  - The new Model Election Rules were issued by the former Foundation Trust Network (NHS Providers) in August 2014 and formally adopted by the trust on 29 February/11 April 2016
  - Amendment of paragraph 16 of the Council's standing orders was approved by the Council on 16 May 2016.
- **2018:**
  - April 2018 minor amendments to Board Standing Orders
  - Addition of Standing Financial Instructions – approved February 2018
- **2019:**
  - Amendment of Annex 1 to a) insert the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency; (b) delete West Wiltshire as a constituency; (c) increase the number of governors for the South Wiltshire Rural Constituency from 5 to 6. – approved November 2019.
- **2020**
  - Annex 8 Standing Orders of the Board of Directors has been completely revised and is included as an appendix to the Constitution.
  - The wards and constituencies have been updated. This includes merging West Wiltshire into South Wiltshire Rural. North Dorset and East Dorset constituencies have also been updated based on the electoral ward.
  - Within Annex 2 the Hotel and Property Class in the Staff Constituency is merged with the Clerical, Administrative and Managerial staff class. The name has been amended to "Administrative, Facilities and Managerial".
  - The unused paragraphs have been removed and the document renumbered and reformatted to reflect this.
- **2021**
  - Wiltshire Clinical Commissioning Group (CCG) is now called Bath and North-East Somerset, Swindon and Wiltshire (BSW)
- **2022**

- Amendments to Annex 6 and Annex 9 to update Governor and Board disqualification criteria.
- Document renumbered.

1 Interpretation and definitions

1.1 Unless otherwise stated, words or expressions used in this constitution have the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

1.2 Words importing the masculine gender only shall include the feminine gender. Words importing the singular shall import the plural and vice versa where it is appropriate that they do so.

1.3 The 2006 Act is the National Health Service act 2006 as amended at any time, and the 2012 Act is the Health and Social Care Act 2012 as amended at any time.

1.4 Monitor is the corporate body known as NHS Improvement, as provided by section 61 of the 2012 Act.

1.5 Constitution means this constitution and its annexes (save that the standing orders set out for convenience in annexes 7 and 8 are not part of the constitution). It comes into effect when it has been approved both by more than half of the members of the Council of Governors voting, and by more than half of the Board of Directors voting.

1.6 The Accounting Officer is the person who discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

1.7 The Code of Conduct is the Code of Conduct as set out in the Standing Orders of the Council of Governors.

2 Name

2.1 The name of the foundation trust is the Salisbury NHS Foundation Trust, and the Trust means that trust.

3 Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to–

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in this paragraph for the purpose of making additional income available in order better to carry out its principal purpose.

3.5 The Trust may carry out research in connection with the provision of health care, and may make facilities and staff available for the purposes of education, training or research carried on by others.

4 Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5 Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 A public constituency

5.1.2 A staff constituency

6 Application for Membership

6.1 An individual who is eligible to become a member of the Trust shall become a member on his application to the Trust to become a member or by being invited by the Trust to become a member of the staff constituency in accordance with paragraph 9.

7 Public Constituencies

7.1 The public constituencies are the areas specified in Annex 1 and individuals living within them may become members of the Trust.

7.2 The individuals who live in the areas so specified are referred to collectively as a Public Constituency.

7.3 An individual who ceases to live in the areas specified in Annex 1 shall cease to be a member of the Trust. A member who moves from one such area to another shall continue to be a member but shall have a right to vote in any election of governors in accordance with the new area.

7.4 The minimum number of members in each Public Constituency is specified in Annex 1, and if the number of members does not equal or exceed the minimum the area shall not be treated as a Public Constituency for the purpose of electing governors.

8 Staff Constituencies

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust other than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided that they have exercised these functions continuously for a period of at least 12 months.

8.3 Individuals eligible for membership of the Trust under this paragraph are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into 5 classes of individuals as set out in Annex 2

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2, and if the number of members in a class does not equal or exceed the minimum number that class shall not be treated as a class for the purpose of electing governors.

9 Automatic Membership by default – Staff

9.1 An individual who is:

9.1.1 Eligible under paragraph 8.1 to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency, shall become a member of the Staff Constituency and in the appropriate staff class without an application being made, unless they inform the Trust that they do not wish to do so.

10 Patients' Constituency

There is no Patients' Constituency

11 Restrictions on Membership

11.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while such membership continues be a member of any other constituency or class.

11.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any other constituency.

11.3 An individual must be at least 16 years old to become a member of the Trust.

11.4 An individual may not become or remain a member of the Trust if they have been convicted of any offence involving violent, threatening or abusive behaviour on Trust property or in connection with receiving services from the Trust.

11.5 A member of the Trust shall inform the Secretary of the Trust of any circumstances which may affect their entitlement to be a member.

11.6 Where the Trust has reason to believe that a person may be disqualified from becoming a member or no longer entitled to be a member, the Secretary may give the member 14 days written notice to show why he should not become or remain a member. On receipt of such response as may be made by the member, or failing any response, the Secretary may, if he considers it appropriate, refuse the application to become a member or remove the member from the register of members. If the person wishes to dispute a decision of the Secretary not to admit him to membership or to remove him, he may refer the issue to the Council of Governors, whose decision by a majority of the governors voting shall be final.

11.7 A member may resign by written notice to the Secretary of the Trust.

12 Annual Members' Meeting

12.1 The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public. This should be held no later than 30th September.

13 Council of Governors - Composition

13.1 The Trust is to have a Council of Governors comprising both elected and appointed governors.

13.2 The composition of the Council of Governors is specified in Annex 4.

13.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency or class is specified in Annex 4.

13.4 No person may stand for election as a governor or be appointed as a governor unless he will be at least 18 years old when he becomes a governor.

14 Council of Governors – Election of Governors

14.1 Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules current at the time of the election.

14.2 The Model Election Rules are those as published from time to time by the Department of Health, and form part of this Constitution. The Rules current at the time of the coming into effect of this constitution are set out in Annex 5.

14.3 A subsequent variation of the Model Election Rules by the Department of Health does not constitute an amendment of the constitution for the purpose of paragraph 48 hereof (amendment of the constitution).

14.4 An election, if contested, shall be by secret ballot.

14.5 In the event of an elected governor ceasing to hold office, if there are then more than 15 months of his term of office left after his resignation, ceasing to hold office or death, then an election shall be held for his replacement. The person elected shall hold office for the remainder of the period for which the governor he is replacing was last elected.

15 Council of Governors - Tenure

15.1 Subject to 14.5 and 15.2, an elected governor may hold office for a period of up to 3 years.

15.2 An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than 9 years in all.

15.3 An appointed governor may hold office for a period of up to 3 years and may then be re-appointed but shall not hold office for more than 9 years in all. He shall cease to hold office if his appointing organisation withdraws its appointment of him by notice in writing to the Trust or if the appointing organisation ceases to exist.

15.4 A governor may resign by giving notice in writing to the Chairman of the Trust.

15.5 In the event of an appointed governor ceasing to hold office, the body appointing him may make a further appointment.

15.6 The limits of 9 years in sub-paragraphs 15.2 and 15.3 shall in the case of an elected governor include any time served as an appointed governor, and in the case of an appointed governor include any time served as an elected governor.

16 Council of Governors – Disqualification and Termination of Office

16.1 The following may not stand for election or continue as a member of the Council of Governors:

16.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

16.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

16.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

16.1.4 The further persons set out in Annex 6.

16.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

16.3 If a governor fails to attend 3 consecutive scheduled meetings of the Council of Governors, he shall cease to be a governor unless a voting majority of the other governors are satisfied that:

16.3.1 the failure was in their opinion due to a reasonable cause or causes, and

16.3.2 he will be able to, and will, start attending meetings of the Council within such period as they consider reasonable.

16.4 A governor shall cease to be a governor if he is adjudged by not less than 75% of the remaining Council of Governors to have:

16.4.1 acted in a manner inconsistent with the core principles set out in the Trust's authorisation, or with the Constitution, or with the Code of Conduct, in such a way that he should cease to be a governor, or

16.4.2 failed to declare a material interest pursuant to paragraph 21 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

16.5 Where circumstances arise which give rise to an issue as to a governor's ability to remain a governor (other than those referred to in paragraphs 16.3 and 16.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

16.6 In the event of a notice being given under sub-paragraph 16.3 which states that the governor is not resigning, or where no such notice is received but circumstances as to a governor's ability to remain a governor (other than those set out in paragraphs 16.3 and 16.4 above) come to the notice of the Trust, the issue shall be considered by the other governors at a meeting and if 75% of the remaining Council of Governors consider that the governor is disqualified from continuing as a governor, he shall cease to be a governor.

16.7 A governor shall not exercise any function as a governor (including attending any meeting of the Council as a governor) if he has not signed and delivered to the Secretary a statement in the form required by the Council confirming that he accepts the Code of Conduct.

16.8 If a governor who is an employee of the Trust is suspended as an employee as a part of a disciplinary process, the Chairman of the Trust may suspend the governor from acting as a governor while the governor remains suspended as an employee.

17 Council of Governors – Duties of Governors, Equipping Governors, Lead Governor and Deputy Lead Governor

17.1 The general duties of the Council of Governors are–

17.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

17.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

17.2 The Trust must take steps to secure that the governors are equipped with the skills and with the knowledge that they require in their capacity as governors.

17.3 The governors shall choose a Lead Governor and a Deputy Lead Governor as set out in the Council's standing orders. The Lead Governor and the Deputy Lead Governor shall have the functions set out in the standing orders.

18 Council of Governors – Meetings of Governors

18.1 The Chairman of the Trust, that is the Chairman of the Board of Directors, or in his absence, the Deputy Chairman or, in his absence, the Lead Governor (or Deputy Lead Governor), shall preside at meetings of the Council of Governors.

18.2 Where it is inappropriate by reason of the subject matter of a meeting that it should be chaired by the Chairman, the Deputy Chairman may preside unless it is also inappropriate that the Deputy Chairman preside, in which case the Lead Governor or in his absence the Deputy Lead Governor may preside.

18.3 Meetings of the Council of Governors shall be open to members of the public, but the public may be excluded from all or any part of the meeting by resolution of the Council for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

18.4 The Council of Governors shall meet at least 4 times a year, including an annual meeting no later than 31 October when the Council shall receive and consider the annual accounts, any report of the Auditor on them, and the Trust's annual report. The meetings shall be called by the Secretary after consultation with the Lead Governor.

18.5 The Lead Governor (or in the case of the Lead Governor's unavailability the Deputy Lead Governor) or at least 10 governors may, by written notice to the Secretary stating the business to be considered, requisition a meeting of the Council, and the Secretary shall arrange for a meeting to be held as soon as practicable after notice has been given to the governors.

18.6 For the purpose of obtaining information about the Trust's performance of its functions or the directors performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18.7 The Council of Governors will establish statutory committees to carry out such functions as are required by law and to carry out such functions as the Council specifies.

18.8 The Council of Governors will establish working groups to carry out such functions as the Council specifies.

19 Council of Governors – Standing Orders

19.1 The Council of Governors shall adopt standing orders for the practice and procedure of the Council. Those in force as at the date of the adoption of this constitution are set out in Annex 7. They may be amended as provided in them.

20 Council of Governors – Referral to the Panel

20.1 In this paragraph the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

20.1.1 to act in accordance with its constitution, or

20.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

20.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

21 Council of Governors – Conflicts of Interest of Governors

21.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21.2 For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

22 Council of Governors – Travel Expenses

22.1 The members of the Council of Governors are not entitled to remuneration, but the Trust shall on application pay travelling and other expenses incurred by a member for the purpose of his duties at rates to be decided by the Trust.

23 Board of Directors – Composition

23.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 a maximum of 7 other non-executive directors

23.2.3 a maximum of 6 executive directors (subject to 23.4 below), to include:

23.2.4 a Chief Executive who shall be the Accounting officer,

23.2.5 a Finance Director.

23.3 One of the executive directors must be a qualified medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and one must be a registered nurse or midwife.

23.4 The number of non-executive directors including the Chairman must always exceed the number of executive directors. At any meeting where there is parity of non-executive and executive directors the Chairman, or in his absence the Deputy Chairman, shall have a casting vote.

23.5 Only a member of a public constituency or the patients' constituency is eligible for appointment as a non-executive Director.

24 Board of Directors – General Duty

24.1 The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25 Board of Directors – Appointment and Removal of Chairman and Non-executive Directors

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the Trust and the other non-executive directors.

25.2 Removal of the Chairman or any other non-executive director shall require the approval of 75% of the members of the Council of Governors.

25.3 The Standing Orders of the Council shall provide for nomination committees to identify appropriate candidates for appointment as Chairman and as non-executive directors.

26 Board of Directors – Deputy Chairman

26.1 After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chairman. The Deputy Chairman shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

27 Board of Directors – Appointment and Removal of the Chief Executive and Executive Directors

27.1 The non-executive directors shall appoint or remove the Chief Executive.

27.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

27.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

28 Board of Directors – Disqualification

28.1 The following may not be appointed or continue as a member of the Board of Directors:

28.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

28.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

28.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

28.1.4 The persons referred in Annex 9.

29 Board of Directors – Meetings

29.1 Before holding a meeting the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

29.2 As soon as practical after holding a meeting the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

29.3 Meetings of the Board of Directors shall be open to members of the public.

29.4 Members of the public may be excluded from all or any part of a meeting by a resolution of the Board for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings

30 Board of Directors – Standing Orders

30.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8. They may be amended as provided in them.

31 Board of Directors – Conflicts of Interest of Directors

31.1 The duties that a director of the Trust has by virtue of being a director include in particular–

31.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust;

31.1.2 a duty not to accept a benefit from a third party by reason of being a director or by reason of doing or not doing anything in that capacity.

31.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.4 In sub-paragraph 31.1.2 'third party' means a person other than the Trust or a person acting on its behalf.

31.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors before the Trust enters into the transaction or arrangement.

31.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

31.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

31.8 This paragraph does not require a declaration of an interest of which the director is not aware, or where the director is not aware of the transaction or arrangement in question.

31.9 A director need not declare an interest –

31.9.1 if it cannot be reasonably regarded as likely to give rise to a conflict of interest;

31.9.2 if, or to the extent that, the directors are already aware of it;

31.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered by a meeting of the Board of Directors, or by a committee of the directors appointed for the purpose under the constitution.

32 Board of Directors – Remuneration and Terms of Office

32.1 The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

32.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms of office, of the Chief Executive and the other executive directors.

32.3 The Chairman and other non-executive directors may be appointed for initial terms of up to 4 years, which may be renewed by the Council for a further term of up to 4 years, and may be renewed thereafter for such term, if any, as will bring the total length of service to 8 years. Where a director has served 8 years, his appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal.

33 Registers

33.1 The Trust shall have a register of members, showing in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which he belongs.

33.2 a register of members of the Council of Governors;

33.3 a register of interests of Governors;

33.4 a register of interests of directors;

33.5 and a register of directors.

34 Registers – Inspection and Copies

34.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out in the next sub-paragraph or as otherwise prescribed by regulations.

34.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:

34.2.1 any member of the Rest of England Constituency; or

34.2.2 any other member of the Trust, if the member so requests.

34.3 So far as the registers are required to be made available:

34.3.1 They are to be available for inspection free of charge at all reasonable times; and

34.3.2 A person who requests a copy or extract from the registers is to be provided with a copy or extract.

34.4 If the person requesting a copy or extract is not a member of the trust, the Trust may impose a reasonable charge for doing so.

35 Documents Available for Public Inspection

35.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

35.1.1 A copy of the current constitution;

35.1.2 A copy of the latest annual accounts and of any report of the auditor on them; and

35.1.3 A copy of the latest annual report

35.2 The Trust shall also make the following documents available for inspection by members of the public free of charge at all reasonable times:

35.2.1 A copy of any order made under section 65D (appointment of special trust administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

35.2.2 A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

35.2.3 A copy of any information published under section 65D (appointment of special trust administrator) of the 2006 Act;

35.2.4 A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

35.2.5 A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

35.2.6 A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

35.2.7 A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

35.2.8 A copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

35.2.9 A copy of any statement published under section 65J (power to extend time), or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

35.2.10 A copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

35.3 Any person who requests a copy or extract from any of the above documents is to be provided with a copy.

35.4 If the person requesting an extract or copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36 Auditor

36.1 The Trust shall have an auditor.

36.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council.

36.3 The auditor must be qualified to act as auditor in accordance with paragraph 23 of schedule 7 to the 2006 Act.

36.4 The auditor shall comply with schedule 10 of the 2006 Act and shall have the rights and powers there set out.

36.5 The Trust shall provide the auditor with every facility and all information which he may reasonably require for the purpose of his functions.

37 Audit Committee

37.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

38 Accounts

38.1 The Trust must keep proper accounts in such form as NHS Improvement may with the approval of the Treasury direct and proper records in relation to those accounts.

38.2 NHS Improvement may, with the approval of the Secretary of State for Health, give directions to the Trust as to the content and form of its accounts.

38.3 The accounts are to be audited by the Trust's auditor.

38.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

38.4.1 the accounts;

38.4.2 the records relating to them; and

38.4.3 any report of the Auditor on them

38.5 The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as NHS Improvement may with the approval of the Secretary of State for Health direct.

38.6 NHS Improvement may with the approval of the Secretary of State for Health direct the Trust:

38.6.1 to prepare accounts in respect of such period or periods as may be specified in the direction; and/or

38.6.2 that any accounts prepared by it by virtue of sub-paragraph 38.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

38.7 In preparing its annual accounts or in preparing any accounts by virtue of sub-paragraph 44.6.1 above, the Trust is to comply with any directions given by Monitor with the approval of the Secretary of State for Health as to:

38.7.1 the methods and principles according to which the annual accounts are to be prepared; and/or

38.7.2 the content and form of the annual accounts

38.8 The Trust must –

38.8.1 lay a copy of the annual accounts, and any report of the Auditor on them, before Parliament; and

38.8.2 send copies of the annual accounts, and any report of the Auditor on them to NHS Improvement within such a period as NHS Improvement may direct

38.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 38.6 above and a copy of any report of the Auditor to NHS Improvement within such a period as NHS Improvement may direct.

38.10 The functions of the Trust referred to in this paragraph 38 shall be delegated to the accounting officer.

39 Annual Report, Forward Plans and Non-NHS work

39.1 The Trust shall prepare an annual report and send it to NHS Improvement.

39.2 The annual report must give:

39.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and of the patients' constituency is representative of those eligible for membership

39.2.2 information on any occasions in the period to which the report relates on which the council of governors exercised its power to require one or more of the directors to attend a meeting as provided by paragraph 18.5 hereof

39.2.3 information on the corporation's policy on pay and on the work of the committee established under paragraph 32(2) hereof and such other procedures as the corporation has on pay

39.2.4 information on the remuneration of the directors and on the expenses of the governors and the directors

39.2.5 any other information that NHS Improvement or requires

39.3 The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement

39.4 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

39.5 In preparing the document, the directors shall have regard to the views of the governors, and the directors shall provide the governors with information appropriate for them to be able to form their views.

39.6 Each forward plan must include information about:

39.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

39.6.2 the income it expects to receive from doing so

39.7 Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 39.6.1, the Council of Governors must:

39.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

39.7.2 notify the directors of the Trust of its determination

39.8 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England, the Trust may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

40 Presentation of the Annual Accounts and Reports to the Governors and Members

40.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council:

40.1.1 the annual accounts

40.1.2 any report of the auditor on them

40.1.3 the annual report.

40.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

40.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 40.1 with the Annual Members' Meeting.

41 Instruments

41.1 The Trust shall have a seal.

41.2 The seal shall not be affixed except under the authority of the Board of Directors

42 Amendment of the Constitution

42.1 The Trust may make amendments of its constitution only if –

42.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

42.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments

42.2 Amendments made under paragraph 42.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result, not accord with Schedule 7 of the 2006 Act.

42.3 Where amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

42.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

42.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment

42.4 If more than half of the members voting approve the amendment, the amendment continues to have effect. Otherwise it ceases to have effect and the Trust must take such steps as are necessary as a result.

42.5 Amendments by the Trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

43 Mergers etc. and Significant Transactions

43.1 The Trust may only apply for a merger, acquisition, separation or dissolution, as referred to in sections 56,56A, 56B, and 57A of the 2006 Act with the approval of more than half of the members of the Council of Governors.

43.2 The Trust may only enter a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

43.3 A 'significant transaction' is a transaction which, if entered into by the Trust:

43.3.1 would increase or reduce the turn-over of the Trust (in a financial year relative to the previous financial year) by £20 million or by 10%, whichever is the greatest;

43.3.2 would involve a receipt of or capital expenditure of £10 million or more; in the case of expenditure, this is after the deduction of any grant or gift which specifically relates to the expenditure in question

43.3.3 would involve a service contract, asset rental or lease running for period of 3 years or more with a planned income or cost over its duration of £10 million or more

43.3.4 would be likely to put at risk the Trust's ability to provide its services as a whole, or a significant part of its services, to the appropriate regulatory standard;

43.3.5 would be likely to put at risk the Trust's ability to maintain the minimum required financial risk rating/ continuity of service risk rating

43.3.6 Where it might reasonably be considered that a transaction falls within paragraph 43.3 the Board shall inform the Council of the transaction at the earliest opportunity

43.3.7 The Board shall in any event inform the Council of a transaction which it is considering and which may involve a sum which is greater than 2% of the Trust's income in the previous year, but the Board need not so inform the Council of any such transaction if the transaction has been clearly identified in the Annual Estimate, the Capital Programme or the Annual Plan

43.4 In deciding whether to approve a proposed significant transaction the Council will:

43.4.1 act in accordance with its judgment of the best interests of the Trust; and

43.4.2 have regard to the risks the transaction might entail and the adequacy of steps proposed to mitigate those risks, and to the risks which not entering into the transaction might entail

43.5 If the Council votes not to approve a significant transaction, the reasons advanced in the course of the Council's discussion of the transaction for and against approval shall be recorded in the minutes.

43.6 The Board shall inform the Council of transactions not featuring in the annual estimates, capital programme or annual plan for the year which the Board is considering which involve a sum which is greater than 2% of the Trust's income or capital in the previous year.

44 Indemnity

44.1 Members of the Council of Governors and of the Board of Directors who act honestly and in good faith will be indemnified by the Trust against any civil liability which is incurred in the execution or purported execution of their functions relating to the Trust, save where they have acted recklessly. The Trust shall take out insurance against liability under this indemnity.

45 Dispute Resolution

45.1 In the event of a dispute arising between the Board of Directors and the Council, the Chairman shall take the advice of the Secretary and such other advice as he sees fit, and he shall confer with the Vice-Chairman and the Lead Governor and shall seek to resolve the dispute.

45.2 If the Chairman is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

45.3 If the dispute is not resolved, the Chairman may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
Salisbury City	3	50
South Wiltshire Rural	6	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area formerly covered by North Dorset District Council, comprising the following electoral wards: ▪ Beacon ▪ Blandford ▪ Cranborne Chase ▪ Gillingham ▪ Hill Forts & Upper Tarrants ▪ Shaftesbury Town ▪ Stalbridge & Marnhull (Marnhull parish) ▪ Sturminster Newton
Kennet	The area formerly covered by Kennet District Council comprising the following electoral wards: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South • Ludgershall & Perham Down • Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke • The Collingbournes & Netheravon • Tidworth • Urchfont & The Cannings

New Forest	The following electoral wards within New Forest District Council: ▪ Downlands & Forest ▪ Fordingbridge ▪ Forest North West ▪ Ringwood East & Sopley ▪ Ringwood North ▪ Ringwood South
Salisbury City	The following electoral wards formerly covered by Salisbury District Council: • Salisbury Bemerton • Salisbury Fisherton & Bemerton Village • Salisbury Harnham • Salisbury St. Edmund's & Milford • Salisbury St. Francis & Stratford • Salisbury St. Marks & Bishopdown • Salisbury St. Martin's & Cathedral • Salisbury St. Paul's
South Wiltshire Rural	The following electoral wards • Alderbury & Whiteparish • Amesbury East • Amesbury West • Bourne & Woodford Valley • Bulford, Allington & Figheldean • Downton & Ebble Valley • Durrington & Larkhill • Ethandune • Fovant & Chalke Valley • Laverstock, Ford & Old Sarum • Mere • Nadder & East Knoyle • Redlynch & Landford • Till & Wylye Valley • Tisbury • Warminster Broadway • Warminster Copheap & Wylye • Warminster East • Warminster West • Warminster Without • Westbury East • Westbury North • Westbury West • Wilton & Lower Wylye Valley • Winterslow

East Dorset	The following electoral wards within the area formerly covered by East Dorset District Council: • Cranborne & Alderholt • St. Leonards & St. Ives • Stour & Allen Vale (Horton, Holt, Hinton, & Charbury parishes • Verwood • West Moors & Three Legged Cross
Rest of England	All other areas of England not covered above

ANNEX 2 – THE STAFF CONSTITUENCY

(See paragraph 8)

The Staff Constituency is divided into 5 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUB GROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries Health Care Assistants (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers Orthoptists Physiotherapists and Helpers Art/Music/Drama Therapists Speech and Language Therapists and Helpers Psychologists and Psychology Technicians Psychotherapists Medical Physicists and Technicians Pharmacists and Pharmacy Technicians Dental Technicians Operating Department Practitioners Social Workers Chaplains Clinical Scientists Biomedical Scientists and Technical Staff Geneticists and Technicians Audiology Staff Cardiographers and Support Staff
Administrative, Facilities and Managerial Staff	Ancillary Staff Works and Maintenance Staff Ambulance Staff
Voluntary Staff	

1. The minimum number of members of each class shall be 10.
2. The Secretary to the Trust shall assign persons to the classes set out above in accordance with the groups set out by each. In case of any difficulty the Secretary shall have discretion to allocate the person to the class which is in his opinion the most appropriate.
3. The Secretary shall maintain a register of volunteer schemes designated for the purposes of membership of the Trust.
4. A volunteer is a person who carries out functions on behalf of the Trust on a voluntary basis under a scheme on the register referred to in paragraph 4 above.
5. Where a person is eligible to be included both in the volunteers class and another class, the Secretary shall assign the person to that other class.

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

(See paragraph 13)

1. There shall be 15 public governors as set out in Annex 1.
2. There shall be 5 staff governors, one to be elected by the members of each class set out in Annex 2 from the members of the class in question.
3. Wiltshire Council may appoint one governor by notice in writing signed by the senior executive of the Council.
4. There shall be one governor appointed by Wessex Community Action.
5. The following Clinical Commissioning Groups may each appoint one governor.
    a. Bath and North-East Somerset, Swindon and Wiltshire (BSW)
    b. Dorset
    c. West Hampshire

6. There shall be one governor appointed by the Commander of 1 Artillery Brigade or the Officer holding a position nearest to that position to represent local army interests

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

PART 1: INTERPRETATION

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PART 3: RETURNING OFFICER

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9. Nomination of candidates
10. Candidate's particulars
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13. Signature of candidate
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20. The ballot paper
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The poll

27. Eligibility to vote
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29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)

33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
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FPP59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

Publicity

63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"***corporation***" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:
- **a)** a Saturday or Sunday;
- **b)** Christmas day, Good Friday, or a bank holiday, or
- **c)** a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

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4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:
- (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
- (b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:
- (a) the constituency, or class within a constituency, for which the election is being held,
- (b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
- (c) the details of any nomination committee that has been established by the corporation,
- (d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation,
but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:
(a) full name,
(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:
(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party,
and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:
(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after

publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge**.**

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:
(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or
(ii) to whom the voter ID number contained within the e-voting information was allocated,
(b) that he or she has not marked or returned any other voting information in the election, and
(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
(d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or
(b) only be sent e-voting information; or
(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
  (i) enter his or her voter ID number; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;
  in order to be able to cast his or her vote;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
  (v) instructions on how to vote and how to make a declaration of identity,
  (vi) the date and time of the close of the poll, and
  (vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
  (i) the voter’s voter ID number;
  (ii) the voter’s declaration of identity (where required);
  (iii) the candidate or candidates for whom the voter has voted; and
  (iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to
  (i) enter his or her voter ID number in order to be able to cast his or her vote; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may

apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election,

notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she

wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified

documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:
(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote

inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

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41. -[NOT USED]

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

PP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified

except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

[PARAGRAPHS 45-50 NOT USED]

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who he or she has declared elected:
  (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
  (ii) in any other case, to the chairman of the corporation; and
(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are

forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

F**PP59.3** Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:
(a) account and record the number of ballot papers, internet voting records, t telephone voting records and text voting records that have been received,
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:
(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS - DISQUALIFICATION

(See paragraph 16)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation;
2. A person who is disqualified from being a company director under the laws of England and/or Wales;
3. A person who is a director of the Trust, or a governor, director, Chairman or chief executive of another NHS Foundation Trust or NHS Trust; However, a governor (other than the lead governor) may be a governor or non-executive director (other than chairman) of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two governorships or directorship and governorship;
4. A person whose physical or mental wellbeing is such that their ability to act as a governor of the Trust is materially affected;
5. A person who occupies the same household as an existing governor or a director of the Trust;
6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election, or becomes employed by the Trust;
7. A person who has had his name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list and, due to the reason(s) for such removal, he is considered by the Trust to be unsuitable to be a Governor.

ANNEX 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(See paragraph 19)

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1. Introduction

1.1 Paragraph 14 of Schedule 7 to the National Health Service Act 2006 provides that the constitution of an NHS foundation trust must make provision for the practice and procedure of the Council of Governors. The Council made such provision in its standing orders adopted in 2006. Paragraph 3.13 of those orders provided that they might be amended as there set out. At a meeting of the Council on 25 February 2013 in accordance with paragraph 3.13, these standing orders as set out herein were adopted in substitution of those orders.

2. Interpretation

2.1 The expressions and terms used herein shall have the same meaning as in the Trust's Constitution.

2.2 'The Constitution' means the constitution of the Trust.

2.3 'The Council' means the Council of Governors.

2.4 A 'motion' means a formal proposition to be considered and voted on at a meeting of the Council.

2.5 An 'item for the agenda' means a matter to be considered at a meeting of the Council.

2.6 'The Secretary' means the person appointed as the Secretary to the Trust.

3. Meetings of the Council

3.1 Paragraph 18.3 of the Constitution provides that meetings of the Council shall be open to members of the public but that the public may be excluded as there set out.

3.2 The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given

3.3 If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4 Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5 Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. Agenda Items and Motions

4.1 Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor.

4.2 A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second the motion, and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chairman of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3 A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the chairman of the meeting.

4.4 No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chairman of the Trust.

4.5 The proposer of a motion shall propose it and shall have a right to speak before a

vote is taken.

4.6 During the consideration of a motion a governor may move:

4.6.1 an amendment to the motion;

4.6.2 that the consideration of motion be adjourned to a subsequent meeting;

4.6.3 that the motion be summarily dismissed and the meeting to proceed to the next business;

4.6.4 that the motion be voted on immediately.

4.7 No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the chairman of the meeting.

4.8 Save where the chairman of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. Quorum

5.1 No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. Relevance and Concision

6.1 Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2 The chairman of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3 In any matter relating to the interpretation of the Constitution and Standing Orders the chairman of the meeting shall consider the advice of the Secretary.

7. Voting

7.1 Save where it is otherwise provided by the constitution or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2 In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3 At the discretion of the chairman of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4 Save in the case of a secret paper ballot, if at least one third of the governors present request, the voting for and against of each governor shall be minuted.

7.5 If a governor requests, his vote shall be minuted.

7.6 No one may vote unless physically present: there shall be no votes by proxy.

8. Minutes

8.1 Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting.

8.2 The minutes shall record the names of those attending.

9. Suspension of Standing Orders

9.1 Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the chairman of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2 A decision to suspend standing orders shall be recorded in the minutes.

9.3 A separate record of matters while the orders were suspended shall be made, and shall be provided to the governors with the minutes.

10. Committees

10.1 The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2 The powers of the Council may be delegated to a committee for a specific purpose if

the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3 The powers of the Council shall be exercised in general meeting.

10.4 The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the committee on such terms as the Council may determine.

10.5 Meetings of the Council's committees, sub-committees and working groups shall be private. Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. Nominations Committee

11.1 Paragraph 27 of the Constitution provides for the appointment and removal of the Chairman of the Trust and the other non-executive directors by the Council. Paragraph 27.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2 For the appointment of the Chairman, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director

11.3 For the appointment of non-executive directors, the Nominations Committee shall consist of:

- the Chairman (or, at the Chairman's request the Deputy Chairman)
- 2 public governors
- 1 staff governor
- 1 appointed governor
- the Chief Executive.

11.4 When the formation of a Nomination committee is required the Secretary shall:

11.4.1 ask governors to put themselves forward as members within 10 days of his request, and if more governors put themselves forward than are places for particular categories of governor shall conduct an election or elections for each category with each governor having one vote in respect of each governor place on the committee;

11.4.2 In the case of a nomination for Chairman invite the non-executive directors to appoint a non-executive director to serve on the committee.

11.5 If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. Declarations and Register of Interests

12.1 Paragraph 21 of the Constitution provides for declarations of interest. It states:

21.1 *If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.*

21.2. *For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question*.

12.2 Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3 If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4 Subject to the exceptions below, material interests include:

12.4.1 any directorship of a company;

12.4.2 any interest held in any firm, company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3 any interest in an organisation providing health and social care services to the National Health Service;

12.4.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

12.4.5 any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter before the Council fairly.

12.5 The exceptions are:

12.5.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

12.5.2 an employment contract with the Trust held by a staff governor;

12.5.3 an employment contract held with the appointing body by an appointed governor;

12.6 If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7 The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting

12.8 The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9 If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the chairman of the meeting shall rule on the question having taken the advice of the Secretary.

12.10 A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11 A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 16.4 of the Constitution.

13. Code of Conduct

13.1 Governors shall agree to, and shall upon appointment sign a copy of, the Code of Conduct set out in the Appendix to these orders, and shall at all times comply with the Code.

14. Confidentiality

14.1 It is the duty of a governor not to divulge any information which he receives in confidence, whether that confidence is expressed or arises from circumstances relating to the information.

14.2 Governors must keep secure all confidential matter recorded on paper or electronically, and must ensure that their NHS mail and forum details are not disclosed.

14.3 Agendas and minutes and information relating to those parts of meetings of the Board of Directors, or of meetings of the Council, which are not open to the public, are confidential.

14.4 The proceedings of committees and working groups which take place in private are confidential until reported to the Council at a meeting open to the public.

14.5 A governor should keep confidential any information which may come into his possession concerning a patient, a person associated with a patient, or a member of staff or a person associated with a member of staff, unless the information has entered the public domain.

14.6 Any matter which the Council has resolved shall be treated as confidential shall be so treated.

15. Expenses

15.1 Paragraph 22 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2 Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3 The total of the expenses paid to governors will be published in the Annual Report.

16. Lead and Deputy Lead Governor's Appointment

16.1 The Lead Governor and the Deputy Lead Governor must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.
b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.
c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead

Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. Lead Governor and Deputy Lead Governor – Roles

17.1 The role of the Lead Governor is:

17.1.1 to chair meetings of the Council which cannot for any reason be chaired by the Chairman or the Deputy Chairman;

17.1.2 to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chairman;

17.1.3 to communicate regularly with the Chairman, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4 to be a point of contact for NHS Improvement when appropriate;

17.1.5 to provide input into the appraisal of the Chairman;

17.1.6 to take an active role in the activities of the Council;

17.1.7 to be a point of contact for governors when they have concerns;

17.2 The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. Lead and Deputy Lead Governors – Vote of No Confidence

18.1 If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor and present it to the Chairman, the Chairman shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2 The Chairman will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting

18.3 The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4 At the meeting the Chairman will present the reasons for the motion and it will be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5 A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governor's present support the motion, then the Lead Governor (or Deputy Lead Governor) shall stand down.

18.6 A Lead Governor or a Deputy Lead Governor against whom a motion of no confidence succeeds shall not be eligible to be Lead Governor or Deputy Lead Governor for 2 years.

19. Directors' Attendance

19.1 Paragraph 18.6 of the Constitution provides that the Council may require the attendance of one or more of the directors to attend a meeting for the purposes set out in the paragraph, which include the purpose of obtaining information about the Trust's performance of its functions.

19.2 The attendance of a director pursuant to paragraph 18.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chairman. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. Forward Plan

20.1 Paragraph 39.5 of the Constitution provides that in preparing the Trust's forward plan the directors must have regard to the views of the governors, and that the directors shall provide the governors with information appropriate for them to be able to form their views.

20.2 The Trust's Strategic Development Working Group shall consider aspects of the proposed plan as they become available.

20.3 The proposed plan shall be considered at a joint meeting of the directors and the governors. It shall be provided to the governors, with the information required to form their views, in good time, at least 7 days, for the governors to consider it in advance of the meeting

21. Amendment of Standing Orders

21.1 Paragraph 19.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders.

21.2 The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors).

21.3 No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included but which has been altered at the meeting.

APPENDIX 7.1

CODE OF CONDUCT

Governors will:

1. Actively support the purpose and aims of Salisbury NHS Foundation Trust;
2. Act in the best interests of the Trust at all times, with integrity and objectivity, recognising the need for corporate responsibility, without expectation of personal benefit;
3. Contribute to the work of the Council of Governors so it may fulfil its role, in particular attending meetings of the Council and training events, serving on the committees and working groups of the Council, and attending members meetings, on a regular basis;
4. Recognise that the Council exercises collective decision-making on behalf of patients, public and staff;
5. Acknowledge that, other than when carrying out their duties as governors, they have no rights or privileges different from other members of the Trust;
6. Recognise that the Council has no managerial role within the Trust other than as provided by statute;
7. Respect the confidentiality of all confidential information received by them as governors as more particularly set out in paragraph 15 of the Council's Standing orders;
8. Conduct themselves in a manner to reflect positively on the Trust and not to conduct themselves so as to reflect badly on the Trust;
9. Recognise that the Trust is a non-political organisation;
10. Recognise that they are not, save in the case of appointed governors and their appointing body, representing any trade union, political party or other organisation to which they may belong, or its views, but are representing the constituency which elected them;
11. Seek to ensure that no one is discriminated against because of their religion, race, colour, gender, marital status, sexual orientation, age, social or economic status, or national origin;
12. Comply with the Council's Standing Orders;
13. Not make, or permit to be made, any statement concerning the Trust which they know or suspect to be untrue or misleading;
14. Recognise the need for great care in making public pronouncements, in particular any statement to the media, and will recognise the harm that ill-judged statements can cause to the Trust and to the patients and public the Trust and its governors serve. To this end:
    a) advice of the Trust's press officer and of the Lead Governor, and take their observations into account;
    b) any request by the media for comment should be forwarded to the Trust's press officer;
    c) if a governor considers that a media story requires a response, he will communicate his concern to the Lead Governor and the Trust's press officer rather than responding himself;
    d) it is not the role of a governor to speak in public on operational matters or matters concerning individual patients or staff;
15. Uphold the seven principles of public life as set out by the Nolan Committee, namely:

Selflessness:

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity:

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity:
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability:
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness:
Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty:
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership:
Holders of public office should promote and support these principles by leadership and example

Governor's undertaking

I,_____, of , undertake as a Governor of Salisbury NHS Foundation Trust to abide by the above Code of Conduct including the obligations as to confidentiality and as to dealing with the media there set out.

Signed:_____ Date:_____

ANNEX 8 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(see paragraph 30)

1. INTERPRETATIONS AND DEFINITIONS

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3. Any expression to which a meaning is given in the Health and Social Care Act 2012, or any legislation or any regulations made under this Act, shall have the same meaning in these standing orders and in addition:

1.3.1 **"Accounting officer"** means the person responsible and accountable for funds trusted to the Trust. The Officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, this shall be the Chief Executive;

1.3.2 **"Board"** means the Board of Directors, consisting of the Chairman, the independent non-executive directors and the executive directors;

1.3.3 **"Audit Committee"** means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework;

1.3.4 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources;

1.3.5 **"Committee"** means a committee or sub-committee appointed by the Trust;

1.3.6 **"Committee Members"** shall be persons formally appointed by the Trust to sit on or to chair specific committees;

1.3.7 **"Contracting and Procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets;

1.3.8 **"Council"** means the Council of Governors, formally constituted in accordance with the constitution and presided over by the Chairman;

1.3.9 **"Director of Finance"** means the chief financial officer of the Trust;

1.3.10 **"Executive Director"** means a member of the board who is an officer of the Trust;

1.3.11 **"Motion"** means a formal proposition to be discussed and voted on during the course of a meeting;

1.3.12 **"Nominated Officer"** means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

1.3.13 **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

1.3.14 **"SFIs"** means standing financial instructions;

1.3.15 **"SOs"** means Standing Orders.

1.3.16 **"Trust"** means Salisbury NHS Foundation Trust

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP AND ROLE OF MEMBERS

2.1 Composition of the Board of Directors

The composition of the Board of Directors shall be in accordance with paragraph 23 of the Constitution.

2.2 Role of Members of the Board of Directors

The Board of Directors will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal members. Their role will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. The Director of Finance shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however; exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair

The Chair shall be responsible for the operation of the Board of Directors and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of employment and with these Standing Orders.

The Chair shall take responsibility either directly, or indirectly, for the induction, portfolios of interests and assignments, and the performance of Non-Executive Directors.

The Chair shall work in close conjunction with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the discussion and ultimate resolutions.

Senior Independent Director

The Board of Directors should in consultation with the Council of Governors, appoint a Non-Executive Director to be the Senior Independent Director. Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board of Directors may thereupon, in consultation with the Council of Governors, appoint another Non-Executive Director as Senior Independent Director.

2.3 Corporate role of the Board of Directors.

2.3.1 All business shall be conducted in the name of the Trust.

2.3.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3.3 The powers of the Trust established under statute shall be exercised by the Board except as otherwise provided for under Section 4 of this annex.

2.3.4 The Board has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters reserved to the Board' and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 Admission of the Public and the Press

3.1.1 The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.1.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Vice Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

3.2 Observers at Board Meetings

3.2.1 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.2.2 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

3.3 Calling of Meetings

3.3.1 Ordinary meetings of the Board shall be held at such times and places as the Board determines. Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board of Directors so resolves for special reasons.

3.3.2 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings

3.4.1 Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear days before the meeting.

3.4.2 In the case of a meeting called by Directors in default of the Chair, the notice shall

be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.10 below

3.4.3 Agendas will normally be sent to members of the Board seven calendar days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than five clear days before the meeting, save in emergency.

3.4.4 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least five clear days before the meeting.

3.5 Agendas and supporting papers

3.5.1 The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 12 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.7 Chair of Meeting

3.7.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and he/she is present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, then the remaining non-executive directors present shall choose which non-executive director shall preside.

3.8 Notices of Motion

3.8.1 A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 12 clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chairman shall include in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. This Standing Order 3.8.1 shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda.

3.8.2 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.8.3 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he/she considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Motions – procedure at and during meetings

3.9.1 Who may propose?

A motion may be proposed by the Chair or any Director present at the meeting. Such motion must also be seconded by another Director.

3.9.2 Contents of Motions

The Chair may (at his discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.8, other than a motion relating to:

(a) the reception of a report;
(b) consideration of any item of business before the Trust Board;
(c) the accuracy of minutes;
(d) that the Board proceed to next business;
(e) that the Board adjourn;
(f) that the question be now put.

3.9.3 Amendments to Motions

A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.9.4 Rights of reply to motions

Amendments: The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Original motion: The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9.5 Motions Once Under Debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put;
- that a Director be not further heard;
- a motion resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.10 Emergency Motions

Subject to the agreement of the Chair and SO 3.9 above, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.11 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matter shall be final.

3.12 Voting

3.12.1 Save as provided in SO 3.15 Suspension of Standing Orders, every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.12.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.12.4 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.14 Quorum

3.14.1 The quorum of a meeting will be at least half of the whole number of members of the Board of Directors (including at least one Non-Executive Director and one Executive Director).

3.14.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.14.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.15 Suspension of Standing Orders

3.15.1 Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present votes in favour of suspension.

3.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the

meeting.

3.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.15.4 No formal business may be transacted while Standing Orders are suspended.

3.15.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.16 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

4.6 Scheme of Delegation

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Discharge of the Direct Accountability

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or NHS Improvement requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by NHS Improvement), the Board of Directors may appoint committees of the Trust

5.2 Applicability of Standing Orders and Standing Financial Instructions to committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of Powers

The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute, or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.5

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.6 Approval of appointments to committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory Functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.8 Committees established by the Board of Directors

The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Disclosure of Interests

The Constitution, the 2006 Act and the Foundation Trust Code of Governance requires Board Directors to declare interests which are relevant and material to the NHS board of

which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 Declaring interests

6.3.1 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.3.2 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.3.3 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.3.4 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.

6.3.5 Financial Reporting Standard (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3.6 This standing order applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

6.4 Register of Interests

6.4.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

6.4.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.4.4 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their

respective Directors for clarification.

6.5 Exclusion of Chair and Members in proceedings on account of pecuniary interests

6.5.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.5.2 The Board of Directors may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

6.5.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.5.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 6.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7 STANDARDS OF BUSINESS CONDUCT POLICY

7.1 All staff and members must comply with the Trust's Standards of Business Conduct, the Regulatory Framework and the National guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff".

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

7.4 Canvassing of and Recommendations by, Directors in Relation to Appointments

7.4.1 Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 7 shall be included in application forms or otherwise brought to the attention of candidates.

7.4.2 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 7 shall not preclude a Director from giving written testimonial of a

candidate's ability, experience or character for submission to the Trust.

7.4.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 Relatives of Directors or Officers

7.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

7.5.2 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.5.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8 CUSTODY OF SEAL, SEALING OF DOCUMENTS ANDSIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

8.2 Sealing of Documents

8.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Trust Secretary; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

8.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly.

(The report shall contain details of the seal number, a description of the document and the date of sealing).

8.4 Signature of documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

ANNEX 9 – Additional Provisions - Directors – DISQUALIFICATION

(See Paragraph 28)

The following may not be appointed or continue as a director:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the law of England and/or Wales.
3. A person who is a governor of the Trust, or a governor, director, chairman or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the chairman) may be a non-executive director or a governor of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two directorships or directorship and governorship.
4. A person whose physical or mental wellbeing is such that their ability to act as a director of the Trust is materially affected.
5. A person who occupies the same household as an existing director of the Trust or a governor.
6. A person who has had their name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list and, due to the reasons(s) for such removal, they are considered by the Trust to be unsuitable to be a Director.